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Effects of Domestic Violence on Children and Adolescents: An Overview

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I. What Is Domestic Violence?

In the past two decades, there has been growing recognition of the prevalence of domestic violence in our society. Moreover, it has become apparent that some individuals are at greater risk for victimization than others. Domestic violence has adverse effects on individuals, families, and society in general.

Domestic violence includes physical abuse, sexual abuse, psychological abuse, and abuse to property and pets (Ganley, 1989). Exposure to this form of violence has considerable potential to be perceived as life-threatening by those victimized and can leave them with a sense of vulnerability, helplessness, and in extreme cases, horror. Physical abuse refers to any behavior that involves the intentional use of force against the body of another person that risks physical injury, harm, and/or pain (Dutton, 1992). Physical abuse includes pushing, hitting, slapping, choking, using an object to hit, twisting of a body part, forcing the ingestion of an unwanted substance, and use of a weapon. Sexual abuse is defined as any unwanted sexual intimacy forced on one individual by another. It may include oral, anal, or vaginal stimulation or penetration, forced nudity, forced exposure to sexually explicit material or activity, or any other unwanted sexual activity (Dutton, 1994). Compliance may be obtained through actual or threatened physical force or through some other form of coercion. Psychological abuse may include derogatory statements or threats of further abuse (e.g., threats of being killed by another individual). It may also involve isolation, economic threats, and emotional abuse.

II. Prevalence of Domestic Violence

Domestic violence is widespread and occurs among all socioeconomic groups. In a national survey of over 6,000 American families, it was estimated that between 53% and 70% of male batterers (i.e., they assaulted their wives) also frequently abused their children (Straus & Gelles, 1990). Other research suggests that women who have been hit by their husbands were twice as likely as other women to abuse a child (CWP, 1995).

Over 3 million children are at risk of exposure to parental violence each year (Carlson, 1984). Children from homes where domestic violence occurs are physically or sexually abused and/or

seriously neglected at a rate 15 times the national average (McKay, 1994). Approximately, 45% to 70% of battered women in shelters have reported the presence of child abuse in their home (Meichenbaum, 1994). About two-thirds of abused children are being parented by battered women (McKay, 1994). Of the abused children, they are three times more likely to have been abused by their fathers.

Studies of the incidence of physical and sexual violence in the lives of children suggest that this form of violence can be viewed as a serious public health problem. State agencies reported approximately 211,000 confirmed cases of child physical abuse and 128,000 cases of child sexual abuse in 1992. At least 1,200 children died as a result of maltreatment. It has been estimated that about 1 in 5 female children and 1 in 10 male children may experience sexual molestation (Regier & Cowdry, 1995).

III. Domestic Violence as a Cause of Traumatic Stress

As the incidence of interpersonal violence grows in our society, so does the need for investigation of the cognitive, emotional and behavioral consequences produced by exposure to domestic violence, especially in children. Traumatic stress is produced by exposure to events that are so extreme or severe and threatening, that they demand extraordinary coping efforts. Such events are often unpredicted and uncontrollable. They overwhelm a person's sense of safety and security.

Terr (1991) has described "Type I" and "Type II" traumatic events. Traumatic exposure may take the form of single, short-term event (e.g., rape, assault, severe beating) and can be referred to as "Type I" trauma. Traumatic events can also involve repeated or prolonged exposure (e.g., chronic victimization such as child sexual abuse, battering); this is referred to as "Type II" trauma. Research suggests that this latter form of exposure tends to have greater impact on the individual's functioning. Domestic violence is typically ongoing and therefore, may fit the criteria for a Type II traumatic event.

With repeated exposure to traumatic events, a proportion of individuals may develop Posttraumatic Stress Disorder (PTSD). PTSD involves specific patterns of avoidance and hyperarousal. Individuals with PTSD may begin to organize their lives around their trauma. Although most people who suffer from PTSD (especially, in severe cases) have considerable interpersonal and academic/occupational problems, the degree to which symptoms of PTSD interfere with overall functioning varies a great deal from person to person.

The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV; APA, 1994) stipulates that in order for an individual to be diagnosed with posttraumatic stress disorder, he or she must have experienced or witnessed a life-threatening event and reacted with intense fear, helplessness, or horror. The traumatic event is persistently reexperienced (e.g., distressing recollections), there is persistent avoidance of stimuli associated with the trauma, and the victim experiences some form of hyperarousal (e.g., exaggerated startle response). These symptoms persist for more than one month and cause clinically significant impairment in daily functioning. When the disturbance lasts a minimum of two days and as long as four weeks from the traumatic event, Acute Stress Disorder may be a more accurate diagnosis.

It has been suggested that responses to traumatic experience(s) can be divided into at least four categories (for a complete review, see Meichenbaum, 1994). Emotional responses include shock, terror, guilt, horror, irritability, anxiety, hostility, and depression. Cognitive responses are reflected in significant concentration impairment, confusion, self-blame, intrusive thoughts about the traumatic experience(s) (also referred to as flashbacks), lowered self-efficacy, fears of losing control, and fear of reoccurrence of the trauma. Biologically-based responses involve sleep disturbance (i.e., insomnia), nightmares, an exaggerated startle response, and psychosomatic symptoms. Behavioral responses include avoidance, social withdrawal, interpersonal stress (decreased intimacy and lowered trust in others), and substance abuse. The process through which the individual has coped prior to the trauma is arrested; consequently, a sense of helplessness is often maintained (Foy, 1992).

IV. Possible Signs and Symptoms of Domestic Violence in Children and Adolescents

More than half of the school-age children in domestic violence shelters show clinical levels of anxiety or posttraumatic stress disorder (Graham-Bermann, 1994). Without treatment, these children are at significant risk for delinquency, substance abuse, school drop-out, and difficulties in their own relationships.

Children may exhibit a wide range of reactions to exposure to violence in their home. Younger children (e.g., preschool and kindergarten) oftentimes, do not understand the meaning of the abuse they observe and tend to believe that they "must have done something wrong." Self-blame can precipitate feelings of guilt, worry, and anxiety. It is important to consider that children, especially younger children, typically do not have the ability to adequately express their feelings verbally. Consequently, the manifestation of these emotions are often behavioral. Children may become withdrawn, non-verbal, and exhibit regressed behaviors such as clinging and whining. Eating and sleeping difficulty, concentration problems, generalized anxiety, and physical complaints (e.g., headaches) are all common.

Unlike younger children, the pre-adolescent child typically has greater ability to externalize negative emotions (i.e., to verbalize). In addition to symptoms commonly seen with childhood anxiety (e.g., sleep problems, eating disturbance, nightmares), victims within this age group may show a loss of interest in social activities, low self-concept, withdrawal or avoidance of peer relations, rebelliousness and oppositional-defiant behavior in the school setting. It is also common to observe temper tantrums, irritability, frequent fighting at school or between siblings, lashing out at objects, treating pets cruelly or abusively, threatening of peers or siblings with violence (e.g., "give me a pen or I will smack you"), and attempts to gain attention through hitting, kicking, or choking peers and/or family members. Incidentally, girls are more likely to exhibit withdrawal and unfortunately, run the risk of being "missed" as a child in need of support.

Adolescents are at risk of academic failure, school drop-out, delinquency, and substance abuse. Some investigators have suggested that a history of family violence or abuse is the most significant difference between delinquent and non delinquent youth. An estimated 1/5 to 1/3 of all teenagers who are involved in dating relationships are regularly abusing or being abused by their partners verbally, mentally, emotionally, sexually, and/or physically (SASS, 1996).

Between 30% and 50% of dating relationships can exhibit the same cycle of escalating violence as marital relationships (SASS, 1996).

V. Helping Children and Adolescents Exposed to Domestic Violence

For some children and adolescents, questions about home life may be difficult to answer, especially if the individual has been "warned" or threatened by a family member to refrain from "talking to strangers" about events that have taken place in the family. Referrals to the appropriate school personnel could be the first step in assisting the child or teen in need of support. When there is suggestion of domestic violence with a student, consider involving the school psychologist, social worker, guidance counselor and/or a school administrator (when indicated). Although the circumstances surrounding each case may vary, suspicion of child abuse is required to be reported to the local child protection agency by teachers and other school personnel. In some cases, a contact with the local police department may also be necessary. When in doubt, consult with school team members.

If the child expresses a desire to talk, provide them with an opportunity to express their thoughts and feelings. In addition to talking, they may be also encouraged to write in a journal, draw, or paint; these are all viable means for facilitating expression in younger children. Adolescents are typically more abstract in their thinking and generally have better developed verbal abilities than younger children. It could be helpful for adults who work with teenagers to encourage them to talk about their concerns without insisting on this expression. Listening in a warm, non-judgmental, and genuine manner is often comforting for victims and may be an important first step in their seeking further support. When appropriate, individual and/or group counseling should be considered at school if the individual is amenable. Referrals for counseling (e.g., family counseling) outside of the school should be made to the family as well. Providing a list of names and phone numbers to contact in case of a serious crisis can be helpful.

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