



National Center on Domestic
Violence, Trauma, and Mental Health

Family-Centered Toolkit for Domestic Violence Programs



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The National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) is one of four Special Issue Resource Centers funded by the U.S. Department of Health and Human Services, Administration for Children and Families, Family Violence Prevention and Services Program. NCDVTMH promotes survivor-defined healing, liberation, and equity by transforming the systems that impact survivors of domestic and sexual violence and their families. NCDVTMH enhances agency- and system-level responses to survivors and their families through comprehensive training and technical assistance, research and evaluation, policy development, and public awareness. Emphasizing an accessible, culturally responsive, and trauma-informed (ACRTI) approach, NCDVTMH offers training and consultation to domestic violence and sexual assault advocates, programs, and coalitions; healthcare, mental health, and substance use treatment providers; legal and child welfare professionals; and local, state, and federal policymakers. For more information, see www.nationalcenterdvtraumamh.org.

Acknowledgments

This toolkit has been a labor of friendship and brings together many years of working in the domestic violence field. Our inspiration for the toolkit came from survivors and their children whom we've been honored to know on their journeys toward safety and healing, and from the staff in programs across the country who are dedicated to supporting families affected by domestic violence.

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We hope this toolkit provides valuable resources and guidance for domestic violence advocates and program supervisors invested in providing integrated, family-centered services to survivors and their children.

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1. Introduction

Why this toolkit?

During the past 20 years, we've become more aware of the effects of intimate partner violence on the healthy development and well-being of children and youth, and how the primary relationships between protective caregivers and their children are often the greatest resource for fostering resilience and healing. We also know that the bonds between survivors and their children can be negatively affected by the experience of domestic violence; this includes power tactics used by abusive partners that can impact responsive caregiving by protective parents. Historically, domestic violence services have been separated into services for adult survivors and services for children, rather than taking a more integrated approach that centers the relationships between adult survivors and their children. We developed this toolkit to help programs envision and implement an integrated approach that supports parent-child relationships and families with a range of culturally responsive, trauma-informed, and developmentally sensitive services for adult survivors and their children.

The scope of this toolkit was shaped by domestic violence services programs and staff who identified complex needs and challenges in supporting families affected by domestic violence. It reflects the voices, stories, and perspectives of adult survivors and their children. The toolkit holds the complexity and diverse experiences and needs of families. The intent is to offer practice wisdom, knowledge, and

accessible resources to enhance and sustain family-centered services within domestic violence programs and organizations.

Format of the toolkit

The toolkit is organized into 13 sections, beginning with this introduction, moving through suggestions of how to build and sustain a family-centered domestic violence program, and ending with support around outcomes. Throughout the toolkit, more specific examples, ideas, and ways to build and embed an integrated approach are shared. The appendix provides references related to content within the toolkit.

Each section also includes guidance on critical conversations related to select topics; these team-based conversations are designed to further develop or enhance knowledge, skills, and organizational supports to build and sustain family-centered services. Most sections also include a vignette to further support those conversations. In addition, in each section, there are categories titled “*What can a direct staff person do?*” and “*What can a supervisor do?*” to offer guidance and suggestions for incorporating knowledge into practice and for supporting staff and programming in these areas. Throughout the toolkit, various topics are discussed with relevant online links for further exploration

and more in-depth information, including links to resources developed by the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH).

How to use this toolkit

This toolkit was developed to serve multiple audiences: for individuals seeking more information for general use or with a specific family or situation, for supervisors to prompt group discussions with staff, and for programs considering how to expand organizational capacity for enhancing family-centered services.

Defining what we mean when we say “family-centered, trauma-informed, and culturally responsive”

Let’s begin with a common understanding of what we mean when say that we are building and embedding “**family-centered, trauma-informed, culturally responsive**” services and programming into our organization to support resilience and healing. We recognize that each organization will have its own vision, mission, values, and unique aspects and challenges for serving families within your area; as a result,

being family-centered, trauma-informed, and culturally responsive may look and feel very different within and across communities.

WE OFFER THE FOLLOWING DEFINITIONS TO GET US STARTED:

Family-centered: Being family-centered encompasses a range of practices that embraces the whole family as defined by each individual and family for themselves. In some families that includes extended family members, grandparents, “aunties,” relatives, other trusted adults, and members within a community. The words “parent” and “caregiver” are used interchangeably throughout this toolkit. And “parent-child” or “caregiver-child” refers to attachment relationships between caregivers and their children that provide consistent nurturance, safety, and responsive caregiving. These relationships scaffold children’s ongoing, healthy development and well-being, and support healing and resilience.

Family-centered is also defined as a mindset that brings parent, child, and family into focus whether or not our roles are more narrowly defined within our program and organization as adult survivor-centered or child- and youth-focused. Being family-centered means that we are able to think about and take actions to support caregiver-child and family relationships.

Trauma-informed: When our work with families is trauma-informed, we recognize that experiencing domestic violence may have traumatic effects on adult survivors, their children, and their relationships with each other, as well as within their families and communities. We recognize that individuals within families may experience other forms of interpersonal violence and abuse that may include cumulative and intergenerational trauma that is collective, historical, and ongoing.

In being trauma-informed, we recognize that the relationships we form with caregivers and their children and families are at the heart of our work and help to support the process of healing and resilience.

As advocates, we can provide information about how domestic violence and other trauma can pose risks for children’s ongoing, healthy development, especially when these experiences are not moderated by protective factors, such as an enduring relationship with one or more nurturing, responsive parents or caregivers. We can also share information with caregivers, as well as other systems and people involved with the family, about how experiencing domestic violence and other trauma may affect children’s behavior, their capacity for self-regulation and learning, and how they relate to others at home, in school or childcare, and in the world at large.

Being trauma-informed also involves our awareness about the potential impact of our work on ourselves. When we have experienced domestic violence and other trauma as children or are adult survivors of childhood trauma, we may experience both empathy and challenges in working with families. We may find that we have strong responses, including our own trauma reminders, particularly when we see how domestic violence and abuse affect the safety and well-being of children. Given the nature of our work, all of us need organizational supports, such as consistent supervision or consultation, to attend to ourselves while helping others.

Trauma-informed organizations are grounded in an understanding of the pervasiveness and impact of trauma as well as a commitment to developing the knowledge, skills, and resources needed to minimize re-traumatization, to support healing and resilience, and to address the root causes of violence.

Culturally responsive: Culture impacts everything we do and think. Cultural influences come from our family systems, communities, and historical and collective experiences that impact what we bring to our own ideas of parenting, our biases, and expectations. When we are culturally responsive, we are considering how a



survivor's beliefs and values may inform their choices. Culturally responsive services honor and respect the survival, healing, and resiliency that is evidenced by survivors.

Culture impacts adults and their caregiving roles with children. Some communities have a complementary balance of responsibilities between partners, while others may hold to more distinct caregiving roles sometimes influenced by religious beliefs or gender roles. In some cultures, the term "*parent*" extends beyond the biological or adoptive "*mother*" or "*father*," with significant parenting roles assumed by community members. Culture includes socioeconomic status and employment and educational experiences that may also influence parenting and disciplining styles. When we are culturally responsive, we respect the values of each family and the unique ways in which they define what family means to them and how they relate.

Core beliefs on the family-centered perspective

Integrating a family-centered, trauma-informed, and culturally responsive approach allows us to view domestic violence survivors and their children holistically. This approach recognizes the innate resources for healing and resilience that we all have and that survivors and their children draw upon to survive and thrive.

Relationship-based work with survivors supports these capacities. We recognize that by embedding family-centered services into domestic violence programming, we are creating inclusive, healing environments for families. As service providers, this means meeting caregivers and families where they are and working from a true place of connection.

Benefits for families: Not long ago, children were viewed as secondary domestic violence victims, often called witnesses. We now have a greater understanding of how experiencing domestic violence and trauma directly affects children. An integrated approach

gives survivors and their children greater opportunities to understand and respond to the impact of trauma in their lives; to reconnect, strengthen, and support their relationships with each other; and to draw on their sources of resilience and reflect on their skills, strengths, and positive attributes for navigating challenges.

Benefits for staff: Domestic violence organizations can intentionally create working environments that support advocates' professional growth and well-being. Attention to the core values and philosophy of the organization, along with quality reflective supervision and generous benefits are ways that organizations can support their employees. Domestic violence direct service staff are likely to experience secondary trauma due to the intensity of their work and what it may evoke based on their own lived experiences. Secondary trauma (*also referred to as vicarious trauma*) is a term used to describe the impact of hearing and holding the experiences and stories of survivors and their families. Training new advocates can take months, so promoting their growth, success, and health is integral to building a sense of community and minimizing secondary trauma. Regular training, supervision, and time off helps sustain advocates, which in turn also benefits survivors and children.

Section 1: Resources and Links



Resources and links to further explore an integrated family-centered, trauma-informed, culturally responsive approach to serving domestic violence survivors and their children:

National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH): <http://www.nationalcenterdvtraumamh.org>

SAMHSA site on trauma-informed care:

<https://www.samhsa.gov/childrens-awareness-day/past-events/2017/child-traumatic-stress-resources>

The Trauma Stewardship Institute to explore the impact on domestic violence providers: <https://traumastewardship.com>

Futures Without Violence Culture Handbook: <http://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/Culture%20Handbook.pdf>

Promising Futures on Cultural Considerations: <http://promising.futureswithoutviolence.org/program-readiness/programpractices/cultural-considerations/>



SECTION TWO

2. Readiness and Getting Started

This section provides an overview of how organizations might begin the process of reviewing services with a family-centered lens and consider implementing a more integrated approach to services. This section introduces critical conversations, helpful suggestions for direct service staff and supervisors, and a vignette to support application of ideas.

Organizations serving domestic violence survivors and their children provide a wide variety of programming—everything from advocacy and safety planning, housing and job support, to counseling and support groups. When considering moving to a more family-centered focus, it is important to recognize that sometimes this shift is not always about adding more services but instead reimagining existing services and how they might transition to be more trauma-informed and family friendly. Some organizations might be newer to creating trauma-informed programming and can get support from the NCDVTMH’s resource on *Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations (ACRTI)*. (See <http://www.nationalcenterdvtraumamh.org/publications-products/tools-for-transformation-becoming-accessible-culturally-responsive-and-trauma-informed-organizations-an-organizational-reflection-toolkit/>).

In an effort to bring increased awareness to family-centered programming, it is important to engage the entire staff in discussions to assess if your organization is ready and interested in this change as well as making decisions about next steps in enhancing family-centered work.

Some initial steps:

Changing the ways organizations support families experiencing domestic violence takes a willingness to undergo self-assessment, constructive critique, and leadership to modify existing services and add new components.

A clear understanding of what services are supportive and which ones may re-traumatize is needed to begin assessing the current programming. Operationalizing a family-centered perspective into accessible, culturally responsive, and trauma-informed domestic violence services can be achieved by building relationships, creating safe environments, and improving empowerment, advocacy, crisis, and treatment services, as well as mental health and substance use support services. This shift can also be supportive to organizations engaged in looking at reducing shelter rules. For more information on rule reduction, see the Missouri Domestic Violence Coalition's helpful tool called "How the Earth Didn't Fly Into the Sun": <https://vawnet.org/material/how-earth-didnt-fly-sun-missouris-project-reduce-rules-domestic-violence-shelters>

Changing how the organization understands the service relationship is an aspect of shifting the paradigm and valuing the voices of domestic violence survivors and their children. Using a family-centered lens, domestic violence survivors and their children are provided individualized, supportive services including advocacy, case management, counseling, life skills, and safety planning. Collaboration with domestic violence survivors and their children is necessary to ensure that their choices and decisions are front and center during all aspects of service delivery.

It is important to consider all aspects of current programming and how children's and families' needs are recognized or perhaps not yet addressed. A first step might include considering current recruiting and hiring practices. Is a background in child development or work experience with children, parents, and families valued? Or are the hiring practices centered around an individual's work experience with adults? Another step may be to review current job descriptions to review explicitly stated expectations of working with both adults and children. Discussions with staff to assess their willingness to work with issues involving children, survivors as parents, and the family as a whole may also help illuminate the current capacity of the organization.



We envision the potential for positive transformation when organizations move toward a more family-centered philosophy guiding their services. This transformation will benefit not only survivors and their children but also direct service staff and managers. Organizations are wise to anticipate challenges that come during organizational changes. The first team-based activity is a guided conversation to begin addressing barriers related to providing family-centered services.

Another consideration might be to think about the organization's physical environment and whether there is suitable space for survivors and their children to connect and play. A next step might be to think through the process of crisis calls, intakes, assessments, service planning, and delivery, through transition and planning to end services and follow-up with a family-centered lens. By assessing the current practices, it can be easier to consider where changes are needed or where consideration for parents and their children may still be needed.

Critical Conversations



The following part offers opportunities for direct service staff and supervisors to engage in critical conversations and guide topics for further exploration, action, and reflection under “*What can a direct staff person do?*” and “*What can a supervisor do?*” We also offer a few team-based activities for consideration. Domestic violence organizations can use these critical conversation prompts and activities to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within their program and organization.

- How does the organization currently provide services to survivors and their children?
- Does the organization have a willingness to work with survivors and children as a family unit?
- Does the organization have job descriptions that describe family-centered work expectations?
- Does the organization have policies that articulate the importance of family-centered practices?
- Does the organization have the physical environment (*inside and outside*) to accommodate the needs of families?
- Are staff discussions (*informal or formal meetings*) generally focused on deficits in families, programming, and funding, or is there an attempt to focus on what is going well?

Helpful Hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing inclusive and compassionate policies within your program.



What can a direct staff person do?

- Develop and maintain a commitment to serving the family unit (*survivor and children*).
- Establish collaborative relationships with both the survivor and their children.
- When engaging with families and children, be genuine and verbalize their strengths, gifts, skills, and protective capacities.
- Maintain respect for the survivor as the expert on their children.
- Keep in mind that many families you work with have experienced multiple types of trauma, including events they may not share with you as well as ongoing stressors related to racism, oppression, and discrimination.
- Be intentional in your interactions with coworkers to actively point out survivors' and children's strengths and avoid participation in negative, deficit-focused discussions.
- Learn more about resiliency and strength-based perspectives.



What can a supervisor do?

- Support staff in developing their skills for supporting families through in-house trainings, webinars, or attendance at conferences and more in-depth external trainings.
- Invite conversations during team-based reviews on child and family status and supervision meetings that are family-centered and consider the complexity of the family's needs and the family's strengths.
- Consider how current organizational "rules" may restrict parenting practices.
- Consider the use of space and if needed, create suitable spaces inside and outside for families.
- Acknowledge negative, deficit-focused perspectives that staff may express, and introduce or amplify strengths-focused dialogue and reflection about survivors and their families, staff, and the organization.

Team-based activities:

Addressing barriers related to creating and sustaining family-centered services: A guided conversation on working with children, teens, and their caregivers

Our community acknowledges the complex needs of children and youth who are affected by domestic violence, and we strive to support families toward a path of well-being and healing. Despite this commitment, most programs continue to offer services for adult survivors that are separate from services for their children. As a result, services and programming for children and families continue to wax and wane with fluctuations in funding. Domestic violence advocates working with adult survivors generally address needs related to the adult survivor for legal, housing, job, and other assistance related to caring for themselves and their family. This guided conversation invites all staff to consider enlarging the lens to include supporting adult survivors in their role as parents and to consider developing more inclusive, family-centered programming and services for all.



One of the most significant barriers can be how staff feel and think about working with children and teens and survivors who are parents. They may also be holding strong beliefs, values, and attitudes about how domestic violence survivors are nurturing and responding to their children's needs in their role as parents.

In preparation for the conversation, we recommend that each staff person have some time to respond to this self-reflective survey:

Pre-conversation self-reflection survey:

- 1.** What drew you to this field and job?
- 2.** What do you think are your strengths and areas for growth as a service provider in this job?
- 3.** What life experiences have you had that help you understand survivors' and families' experiences?
- 4.** Are you comfortable working with young children, school-age children, and teens? If not, what do you see as the barriers both personally and professionally for you?
- 5.** Are you comfortable engaging and supporting caregivers who have experienced domestic violence in their parenting role? If not, what do you see as the barriers both personally and professionally for you?
- 6.** Do you feel comfortable talking about these items with peers on your team? With your supervisor? If not, what would you need in order to participate in an open dialogue?

Visioning activity for building and sustaining family-centered services:

Organizations may choose to do this activity in tandem with the conversation on barriers to moving toward family-centered services.

- Begin by mapping out what services are currently being offered in your program and organization using a family-centered lens.
- Discuss what our vision is for building and sustaining family-centered services.
- Draw a vision board to capture what these services might include (*e.g., playground area on the grounds, more parent-child counseling services, increased family group activities and family outings, animal-assisted programming, etc.*).
- Determine what resources it would take to meet our vision. These would include staff and volunteer, fund raising and donations, and staff training, ongoing consultation, and support.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions for what you can do.

June is a community-based domestic violence program supervisor. She has noticed over the past few years that she and the staff have implemented more and more “rules” for families to follow. These rules started out as guidelines to increase safety for everyone, but it seems like it might be creating some barriers for survivors and their children. June looked at the poster in the waiting area today that outlined the top 10 rules for families, including: Children must be with parents at ALL times. June wants to make some changes in her program and her director told her to “go for it,” but June isn’t really sure where to start and is concerned about pushback from some of the staff.



Things to consider:

- Sometimes staff and supervisors can be resistant to change. Consider initiating conversations regarding change as one way to help prepare everyone for possible program changes.
- Rules often are established out of concern for safety. What is most critical to maintaining safety and what might be eliminated?

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin with empathizing with staff concerns for safety, feelings of being overwhelmed, helplessness, or anger.
- Initiate the dialogues (*see “critical conversations” above*).
- Explore resistance to change.



Section 2: Resources and Links

ACRTI “Before You Get Started”: <http://www.nationalcenterdvtraumamh.org/publications-products/tools-for-transformation-becoming-accessible-culturally-responsive-and-trauma-informed-organizations-an-organizational-reflection-toolkit/>

“How the Earth Didn’t Fly Into the Sun,” a helpful tool from the Missouri Domestic Violence Coalition regarding rule reduction in shelters: <https://vawnet.org/material/how-earth-didnt-fly-sun-missouris-project-reduce-rules-domestic-violence-shelters>



3. Organizational Commitment and Infrastructure

This section offers an overview of ways to build infrastructure to support staff and maintain a family-centered approach. Some guidance and activities are offered for supporting our own well-being and resilience within our organizations. These include recognizing the impact of the work on each of us and understanding trauma-related responses that may arise as part of doing this work.

There are several resources available to organizations interested in assessing their current programs and considering implementation of more trauma-informed and family-focused services. These tools provide reflective questions that programs can ask themselves to initiate deeper conversations about overall philosophies with staff. It is important when considering assessing an organization that time and resources are committed to this process to ensure successful outcomes.

There may be different areas of your organization that require assessment. Consider using a family-centered lens when assessing current programs. When assessing programs, consider what it might be like to be a child or caregiver entering your organization. Although providing services to survivors (*i.e., orders of protection, counseling, and advocacy*) may positively impact their children, we know that engaging children and their caregivers together supports healing and resilience for all.

Sustaining a family-centered approach to services requires overall vision, leadership, and agency-wide commitment. When there are

transitions in leadership and staff who have championed this approach, we find that the organizational culture may shift, and agencies may find themselves back at “ground zero.” In considering sustainability, it’s wise to think about ways to “institutionalize” this approach into the fabric of the organization. This might include establishing an agency-wide committee that includes representation from leadership, the board, frontline staff, survivors, and youth and community partners from the public and private sectors. Some agencies have created manuals that are part of the onboarding process that include resources for sustaining family-centered and trauma-informed knowledge, skill sets, and resources. This toolkit could be adapted as a resource. Storytelling and documentation that reflects the journey toward family-centered services and measures the impact of these shifts can also be another powerful tool for sustaining change. This then becomes part of the agency’s organizational culture.

Personnel practices, policies and procedures, and training

All organizations have values and philosophies that guide their programs. Some agency policies and procedures have been around for years and may benefit from an in-depth

review. Others are more recently developed and clearly reflect the mission and vision of the program. Whatever the organization’s current situation, it is worth taking the time to review and reflect on the practices and policies to see if they represent how staff is ACTUALLY working with families engaged in their programs.

Employee development—training and supervision

Employee development is an integral part of maintaining a family-centered, trauma-informed, culturally responsive work environment. Once staff are hired, it is important that both internal and external training takes place. The initial training can include the philosophy of the organization and expectations of family-centered practices. Organizations can facilitate ongoing trainings that support all staff in developing skills and knowledge specific to the needs of families. Some topics might include: how to recognize the needs of the family, how best to work with families, how to engage with children, how to recognize the impact of domestic violence on the child, how to support survivors’ parenting, and how to support the relationship between the survivor and their children. Training is necessary for staff to feel confident in engaging and working with families.

An important part of preparing staff to deliver effective family-centered services is about the organization's commitment to providing ongoing, regularly occurring supervision; in doing so, this signals the value within the culture of the organization of promoting staff's own professional development, including knowledge and skills related to working with children, teens, and their caregivers. Supervision, in general, promotes accountability, provides clear expectations and resources for doing the work well, honors strengths and our lived experiences, and attends to the inherent disparities related to power, privilege, and oppression.

Reflective supervision promotes self-awareness, provides an opportunity to reflect on our own feelings and thoughts in doing the work, helps to expand our perspectives, and encourages a collaborative approach within a partnership that engenders empathy and allows us to pause and regain a state of more presence and connection with families.

Often staff can feel challenged in forming and sustaining meaningful relationships with families and may feel like “*nothing's*

working.” Reflective supervision is valuable because it's so common for us to feel “*stuck*” at some point during the process of engaging with families and, at times, less hopeful and more despairing about positive outcomes for families. Reflective supervision also recognizes and attends to the impact of trauma on families and in our own lives (*as these may intersect*). It allows us to relate with kindness, sensitivity, and culturally attuned awareness to the unique needs of each family without contributing to inadvertent re-traumatization or a sense of exclusion or alienation.

Supervisors also benefit from training and support in being able to offer reflective supervision to staff through both individual and team-based meetings. In doing an organizational self-assessment, we may find that the complex needs of the families served and the kinds of skill sets, knowledge, training, and level of comfort that supervisors bring in supporting staff to deliver child and family-centered services may not be enough. In those instances, many organizations have invested in hiring an outside consultant to support program staff in building capacity in this area.

Supervisors benefit from training on effective supervision, including trauma-informed, reflective practice. This training helps set the stage for supervisors to engage in dialogue with their staff about how the supervision

supports their work. Supervision for family-centered, trauma-informed, culturally responsive practices can help develop and support employees who may be challenged by the complexities that families affected by domestic violence, and other adversities, may be experiencing. Trauma-informed supervision is parallel to the principles of trauma-informed practices including safety, trustworthiness, choice, collaboration, and empowerment (SAMHSA, 2014). Initiating and maintaining a regular structure for supervision is vital to building capacity for reflection, skills, and knowledge, and it can mitigate the risks for vicarious traumatization and burnout. (See resources on reflective practice and supervision)

[\(Link to "Reflection Supervision in Domestic Violence Programs" Handout\)](#)

Survivors working as advocates and volunteers bring personal experiences that enhance their understanding of the challenges of domestic violence. Advocacy is powerful work, and it is important to recognize the potential for survivors working as advocates to be re-traumatized. Ensuring that organizational supports, including quality supervision, creating a caring peer community within the agency and program, and practicing self-care can help minimize re-traumatization for all advocates.

Guidelines related to hiring volunteers for working with children and families and offering mentoring and enrichment opportunities

Volunteers need to know what to expect from their volunteer experience and have a clear understanding of what the organization expects of them. Volunteers benefit from trainings provided by the organization regarding domestic violence and the impact on children and adult survivors. It can be helpful to volunteers to include them in the trainings provided to employees to ensure consistency in general knowledge and responses.

Volunteers should have an understanding of their role and how best to support the families. Volunteers can provide direct support by offering activities (*such as arts and crafts, reading stories, and outside play with supervision*). Volunteers can also support family time (*in the form of craft night, helping caregivers teach their children something new, and safe and approved field trips*). Volunteers can also help in a wide range of activities that have less interaction with the families (*cooking a meal and bringing it to the shelter or organizing donations*).

Consider collaborating with a local university. Often students pursuing degrees in social work or counseling are required to complete internships or field practicums. These student volunteers can perform many activities after receiving training and with ongoing guidance and supervision. Undergraduate students can help with advocacy and crisis intervention while graduate-level students may be able to co-facilitate groups and provide counseling for families.

Benefits and recognition

Assessing the benefits of an organization is an important aspect of family-centered, trauma-informed, and culturally responsive work. There are many ways that organizations can show they value their employees through livable wages, vacation days, paid time off, health-care plans, retirement plans, and more. Employees may see how much they are valued through encouragement to take time off when needed. Individuals who are employed or volunteer with domestic violence organizations are some of the hardest working people in the non-profit world. Ensuring the 24/7 coverage of hotlines and residential shelters can be a struggle for managers, all while encouraging staff and volunteers to take well-deserved time off. But this is an important balancing act to ensure the well-being of the staff and volunteers.

Recognizing employees for their work can be a way to make people feel valued. An appreciation board in the break room is an easy way for all employees and managers to write a quick note of thanks highlighting someone for their commitment to their work. A “*kudos box*” is another way to create opportunities for peer and manager recognition. This anonymous box holds small notes of appreciation that are read during weekly staff meetings. Celebrating personal accomplishments—like earning a degree or training certificate to remembering work anniversaries—can be other ways to recognize employees for their service.

Supporting well-being

We need both personal strategies for self-care and organizational supports to stay aware, balanced, and healthy¹. Our well-being can be enhanced through self-care practices. Self-care for those working in the domestic violence field is not only encouraged but seen as a necessary part of the job for a sustainable career. Stress is real! We experience stressors in our work, in our daily lives with family and friends, in our communities, and even watching the news or scrolling through social media.

1 Partly adapted from NCDVTMH’s handout on “Supporting Wellbeing” (revised 2017).

Self-care is not about self-improvement. It's more about self-awareness, "being" rather than doing, resting, and engaging in activities that promote a sense of well-being and connection to others, meaningful work, the larger community, and the natural world around us.

This will look different for each of us and may vary depending on the immediate and ongoing stressors we are experiencing in our lives. Often when asked what self-care means, advocates and others may respond with activities like taking a bath, listening to music, or hiking with a friend. These activities may be rejuvenating but they might require time or money. As an alternative, we can engage in small actions "on the job" and throughout the day to promote and sustain our well-being within a time-pressured and demanding schedule. Self-care might be as simple as remembering to breathe or drink more water or pausing before answering the crisis line.

Here are some individual strategies for managing daily stressors and staying in balance:

- Be aware of our own responses and pace ourselves
- Take breaks: to breathe, stay hydrated, walk, or meditate (*throughout the day or evening while at work*)
- Check in with peers: receive and give support
- Seek out supervisory support to process urgent concerns
- Know that we can't change everything
- Stay connected with others who can support and encourage our personal growth, healing and resilience

Organizational wellness is a part of self-care. By caring for one's self, you may be actively engaging in a change process for your organization and the culture of your work environment. Sometimes employees are praised for their hard work and never taking a day off. This may inadvertently discourage employees from taking care of themselves

and using their vacation days or sick leave. The health and wellness of the individual employees impacts the overall health of the organization, and in turn the organization can directly impact the wellness of the employee. Both individual staff members and supervisors can support the overall wellness of all by engaging in discussions regarding the culture of the organization and encourage the self-care practices of each individual.

Here are some ways that our organizations can support us in our work:

- Provide ongoing training that builds confidence and competencies and promotes professional development
- Offer regular and consistent reflective supervision or outside consultation
- Create a sense of belonging for all within the team, program, and organization
- Join with others in the larger community to advocate for our communal well-being and the right to be free from interpersonal violence and oppression
- Understand that secondary trauma responses are part of doing this work
- Create policies that support this recognition, which include:
 - Flexible scheduling and hours

- Adequate coverage and backup for program
- Opportunities for peer support and self-care for employees (*e.g., a quiet room, yoga, or meditation*)
- Provide excellent mental health insurance benefits

Understanding the impact on us as service providers

Everyone we serve has experienced intimate partner violence and may also have lived experiences of other kinds of abuse, trauma, loss, and adversity in their lives.

When we open our hearts and minds and offer a safe space for others to share and hold their experiences with us, we are affected and may be vulnerable to having a range of secondary trauma responses.

These may deeply affect us, temporarily or over the long run, and impact our effectiveness as providers. These trauma responses may include physical and emotional

responses and may also impact how we see ourselves and others and the world around us. We may have trouble sleeping at night, find that we are getting colds and viruses more frequently, feel overwhelming fatigue, or find that we have racing thoughts and images of what's happened to others, etc. We may find ourselves feeling off balance, disconnected from others, or emotionally dysregulated. Laura van Dernoot Lipsky names common trauma exposure responses that providers in our work may face (***see handout on "16 Warning Signs of Trauma Exposure Response" in this section***).

These include feeling helpless and hopeless and experiencing fear, guilt, anger, cynicism, and a sense of persecution. We may become hyper-vigilant, reading the environment for cues of danger; we may start to feel numb and find that we're unable to empathize with others. We may lose our ability to listen openly and with compassion. We may find that we've lost our sense of humor and that we begin to minimize others' situations. We may lose our capacity to hold complexity and to be flexible in our responses in the moment.

There are practices that we can incorporate into our daily lives that are antidotes to the secondary trauma responses that we may experience as part of doing this hard and rewarding work. Being mindful of our own

responses is a good starting point. Holding these responses without judging ourselves is important in examining our own beliefs, attitudes, and responses in the moment. When we become emotionally dysregulated, it's helpful to use mindful awareness paired with mind-body practices. These include: working with our breath to calm our central nervous system and "reset" our emotional temperature; using movement (*shaking it out, walking, dancing, etc.*); visualizations; meditation practice; grounding; and attending to our sensory environment (*for comfort, self-soothing, stimulation, and relaxation*). We can also incorporate micro-practices into our daily routines. These might include: setting an intention for the day or before each session or service encounter; pausing and taking a deep breath before answering the phone or entering a room; staying hydrated; taking breaks; getting outdoors and into green spaces when possible; and listening to our favorite music. Within this toolkit, we have activities that can be helpful to children and their caregivers and families in relieving stress, distress, or dysregulation that are also helpful for us as providers (***see Section 12***).



Guidelines around funding (for materials, training, building family-centered spaces)

Domestic violence programs are usually doing amazing work with very little funding. It may seem that in considering more family-centered work that organizations need to seek out additional funding sources. While this is a great idea, we also want to help support you in building capacity for families with minimal additional funds.

First, consider what you already do and the resources you already have. Is it possible to turn that group room into a child and family-friendly space? Maybe the arts and crafts you use for your survivors' groups might also be used for family craft evenings. Then think about your community partners;

let them know that you are building capacity for families at your organization and are interested in their expertise. They may be willing to present relevant trainings to your organization. Or maybe you might connect with family-centered programs to share the cost of trainers' fees. Think about your local resources and professionals in the community. Contact the school districts and private schools to request used (*but still safe*) play equipment and supplies. Often at the end of the year, gently used art supplies can be donated. Place a free ad in your paper requesting lightly used toys and watch for garage sales. People are usually willing to donate everything from bikes to playhouses if you have your business card on you. Make friends with thrift store managers so that they call you when they get a double stroller in. Connect with retiring play therapists, clinical social workers, and art therapists for therapeutic supplies.

Critical Conversations



- Consider whether you and others in your organization have an interest in engaging in an organizational self-assessment process with a focus on family-centered services.
 - What are your hopes for engaging in an organizational assessment process?
 - What might be some challenges regarding this process?
 - Do you have any thoughts regarding solutions to those potential issues?
 - Do the organization's policies and procedures reflect the work your organization actually does with survivors and their families?
- How is staff well-being encouraged and supported in your organization?
- What organizational and communal supports are offered to staff?
- If a survivor is interested in being a volunteer or employee, how are they supported or encouraged to move into those roles?
- How is supervision integrated to meet the needs of all staff in the organization?

Helpful Hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing inclusive and compassionate policies within your program.



What can a direct staff person do?

- Consider who in your organization might be a leader in initiating an organizational self-assessment process.
- Think about what you might offer as a participant or leader in this process.
- Make sure that you are familiar with the organization's policies and procedures regarding families.
- Seek out guidance from a supervisor if you have questions about differences between the policies and procedures and organizational philosophy.
- Monitor your own needs for self-care and what comes up for you in working with families.
- Seek out support and guidance from supervisors and coworkers regarding opportunities for continued learning and professional development.



What can a supervisor do

- When discussing program components, are you able to use a family-centered, trauma-informed, culturally responsive lens?
- Ensure that all staff have access and time to familiarize themselves with the policies and procedures regarding families.
- Engage in conversations about policies and procedures. Reflect on consistencies between the policies and procedures and current practices. If there are any discrepancies, is there room to make changes to the policies and procedures that more accurately reflect family-centered practices?
- Support staff by offering both individual and group supervision opportunities.
- Encourage time off for vacations and self-care.
- Engage in conversations to support self-care practices during work and outside of work.
- Consider increasing training budgets and benefits packages for all employees.
- Support survivors in transitioning to being advocates.
- Consider offering scholarships to employees who are also taking continuing education courses.
- Consider the “*wellness*” of your organization. What organizational and communal supports are offered to staff that promote and sustain their own well-being and the health of the organization? What changes might be made, no matter how small, that could contribute to greater wellness within the organizational culture?



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Note: This vignette may pair well with the activity on *“Survivors Who Are Advocates: Creating an Environment of Safety and Trust.”*

Justine is a survivor of domestic violence. She credits a shelter in another community for helping her and her children escape an abusive partner years ago. Justine has shared that she has done her own counseling and started volunteering at your shelter once her children were grown. She works well with the families living in the shelter and is appreciated by the other volunteers and staff, including yourself. Occasionally, you notice that she gets emotional after engaging with some of the children. Your coworker Sue tells you that she is being promoted and her advocate position will be open and posted next week. Sue suggests that Justine might be a perfect candidate for the advocate position but says she hasn't recommended Justine to the director yet because she questions whether Justine has had enough time away from her abusive situation to not become *“triggered.”*



Things to consider:

- Every trauma survivor has resilience, and there is not an established time frame for healing from trauma. Healing is not linear, and it is unique to each person.
- Guidance regarding time periods for survivors to wait before they can volunteer or work for an organization is artificial, discriminatory, and doesn't take into account personal resilience and our capacity for healing.

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- If you are concerned about Justine, initiate a dialogue directly with Justine about what you are noticing.
- Explore self-care strategies together.
- Share information about the advocate position and encourage her to reflect and consider for herself if it is or isn't a good fit for her.



Section 3: Resources and Links

NCDVTMH Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations: <http://www.nationalcenterdvtraumamh.org/publications-products/tools-for-transformation-becoming-accessible-culturally-responsive-and-trauma-informed-organizations-an-organizational-reflection-toolkit/>

Futures Without Violence -Promising Futures: Program Readiness Checklist: <http://promising.futureswithoutviolence.org/files/2012/01/Program-Readiness-Checklist.pdf>

Children/Teen Programming and Supporting Parents Capacity Assessment for DV/SV Programs: http://promising.futureswithoutviolence.org/files/2012/01/DVSV-Children.Teen_.Parent-Program-Assessment-Tool.pdf

Print resources on reflective supervision and practice:

Heller, S. and Gilkerson, L. (Eds.). (2009). *A Practical Guide to Reflective Supervision*. Washington D.C.: Zero To Three.

Heffron, M.C., and Murch, T. (2010). *Reflective Supervision and Leadership*. Washington, D.C.: Zero To Three.

Self-led and team-based conversations and activities:

- My North Star activity is about our deepest motivation for doing this work and what resources and supports are in our star constellation. Each team member can fill out their own North Star and then bring insights to a team-based discussion. Staff who have used this activity comment that it's helpful to be reminded of what motivates and sustains us in this work, and that their universe, or "star constellation," of resources and supports may change and grow over time ([Link to My North Star Handout](#)).
- Creating a Self-Care Plan with guidance. Remember: our self-care plans are unique and will vary over time. Self-care is not about self-improvement and should not be a programmatic expectation. Well-being at work involves opportunities for communal and organizational supports ([Link to Creating a Self-Care Plan handout](#)).
- 16 Warning Signs of Trauma Exposure Response (*van Dernoot Lipsky*) invites us to explore our own secondary trauma responses with instructions to focus on work with a caregiver or family that may elicit these responses. Talk about it with your team and discuss ways to transform the effects (*think about the value of being in community with others who are doing similar work*) ([Link to 16 Warning Signs of Trauma Exposure Response](#)).
- The links to tools from the National Center on Domestic Violence, Trauma, and Mental Health and Futures Without Violence—Promising Futures (*website*) can be used to assess your organization's current capacity and may be helpful in developing, enhancing, and sustaining child, youth, and family-centered practices and programming. You can engage in team-based assessments and dialogues about where you are now and what next steps and actions can be taken.

Survivors who are advocates: Creating an environment of safety and trust

We know that staff within your program and organization may have experienced domestic violence during childhood and may also be experiencing or have experienced intimate partner violence as adults. The women who founded the domestic violence movement were inspired by their own lived experiences to help others in similar situations to access resources and achieve safety and well-being and to fight for gender equality and social justice. There has been a sea change in many organizations from their grassroots origins; advocates and mental health clinicians working in domestic violence settings today have shared that they don't feel comfortable disclosing their current or past history of domestic violence and other trauma.

Questions to consider:

What are your organization's practices and policies about hiring staff who may have experienced domestic violence? How do these practices align with your organization's values? Is your organization welcoming and supportive of staff who have experienced domestic violence and other trauma? What do you currently do to support staff who are also survivors? What else could you do to create a work environment that is open, respectful, and supportive of everyone's lived experiences.

Any conversation about working with children and parents should take into account how this work might evoke strong feelings based on our personal history and experience.

Conversation starters:

- What do you see as some of the advantages of this change?
- What do you see as some of the barriers of this change?



SECTION FOUR

4. Creating a Welcoming, Family-Friendly Environment

Creating a welcoming, family-friendly environment demonstrates our interest and commitment to serving children, teens, and their parents or caregivers together. Feeling welcomed will mean different things to different families but will convey a sense of belonging and inclusion for all who seek services with our organization. In building a family-centered, trauma-informed, and culturally responsive environment, we want to be thoughtful about what might be potential trauma reminders or “triggers” within the environment and how to avoid re-traumatizing families by staying open to understanding the individual and specific needs that each family brings. We can have conversations about this up front as families enter services or programs so that we can anticipate what might be problematic or challenging for them. When we do that, we create an environment that allows for family choice and voice and honors coping skills, lived experiences, and a range of capacities. We also know that dialogues will develop as we establish safe and trustworthy relationships over time.

Family-centered environments

There are three components to consider as we build welcoming, family-centered environments: (1) the physical environment itself, (2) the sensory aspects of the environment, and (3) the relational environment.

1. The physical environment: What engenders a sense of welcome, safety, and trust?

- What does it feel like to enter this space? How is the main entry or waiting area laid out? What do I see at eye level as a child (*throughout the space*)? Are there pictures and other ways of communicating with children who don't read or folks with low literacy levels in English? Is the space physically safe for children?
- Is there dedicated, inviting space with child-size chairs and tables, rugs, toys, and art supplies that children can choose from? Are the toys and games intact and clean?
- Am I represented in this space? My family? My culture (*as defined by each individual and family*)? What's hanging on the wall? Is the artwork inclusive (*for example: seasonal decorations for holidays celebrated by all*)?
- Are there homelike, cozy, family-friendly spaces that meet the developmental needs and capacities of babies and young children, school-age children, and teenagers? This might include a quiet space or area for reading books, doing puzzles, and snuggling together with younger children and their parents or caregivers. For teens, it might include a computer space with games and a "hang-out" room.
- Are there communal spaces for families? Is there a space for crafts and fine motor activities for children of all ages and their parents or caregivers? Is there a mixed use of space for both private and communal activities?
- Is there outdoor space that allows children to run and play and do large motor activities with each other and with their parents or caregivers in a safe, contained area?

2. The sensory aspects of the environment:

Does the space accommodate a range of sensory preferences and needs and foster connections between parents or caregivers and their children?

- Children and adult caregivers may have sensitivities to light, noise, sound, scents, visual stimulation, or lack of stimulation in the environment. How does the sensory environment nourish and support parent-child relationships and daily routines? What accommodations can be made to meet the sensory profiles of children and caregivers in this space?
- Are there green spaces within the environment or outside that are visible from within? Growing herbs and plants indoors and creating garden spaces outdoors can be wonderful activities for children and families to see how their attention and care is nourishing, relaxing, yields beautiful results, and has continuity over time.
- Are there aspects of the sensory environment that are both comforting and soothing as well as fun and energizing for the families coming through our doors and staying in domestic violence residential or shelter settings?

- Have programs gotten feedback from families using their services on what aspects of the environment might be adapted? Are there aspects of the sensory and physical environment that are inadvertently re-traumatizing or challenging? And, conversely, what would be healing and restorative?

3. The relational environment: How are families treated by us and others, and what does it feel like to use services at our organization?

- Is our space organized in a way that allows for privacy between survivors and advocates and attends to the needs of children regarding separation from their parent or caregiver?
- Are we clear and transparent about how we operate our services? This includes providing information about what to expect (*including: what comes next for young children and being trauma-responsive to separations from their primary caregiver and older siblings; defining the roles and responsibilities of parents for their children's well-being and safety; offering opportunities for respite and support to parents; explaining the mandated reporting role of staff and policies for including parents in the process, whenever possible*); what their

options are for voluntarily participating in services; honoring parents' authority in decision-making related to their children; and involving children and teens in making choices and giving voice to their perspectives on what's helpful, fun, and healing.

- Are staff able to foster healing connections between parents or caregivers and their children within and across families? Do we use a trauma-informed, culturally responsive, family-centered approach to understand healing and connection?
- Do staff have regular reflective supervisory support to work through challenges that may arise in setting personal boundaries and limits, in maintaining standards of fairness and inclusion for all, and in relating to particular parents, children, and families?

The three components of establishing and sustaining a welcoming, family-friendly environment are interrelated and are woven together by the relationships we form with families and how we express our values of respect, kindness, compassion, fairness, and caring for those using our services.



Considerations for engaging with and supporting families in culturally responsive ways

Culture provides meaning to all families' lived experiences and the world around us. Culture encompasses traditions, values, beliefs, and customs related to child-rearing and socialization. Culture is encoded before children learn to talk and is learned primarily through language and everyday patterns of relating and interacting as we grow within our caregiving environments.

Children and families experience trauma and healing through a culturally constructed lens.

What one culture defines as trauma may be differently perceived by another. Culture helps buffer and protect children who are experiencing trauma. Culture may also create risks and vulnerabilities for families through intergenerational legacies of collective and historical trauma and ongoing racism, oppression, and discrimination.

We can ask ourselves: *“How does culture play a role in understanding children’s and their caregivers’ experiences of trauma?”* It’s multifaceted. Lewis and Ghosh Ippen (2004) propose a model that encompasses the dominant culture, the family’s culture of origin, the effects of collective and historical trauma and ongoing racism, oppression, and discrimination, and how these layers may all impact caregiver-child attachment relationships in relation to trauma. We can consider the family’s culture of origin, acculturation, and assimilation to the dominant culture over time. The level of acculturation and assimilation may vary between individual family members and across generations. This can lead to tension between caregivers and their children who may hold differing beliefs and expectations about what behavior and practices are valued.

Here are some practice considerations to keep in mind:

1. Be aware of your own values, beliefs, and biases about parenting, child-rearing, children’s growth and development, child behavior that is labeled as typical or concerning, and how you define trauma, loss, and adversity.
 - Reflect on how these are related to your own child-rearing experiences and cultural identity (*including socioeconomic status, religious and spiritual practices, ethnicity, race, class, gender, gender identity, immigrant or refugee status, education, and sexual orientation*).
 - How are these similar to and different from the dominant culture in the United States?
2. Children’s experiences of trauma are implicitly constructed by their family’s and community’s beliefs, traditions, and cultural practices. Young children, in particular, take their cues from their caregivers on how to respond. Caregivers may make meaning of their children’s behavior, reactions, and responses to traumatic experiences based on how they see the situation and its effects.

- We can ask ourselves: What is the child's stage of development and capacity for mastery at the time of these experiences and how aligned is our own understanding and assessment of what happened with that of the child's or youth's primary caregiver or caregivers?
- 3.** Parents' and caregivers' capacity to respond to their children may be affected by whether or not they have been able to get needed supports and resources to resolve their own grief, loss, and trauma. This can make it harder for caregivers to help their children to regulate their own reactions and to heal from traumatic experiences.
- We can ask ourselves: How does the caregiver's ethnic, racial, and cultural identity influence how they might advocate for services for their child? How is this caregiver's own emotional history of loss and trauma related to being a part of an ethnic, racial, or religious minority? To experiences of ongoing oppression, discrimination, violence within the United States, or recent family separation practices at the southern border? Or war, torture, and abuse within their country of origin?
- 4.** Taking a stance of cultural humility and curiosity, be prepared to learn more about each family in your practice. It will be important to gain more understanding of the sociocultural context of their lives and to hear their stories. In working with immigrant and refugee families, we can consider how their experiences with child and family serving systems may play a role in their hesitancy to engage in services. Many survivors and their families experience discriminatory practices and systems of care that are not culturally responsive.
- We can be curious about the following:
 - Where did the family relocate from?
 - What was the relocation process like?
 - What were the driving motivations to come to the United States? Were there other traumatic experiences on the way to this country (e.g., violence, re-traumatization, separation and loss of family members, refugee camps)?
 - What are their current circumstances like now (including housing, resettlement, community supports, others with similar language and life experiences, etc.)?

- How do they make sense of their experiences based on their culture of origin (e.g., is domestic violence identified or considered to be trauma)? What rituals, practices, and beliefs are protective, based on the family's culture? How do these fit with or differ from the dominant culture?

5. Children from diverse cultural backgrounds may find that school (*and the wider society*) and family hold different and conflicting perspectives on what's valued. For instance, some cultures value the family, community, and interdependence over independence and autonomy, as seen in the dominant culture in the United States. This may play out in intergenerational conflicts, discontinuities, and disconnections between caregivers and their children.

- We can be curious about how this is related to identification with the culture of origin, acculturation, and assimilation to the dominant culture in the United States.
- We may need to better understand what is driving the conflict, based on the caregiver's own history, experiences, and valued traditions, practices, and beliefs. What is their history with their own caregivers and across generations, and how might this be impacting their relationships with their children?

- We can help make these differences explicit and provide information to caregivers about expectations and norms in the dominant culture. We can help to preserve what is most important, while brokering and navigating this new terrain.
- We can facilitate communication that allows children and parents to explore these issues together and to problem-solve resolutions, compromises, and shifts.

6. Parents and caregivers have their own beliefs about parenting and discipline, based on culture and how they were raised.

- It's helpful to ask about these beliefs and practices when engaging in services.
- We can also be curious about the process of communicating behavioral expectations within the family. When the children require redirection, what do they do? Following any disciplinary actions, how do they reconnect with their children? As an example: In some traditional Indigenous communities, child-rearing includes indirect guidance and modeling as ways to communicate expectations of children's behavior (Bigfoot and Funderbunk, 2011; Weaver, 2019).

Additional considerations for providing direct services to culturally diverse families

- Children and adults may be bilingual in English, but their native language may serve as the language of feelings. We can ask about an individual child's or adult's preferences for engaging with an advocate or counselor who speaks their native language. Memories and feelings may be encoded in the native language, and it's helpful to engage in therapeutic work with a counselor who speaks that language.
- Although children's play is universal, caregivers may hold different beliefs and perceptions about the meaning and value of play and using play in parent-child interactions. It's important to ask about parents' and caregivers' cultural beliefs, such as whether it's customary to "get down on the floor" and play with children as an adult. Sometimes, it is helpful in parent-child therapy with younger children to have the caregiver participate in co-constructing a trauma narrative to resolve the traumatic experiences, regain developmental momentum, and increase bonding and protection within the attachment relationship. In those situations, the therapist can explain and demonstrate how play is used therapeutically, while also acknowledging, adapting, and working through the parent's participation in the process.
- Some families may live in multigenerational households or maintain connections within their cultural communities. Some multigenerational families may experience differing stages of acculturation and assimilation between family members and across generations that are sources of strength, resiliency, and, at times, challenges. Advocates and therapists can ask family members about specific topics where differing perspectives are held by family members that may lead to disagreements. They can help families by acknowledging the struggle between generations to continue some traditions and maintain connections to their own culture, while helping children and teens navigate the pull to connect with peers and alternative mainstream culture.

Sharing office space or “on the go” work with families

When you’re working with children, their parents or caregivers, and families outside of the office, it calls for flexibility and “going with the flow.” Children respond differently depending on the physical and relational environment itself but also within relationships between family members in their own natural setting. There are also opportunities to provide enriching child and family experiences through your visits, in the community, and by helping children “get their energy out” through large motor activities in playgrounds and parks. Being together over time builds rapport and trust, creates positive memories and experiences, and helps families feel safer and more comfortable in relating to us.

You are the constant! It can be helpful to apply some of the same principles of reliability, consistency, and routine by what you bring with you to the visit and how you structure your time together. Create routines and rituals by having a clear beginning, middle, and ending to each visit. Bring a carryall bag that contains a rug or mat to sit on and a range of toys and materials that are the same each time (*unless you’re introducing something new*) and fit with the child’s age, developmental

capacities, and the focus of your work with the family. You may choose to lend or give books and other materials to the family that you introduced during the visit. These can then be incorporated into special family time and shared activities that the family can do on their own, creating community, fun, and greater closeness between family members!

Delivering virtual services

Remote or virtual services are often referred to as tele-therapy or tele-health. These are synchronous live video or telephonic real-time services delivered remotely to individuals and families in lieu of face-to-face contact. Advocates can safety plan with survivors around virtual advocacy and counseling services based on each survivor’s situation. Advocates can follow specific agency protocols and use secure videoconferencing platforms or apps to maintain ethical standards. For more information on best practices for domestic violence agencies’ use of technology to provide services to survivors, see the National Network to End Domestic Violence: <https://nnedv.org/content/technology-safety/>.

Building rapport and establishing connection is still the foundation of our work! It may be a little more challenging for some individuals and families to trust and feel connected to us

when using technology to engage in services, and others may feel very comfortable using technology and may be even more open to sharing about themselves. We may also have challenges using technology ourselves to support individuals and families. There are both benefits and challenges that may arise when providing remote services. Whether this is a temporary transition or a more permanent option for clients, below are some things to consider as we provide services remotely:

- Establish safety. Using technology may increase risks for survivors.
- Schedule virtual appointments when the abusive partner will not be around the survivor.
- Ask clients about their space and ability to share and talk openly. Remember that some families live in multigenerational homes, and family members or others may be able to listen in to the session. Be creative about planning for confidential space prior to sessions (*in the car, outside on a walk, in another room with music playing*).
- Assess clients' consistent access to reliable technology (*limited access to internet bandwidth, computers, or smartphones*).
- Assess clients' comfort using technology and access to family or friends for support in navigating new technology.
- Consider clients' preference for telephone or video contact and use that modality.
- Encourage use of headphones and chat functions to limit the survivor being "*heard*."
- Make sure you know how documents and websites will "look" when you screen share during sessions via smartphone or computer.
- Make sure that clients are clear about providing their informed consent for services. It is recommended that clients give not only verbal but written consent, if possible.
- Be detailed with clients about your adherence to their confidentiality. Share specific information regarding your space and how that might impact their privacy. For example, explain how your office door is closed during sessions with a sign to please not interrupt. Consider where your computer screen is positioned and if someone might be able to see it through a window. Use headphones or earbuds to decrease chances of survivors being overheard.

- Let clients know how they can access their own records you are maintaining.
- Maintain appropriate professional boundaries while sharing briefly about yourself and providing relevant information about your training and knowledge (*especially during a first session*).
- Consider your surroundings and think about the lighting, as well as what is behind you and visible to clients during your sessions.
- Be present! The use of technology does not negate the need to communicate our presence to clients. Just like face-to-face sessions, do not become distracted by text messages on your cell phone or email notifications that might pop up on your computer screen.
- Try to minimize distracting noises. Use earbuds and noise-cancelling machines.
- Be clear in your communication and frequently check in with clients that the messages you are sending and receiving are accurate. Encourage clients to clarify information with you too. Remember that you may miss nonverbal cues (*all the body language cues that occur beyond the face*).
- Establish consistent ways of opening and ending sessions. Individuals and families will appreciate knowing what to expect when they meet with you.
- Offer opportunities to co-regulate. Maybe take a few deep breaths together. Maybe focus on the five senses and share with each other.
- Increase your self-regulation during sessions through your own mindful practices.
- Be transparent with clients and ask them what is working and what could be done to make improvements in the sessions.
- Check in regularly with clients about the platform you are using and stay open to making adjustments (*for example, switching from video to phone or vice versa*).
- Remember that assistive technology used by clients with disabilities may not be compatible with your platforms. Make every effort to ensure accessibility by asking survivors for recommendations on preferred software and platforms.
- Be prepared for technology failures. Plan for “*unplanned*” interruptions!

- Develop safe words or phrases to address any safety concerns.
- Integrate regular self-reflection following each session: What worked? What might you change for next session?
- Use supervision time to process challenges and increase understanding of best practices when using technology with clients.
- Do a “*practice run*” with technology. Ask a supervisor or colleague to practice with you prior to working with clients.

Toys and materials

Part of creating a family-friendly environment includes having a range of supplies to support a variety of activities, from caregivers playing with their children to advocates facilitating a family group. In general, you will want toys and materials that are matched to the child’s age and developmental capacities and that encourage the child’s own imagination. It is important to note that sometimes teens like to play with toys and materials for younger children, so as you’re establishing rapport, you may want to have a wide range of choices available. Remember to consider how to clean and disinfect toys that will be used by multiple children.

Consider asking families directly about what toys and play materials are culturally familiar and valued. In using dolls and other figures, be sure these are inclusive and representative of the families you are working (e.g., multicultural, multiracial, and multigenerational). For families with few toys at home, you might provide books and other materials (perhaps some that were introduced within your program) to take home—with parents making the decisions about what would be welcomed.

Children may feel overwhelmed by the array of toys and play materials in your playroom or program. Allow for children to make choices, but also think about being selective with what’s visible and what’s kept out of sight and safely stored. In this way, you can keep the focus on imaginative and interactive play that centers our relationships with children and their caregivers.



Toys and Materials

Here is a beginning list of supplies that can support a family-friendly environment and interventions:

Art supplies:

- Clay (*including Play-Doh or Sculpey*)
- Lots of paper! Newsprint, butcher paper, construction paper—different sizes, colors, and textures
- Paints: acrylics, watercolors, finger paints
- Paint brushes
- Fabric and fabric paint
- Crayons
- Markers
- Colored pencils and erasers
- Chalk, chalkboards, erasers
- Large chalk for outside cement drawings
- Safety scissors (*right- and left-handed*)
- Glue sticks and rubber cement
- Yarn and string
- Paper bags, lunch size
- Paper plates
- Pipe cleaners
- Ribbons, feathers, gems
- Stickers
- Rocks (*for painting and meditation*)
- Socks (*for sock puppets*)
- Magazines for making collages
- Blank greeting cards and envelopes

- Stringing materials: beads, buttons, pasta
- Building materials: cardboard boxes, craft sticks, toothpicks, wood scraps, cotton balls,

Pretend Play:

- Blocks of all sizes and shapes
- Stuffed animals
- Dolls, stuffed animals, and small figurines (*include multicultural, multiracial, and multigenerational*)
- Doll beds and blankets
- A variety of figures (*realistic and imaginary people and animals*)
- Cars and trucks, boats and planes
- Dollhouses
- Play phones, play computers, communication devices
- Puppets
- Play kitchen and pots and pans and utensils (*include an horno, or tortilla warmer, and other multicultural cooking supplies*)
- A large supply of dress-up clothes, scarves for capes, and hats

Toys and Materials



Music:

- Musical instruments (*drums, bells, rattles, recorders*)
- Radio, CD player and recorder, blank CDs, CDs of children's music
- Musical toys for infants and toddlers
- Music for relaxation

Movement:

- Large supply of balls in all shapes and sizes
- Hula-hoops
- Swing set
- Slides and climbing gyms
- Scooters and riding toys
- Sandbox and toys

Books:

- Soft cloth books for infants
- Picture books for toddlers
- Books for talking about feelings and entering therapy to process trauma
- Special topic books on domestic violence, attachment, parent-child separations, divorce, and child sexual abuse (*see the list and helpful links in resources*)

Trauma-specific toys:

- Rescue vehicles and figures, such as firefighters, police officers, doctors, and nurses
- Play telephones
- Medical kits, including realistic bandages, gloves, and stethoscopes

Other items:

- Board games, cards, and puzzles for all ages and stages. Make sure to think about storage for games and puzzles. Consider having a designated secure place in order to keep all necessary pieces intact, realizing that they will need to be replenished from time to time.
- List of fun activities like "*red light, green light*" or "*red rover*."



Critical Conversations

Helpful Hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing inclusive and compassionate policies within your program.

The following part offers critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

- Consider how your organization can create more welcoming and family-friendly environments.
- Consider supplies that you may already have that might be used for family-friendly activities.
- Discuss and assess any remote service delivery. Take time to discuss what is working and what challenges are arising.



What can a direct staff person do?

- Consider engaging families in activities that don't need supplies (*develop an easily accessible list of fun games and activities*). **(See [link to virtual activities with children, youth, and caregivers](#).)**
- Consider putting together a “*care package*” of art supplies and activities that can be picked up at the center for use in virtual sessions.

What can a supervisor do?

- Consider adding in a budget line item for supplies to ensure an ongoing family-friendly environment at your organization.
- Think about ways to collaborate with other organizations in your community to build both indoor and outdoor family-friendly areas.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Tanya and her 15-year-old son, Ryan, recently entered services at your shelter. Tanya shares that her son is isolating in their bedroom and doesn't feel comfortable in the shelter. He told her after attending group counseling with some preteens that he will not be returning to group and that the shelter seems nice for "*little kids*" but he would rather stay in their bedroom.



Things to consider:

- Sometimes older teens may not be comfortable in shelter if there are a lot of babies, toddlers, and young children. Are there opportunities for teens to have separate space away from the younger children?
- Teens and children may have a preference for individual or group work. Are there individual and group counseling and advocacy options for children and teens?
- The shelter census may be frequently changing, and age ranges for group participants may quickly shift. It is important to have a wide range of services and activities to engage children of all ages.

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin with empathizing with Tanya's concern and ask permission to include Ryan in dialogue.
- Initiate the dialogue with Ryan—first validate his feelings and then identify his needs.
- Explore and problem-solve with Ryan ways he might begin to meet his needs and encourage use of the shelter's indoor and outdoor spaces.

Section 4: Resources and Links



NCDVTMH's ACRTI Focus Area 3: <http://www.nationalcenterdvtraumamh.org/publications-products/tools-for-transformation-becoming-accessible-culturally-responsive-and-trauma-informed-organizations-an-organizational-reflection-toolkit/>

Bigfoot, D. S., and Funderbunk, B. F. (2011). Honoring children, making relatives: The cultural translation of Parent-Child Interaction Therapy for American Indian and Alaska Native families. *Journal of Psychoactive Drugs*, 43(4), 309-318. doi: 10.1080/02791072.2011.628924

Weaver, H. (2019). *Trauma and Resilience in the Lives of Contemporary Native Americans: Reclaiming our Balance, Restoring our Wellbeing*. New York, NY: Routledge

Resources for those using technology to work with survivors of violence:

NNEDV: https://nnedv.org/latest_update/resources-response-coronavirus-covid-19/

U.S. Department of Health and Human Services, Telehealth HIPAA amendment:<https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>

Tip sheet on 10 Creative Ways to Engage Children and Youth Through Virtual Activities:<https://dvchildwelfare.org/wp-content/uploads/2020/05/FWV-QIC-Tip-Sheet-Child-Engaged-02-copy.pdf>

Face mask tip sheet: <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2020/04/ACRTI-Face-Mask-Tip-Sheet-FINAL.pdf>

A few articles for further reading:

Anton, M. T., and Jones, D. J. (2017). Adoption of technology-enhanced treatments: Conceptual and practical considerations. *Clinical Psychology: Science and Practice*, 24(3), 223-240.

Doss, B. D., Feinberg, L. K., Rothman, K., Roddy, M. K., and Comer, J. S. (2017). Using technology to enhance and expand interventions for couples and families: Conceptual and methodological considerations. *Journal of Family Psychology*, 31(8), 983-993.



Print Books

This list contains mostly picture books on various topics that parents and caregivers, advocates, and others can read aloud to children, ages 3-6 years and older as indicated. Some contain “parent guides” to spark conversation (adapted and updated from NCDVTMH’s Children Exposed to Domestic Violence):

Domestic violence

- *The Day My Daddy Lost His Temper*, Carol McCleary
- *A Place for Starr*, Howard Schor (ages 9-10)

For introducing the idea of therapy and helping children talk about trauma

- *Once I Was Very, Very Scared*, Chandra Ghosh Ippen
- *A Terrible Thing Happened*, Margaret Holmes (ages 3-9)
- *Jenny Is Scared!*, Carol Shuman
- *Tanya and the Tobo Man*, Lesley Koplou
- *Depression Is the Pits, But I’m Getting Better: A Guide for Adolescents*, E. Jane Garland (ages 9-13)
- *Feeling Better: A Kid’s Book About Therapy*, Rachel Rashkin

Feelings

- *The Rabbit Listened*, Cori Doerrfeld
- *When Sophie Gets Angry—Really, Really Angry*, Molly Bang
- *Holdin Pott*, Chandra Ghosh Ippen
- *My Many Colored Days*, Dr. Seuss
- *Stolen Smile*, Thierry Robberecht
- *Double-Dip Feelings*, Barbara S. Cain

- *Jenny Is Scared!*, Carol Shuman
- *Glad Monster, Sad Monster: A Book About Feelings*, Ed Emberley and Anne Miranda
- *Feelings*, Alikei Brandenburg
- *The Way I Feel Books*, Cornelia Maude Spelman (series that includes *When I Feel Angry*, *When I Feel Sad*, *When I Care About Others*, *When I Feel Good About Myself*, *When I Feel Jealous*, *When I Feel Scared*, and *When I Miss You*)

Attachment and separation

- *The Kissing Hand*, Audrey Penn
- *I Love You All Day Long*, Francesca Rusackas
- *The Invisible String*, Patricia Karst
- *Don’t Forget to Come Back!*, Robie H. Harris
- *Safe, Warm, and Snug*, Stephen R. Swinburne
- *I’ll Always Be Your Friend*, Sam McBratney
- *Come Along, Daisy!*, Jane Simmons

Parent-child separations

- *You Weren’t with Me*, Chandra Ghosh Ippen
- *The Magic Box*, Marty Sederman and Seymour Epstein (up to age 9)

Print Books



- *Goodnight, Daddy*, Angela Stewart (up to age 9)
- *Do I Have a Daddy?*, Jeanne Warren Lindsay

Divorce

- *Was It the Chocolate Pudding?*, Sandra Levins
- *Dinosaurs Divorce*, Marc Brown and Laury Krasny Brown (up to age 9)
- *I Don't Want to Talk About It*, Jeanie Franz Ransom
- *What Can I Do?: A Book for Children of Divorce*, Danielle Lowry (ages 9-13)
- *My Parents Are Divorced, Too: A Book for Kids by Kids*, Melanie, Annie, and Steven Ford, as told to Jann Blackstone-Ford (ages 9-13)

Behavior challenges for young children

- *Alexander and the Terrible, Horrible, No Good, Very Bad Day*, Judith Viorst (up to age 9)
- *Hands Are Not for Hitting*, Martine Agassi
- *Feet Are Not for Kicking*, Elizabeth Verdick
- *Teeth Are Not for Biting*, Elizabeth Verdick
- *Words Are Not for Hurting*, Elizabeth Verdick

Sibling rivalry

- *Julius, the Baby of the World*, Kevin Henkes
- *A Pocket Full of Kisses*, Audrey Penn
- *What the No-good Baby Is Good For*, Elsie Broach and Abby Carter
- *It's Not Fair!*, Anita Harper and Mary McQuillan

Wake-up and bedtime

- *Good Morning Yoga*, Mariam Gates
- *It's Too Soon!*, Nigel McMullen
- *Good Night Yoga*, Mariam Gates

Parents with depression

- *Why Are You So Sad?*, Beth Andrews
- *Sometimes My Mommy Gets Angry*, Bebe Moore Campbell (up to age 9)

Child sexual abuse

- *I Can't Talk About It: A Child's Book About Sexual Abuse* (Hurts of Childhood Series), Doris Sanford
- *Fawn's Touching Tale: A Story for Children Who Have Been Sexually Abused*, Irene Wineman Marcus and Agnes Wohl



Section 4: Resources and Links

Additional links to resources for children’s books on various topics:

Zero To Three has a list of favorite books for supporting young children through stressful and traumatic situations :<https://www.zerotothree.org/resources/3399-our-favorite-books-for-families-facing-tough-times?fbclid=IwAR09jepGIazRd-eDRu0EEIH93NHfePOdGGelK7Oytj-PovGgPUASzY4mIKpQ>

American Psychological Association. Browse through the list of children’s books on various topics from Magination Press: <https://www.apa.org/pubs/magination>

Child Abuse/Family Violence: Resources for Kids & Teens on Prevention, Disclosure & Healing: https://www.parentbooks.ca/Child_Abuse_Resources_for_Kids.html

Abuse/survival books for children and teens from Independent Bookseller:
<https://www.charisbooksandmore.com/localauthors/219636>



5. Child, Teen, and Family-Centered Practices, Programming, and Services

This section offers guidance on the initial stages of engaging children and families in our services. Safety planning suggestions and templates are provided as a crucial first step in supporting families seeking safety. Additional information is offered on collaborating with multiple systems that support children and families whom we serve.

Intake process with children and families

The intake process begins with a welcoming environment. Consider the physical space where the intake process occurs. Is it flexible for the needs of individuals and families? Are there quiet and private spaces available? The organization's intake process can be enhanced through transparency about what needs to occur. If there is paperwork required, let the domestic violence survivor know how long it might take to complete and what options might be available for rescheduling the intake process.

Families can be further supported by creating choices for survivors and their children. Due to recent trauma and many other factors, children may be resistant to leaving their parent during the intake process. Survivors may also be reluctant to leave their children in the care of strangers while they engage in the intake process. After



assessing for immediate safety issues, the intake process might be delayed while the family gets settled and has a snack and some general conversations with the advocate. Paperwork and gathering of demographic information could occur with children present, and, if age appropriate, with their parent's consent, questions might also be asked directly to their children. Before beginning the intake, it is recommended that survivors understand the limits of confidentiality and mandatory child abuse reporting laws in your state. It is important that the staff remain flexible and support both the domestic violence survivor and their children's multiple and immediate needs.

Questions pertaining to the violence and abuse experienced by survivors should be asked privately to allow survivors to fully disclose the situation and experiences. Children might be asked their own intake

information only if the parent gives permission and, again, if it is age appropriate. It is important that advocates consider the child's age and developmental stage when engaging in the intake process. Building rapport with survivors and their children is an important part of engaging in the intake process. Intake questions may feel intrusive to survivors and children, so advocates must work to build trustworthy relationships with the family to elicit answers over time.

Cultural considerations for families must be addressed. Advocates can ask survivors and children about their community and how service utilization, activities, and counseling are viewed. Some families have never disclosed the violence and abuse and in doing so may be violating a "*family rule.*" Understanding a family's experiences with ongoing, historical, and intergenerational trauma can place the effects of experiencing domestic violence into a broader context. Language may be a barrier for some families, but it is critically important that children are not used as interpreters for their parents. While children might help their parents understand and communicate with others because they are more fluent in English, conversations held with adult survivors who are disclosing violence and discussing traumatic experiences should be held privately, with the use of an adult interpreter if needed, so that children are not re-traumatized during these contacts.

Intake questions cover demographics and may also assess immediate needs. Asking about the children's sleeping routines and eating habits, along with stressors and emergent health or mental health needs, gives you an understanding of how the children are doing. It can be helpful to ask how the family manages comfort and discipline and what structures may be supportive to that family.

Building a connection and rapport with children and teens can assist in the intake process. Using active listening skills and open-ended questions can help build trust. Some active listening skills might include some eye contact, leaning forward and appearing interested, nodding, and using encouragers like "go on" or "please tell me more." Open-ended questions allow children and teens to choose what to discuss and how much they want to elaborate or describe.

When seeking information about very young children, it's best to direct those questions to their parents. We can also learn by watching the interactions between caregivers and their children. Using a trauma-informed lens helps to remind us that parents may be in crisis when we initially meet, and their interactions with their children may not be typical, given the current situational stressors.

In addition to creating a welcoming environment and asking questions about children's or teens' school experiences, activities, and hobbies, you may also want to ask questions to further your knowledge of the child's understanding of domestic violence and the need for services.

Questions to consider for elementary-aged children:

- Do you know why you and your family are here at (*name of organization*)?
- What do you think about being here?
- Do you have some ideas of what we do here?
- How do you keep yourself safe when your (*parents, or use the term the child uses*) are arguing and fighting?

Questions to consider for teens:

- Do you understand why you and your family are here at (*name of organization*)?
- What is your understanding of domestic violence?
- What kind of support might be helpful for you (*the teen*)?
- How have you been keeping yourself safe?
- What challenges do you think might arise from attending services here at (*name of organization*)?

Safety planning across ages and developmental stages

Safety planning with survivors can be enhanced by creating opportunities to support families by including children in the safety planning process.



It is important for survivors who have children to consider their child's age and developmental stage when thinking about how best to include them in the planning.

Connecting and building relationships with survivors and their children is key to talking about safety planning. Building a safety plan that is co-created and relies on the expertise of survivors and their experiences will aid families in being safe. Advocates can work to quickly build rapport with children as safety planning can be an immediate issue, especially for advocates working in shelters, since survivors and their children may return home to abusive partners.

Cultural considerations for families are critically important as some families need and want to continue involvement with their extended family and community. Pueblo feast days, religious observances and traditions, and extracurricular school and community

events are just a few examples of additional considerations for safety planning so that families can continue to participate in their communities.

Safety planning can be helpful when discussing visitation exchanges, school and day care drop-off and pickup, and playdates with friends and family. Additional safety procedures may need to be explored if there are firearms or other weapons in the home.

When safety planning involves quickly leaving a volatile situation, advocates may want to consider offering additional ideas for what children can take, depending on their age and developmental stage.

- **Babies and toddlers:** comfort items, favorite blanket, nightlight, stuffed toy.
- **School-age children:** comfort items, favorite book and toy, schoolwork and contact information for teacher, any electronic devices and chargers.
- **Teens:** comfort items, favorite clothing, books, schoolwork and contact information for teachers, any electronic devices and chargers.

Advocates can use the handout on Our Family Safety Plan as a **template for creating safety plans** with families and children that meet their unique needs and circumstances. Remember to revisit safety plans frequently. It is important to continually review and modify safety plans with children and their families

and make modifications based on any changes in their situation ([link to handout on Our Family Safety Plan](#); also see [link to My Safety Plan for a child and youth safety plan template](#)).

Issues of confidentiality

When offering child and family-centered services, our lens is expanded from a sole focus on adult survivors and their needs and issues. With this shift in focus, we now have to consider the well-being, safety, and needs of children as part of our framework. This expands what we keep confidential and how we communicate about this. It may also affect our relationships with the adult survivors who are parenting.

The following issues are helpful to prepare for in advance:

- Explain confidentiality and your responsibilities as a mandated reporter. Refer to your agency policies on this and think about how and when you might present this information in a way that is clear and as nonthreatening as possible (*e.g., if you do have to make a report, how is the parent involved, and how will your program support the parent and family?*).

- You may want to communicate with other providers and systems to gather information and also share information about the child and family, such as schools, child welfare, and other specialized services that the child may be receiving. This would be preceded by a conversation with the custodial parent to explain why this might be helpful and to get their permission to obtain time-limited releases with specific language about what information is to be shared and with whom.
- If parents are separated or divorced, find out about current visitation and custody arrangements. This might vary if children have different biological or adoptive parents. This is relevant because in situations of joint custody, both parents may need to give permission for ongoing services, including therapy, for children.
- When advocates and therapists are seeing children without their parents present, then it is important to establish in advance with both the parent and child what will be shared with the parent after each meeting and what will be kept private. The advocate or therapist can also discuss with the child what will be up to the child or adolescent to share with their parent directly.
- Advocates and therapists employed within the same organization and working with various members of a family will need to be clear about what needs to be kept confidential from the individual session with the child or parent and what needs to be shared with team members. The supervisor(s) of the various staff involved with the family will need to be part of formulating that agreement and helping ensure adherence to confidentiality. And the advocates and therapists working with the individual family members need to be upfront with them about what they will be sharing with other team members. This transparency about communication will foster trusting, collaborative relationships with family members and between team members.

Making referrals and establishing community partnerships

Building and maintaining collaborations with other agencies and community organizations serving survivors and their children will benefit the families you support. Ensuring that local agencies know your program's range of services and knowing where to refer current clients for family-centered, trauma-informed, culturally responsive support can expedite the referral process. Sustaining relationships with local community providers may take time and effort, but the results are increased resources and support for families.

Some communities have multiple organizations providing necessary services. But others may be lacking in specific resources. If your community does not offer a particular service that would benefit families you regularly serve, consider the possibility of collaborating with other organizations to develop needed programming. Other options might include cross-training and enhancing cross referrals with other organizations that share your agency's values. It can be important to get regular feedback from survivors and their children regarding their use of referrals and the referral process to ensure quality services.

Adhering to strict confidentiality is important in sustaining a trauma-informed organization. Confidentiality can be maintained by ensuring that your organization utilizes best practices regarding release of information documents,

The safety of domestic violence survivors and their children depends on the ability of advocates and others to maintain confidential information while helping them access community resources.

including having domestic violence survivors present during referral phone calls and encouraging them to read through the information to be released (*see section below for additional information regarding confidentiality*).

Some barriers to accessing resources exist for many reasons. Advocates can anticipate potential barriers by ensuring transportation for appointments, organizing necessary paperwork and making sure documents are in order, and role-playing worrisome situations. For domestic violence survivors who may be hesitant to access services outside the domestic violence organization it can be helpful to provide a "warm handoff" referral that includes the advocate providing detailed information about the services, participation

in a joint phone call to establish eligibility and an understanding of safety concerns, as well as attending the first appointment.

Advocates working with families need to become familiar with child and family serving systems to make referrals and best support coordinated efforts on behalf of children and their caregivers. These systems might include: the local school system, day care or childcare programs and providers, pediatricians and other medical providers, early intervention services, infant mental health providers, community programs, cultural centers, child and family mental health providers, sexual assault programs, family court, and child welfare. Advocates and staff from domestic violence organizations can provide parent advocacy in situations where the provider may not understand the safety concerns or lethality of the domestic violence situation. Parent advocacy may include role playing with parents to practice advocating for themselves and their children, practicing assertive communication skills, and offering community providers general information on children's trauma reactions related to experiencing domestic violence. Sharing information about children's trauma responses can help other providers understand children's behaviors that may be misunderstood as *"misbehaving,"* and parents aren't then put in the position of having to defend their child.

Advocates can also ask caregivers: *"What kinds of resources might be helpful for you and your family? What resources would you like us to explore together?"* It's helpful to find out what their past experiences, if any, have been with accessing services in the community for themselves and for their children.

The following systems may be important to connect with as we support domestic violence survivors and their children:

SCHOOLS:

Not all children are involved with the local public-school systems. Babies and toddlers are usually too young for public-school programs, although it is important to know whether your local school system offers free pre-kindergarten opportunities for 3-, 4-, and 5-year-olds. Children ages 5 to 18 may be homeschooled and not enrolled in traditional schools. It is important to know your statewide homeschooling guidelines to support survivors' homeschooling efforts. Some public schools include homeschoolers in their extracurricular activities such as team sports, clubs, and after-school activities. Knowing contacts at the local schools can help connect survivors with resources for their children.

Children may have difficulties academically and socially at school that can be addressed through supportive interventions with classroom teachers and resource specialists. School therapists or behavioral specialists may be able to offer supportive services when concerns include aggressive behavior, withdrawing, inability to focus, frequent post-traumatic play, or self-endangering behaviors. Domestic violence advocates can support children's caregivers during the process of evaluating needs and obtaining services for their children within the school system. Coordinating services and interventions is vital for collaboration in providing comprehensive services for children and their families.

CHILDCARE:

Depending on the age of the children and the needs of the survivor, childcare or day care programs may be an important way to support a survivor looking for employment, trying to regularly attend counseling, or even seeking respite from childcaring duties. Advocates can help survivors by knowing local day care providers and early childhood programs, having applications on hand, details of what services they provide, costs involved, and general ideas of waitlists. Some states and local communities offer subsidized childcare that provides sliding scale or low-cost childcare for families who qualify.

MEDICAL PROVIDERS:

Different communities may have a variety of pediatric clinics or urgent-care providers that can quickly see survivors and their children for everything from well-child checkups and preventive vaccinations, to illness and injury treatment. Other communities may have limited medical providers and require families to travel to access services. Advocates can assist families by knowing where to refer families for both emergent and preventative care.

EARLY INTERVENTION SERVICES:

Early intervention is a general term to describe supports and services for infants and young children, ages 0 to 3 years, who may have developmental delays or disabilities identified by a medical provider. Advocates can make referrals to pediatricians or local early intervention programs if a caregiver or parent has concerns about their child's development. ***(See also Section 6 for information on understanding trauma and its impact on development.)*** Early intervention may include speech therapy, physical therapy, and other types of services based on the specific needs of the infant, young child, and family. Early intervention services can significantly impact and improve a child's future success. Programs offering early

intervention services for free or at reduced rates are available in each state: <https://www.cdc.gov/ncbddd/actearly/parents/states.html>

FAMILY COURT SYSTEMS:

Custody for families impacted by domestic violence often requires court involvement to determine custodial arrangements following orders of protection or formal separation. Family court systems may include family court mediators who work with both parents to recommend custody to judges or determine visitation schedules. When domestic violence is an issue, family court mediators should be aware that joint meetings between survivors and their abusive partners are contraindicated; instead, they can use trauma-informed protocols for protecting the safety and well-being of survivors through private and separate contacts. Family courts may also have referrals for supervised visitation locations and safe custody and visitation exchanges.

INFANT MENTAL HEALTH PROVIDERS:

Infant mental health services may be available in your community. Children 3 years and under and sometimes 5 and under may qualify and also benefit greatly from infant mental health services. Infant mental health programs are focused on the parent-child relationship

and early childhood developmental issues.

Domestic violence survivors may feel supported in these services while strengthening their relationship with their child. These services may also include help with parenting issues or offer parenting support groups like Circle of Security®. (See *website for Circle of Security®* <https://www.circleofsecurityinternational.com/> for more information on this approach.)

CHILD AND FAMILY MENTAL HEALTH PROVIDERS:

Not all children experiencing trauma reactions related to domestic violence need mental health services. Domestic violence advocates can provide a great deal of support to survivors and their children by ensuring a trauma-informed, family-focused environment that contributes to their resiliency and helps restore their relationships with each other. We know that attachment relationships can be disrupted by experiences of domestic violence.

Restoring a sense of safety and responsive caregiving within attachment relationships is critical to children's well-being and ongoing healthy development.

Although some children’s mental health providers may see children individually from a very young age (starting as early as 3 years), it is considered a best practice for survivors and their young children, under age 5, to be seen together for mental health services. The only caveat is that trauma-specific treatment services may need to be sequenced if survivors experience trauma-related responses (e.g., trauma reminders, flashbacks) to their children’s play; whenever possible, the parent will be brought into the playroom to acknowledge and work through past traumatic experiences together to reestablish a sense of safety and protection. Some children may be experiencing a psychiatric crisis due to ongoing violence they’ve experienced or prior mental health issues that have been exacerbated due to domestic violence. They may need further evaluation and possible psychiatric treatment services. While it is important to identify providers in your community that work with children and adolescents, some communities may not have these resources. Consider collaborating with nearby urban areas that may have psychiatric services and in-patient treatment programs for children and teens.

Advocates can provide parents with information about mental health providers who are knowledgeable about the traumatic effects of domestic violence on children and



their primary relationships, and who are skilled in helping them regain a sense of safety, while addressing trauma-related responses and vulnerabilities in the relationship. When children are seen separately, it’s important to have mental health providers who are sensitive to forming therapeutic alliances with their parents and caregivers. ***(See Section 7 for additional information regarding children’s and teen’s mental health concerns and making referrals for mental health services and trauma-specific treatment.)***

CHILD SEXUAL ASSAULT SERVICES:

Children who have experienced domestic violence in their home may also have experienced child abuse and child sexual abuse. Some communities have child advocacy centers that can provide a range of services including specialized forensic interviewing services for children who may have experienced physical or sexual abuse.

These “safe house” programs may provide additional legal advocacy, medical exams, and follow-up counseling for children and families. Advocates can assist families by having contacts within local programs or knowing the nearest resources. *(See Section 7 for more information on responding to child sexual abuse.)*

CHILD WELFARE SYSTEM AND CHILD PROTECTIVE SERVICES:

Survivors and their children may be involved with the child welfare system for a range of reasons including child abuse, neglect, and other issues related to perceived lack of safety, adequate child supervision, and risk of harm related to domestic violence. We know that abusive partners often threaten to call the authorities, such as child protective services, on their partners as a tactic of control and intimidation and may attempt to undermine their credibility with systems that survivors might use to seek support. In addition to threats, abusive partners may make false reports against their intimate partners that can result in survivors being separated from their children.

State and county child welfare systems vary greatly in how child protective services investigators may view child exposure to domestic violence as a form of child maltreatment. There is no clear federal guidance. States and counties act in

accordance with their own written guidelines and statutes. Child exposure to domestic violence, defined as seeing or witnessing violence between intimate partners or its aftermath of injury and property damage, has been directly linked to more than 20 percent of substantiated referrals across the United States based on findings from the National Survey of Child and Adolescent Well-Being II (Lawson, 2019)². At the current time in the United States, most states do not have protections against holding domestic violence survivors responsible for “failure to protect” their children from the actions of their abusive intimate partners. As a result, domestic violence survivors are more vulnerable to having their children removed from their care and may have a harder time reunifying with their children because of societal stigma about domestic violence and implicit bias in the system. Mothers are often unfairly held to a higher standard than fathers by the court system. Child welfare system involvement is often retraumatizing for survivors and their children.

2 Lawson, J. (2019). Domestic violence as child maltreatment: Differential risks and outcomes among cases referred to child welfare agencies for domestic violence exposure. *Children and Youth Services Review*, 98, 32-41.

When a family is currently under investigation or involved with the child welfare system, advocates can play an important role by helping survivors access legal representation and other resources needed to keep their children or to regain custody. Advocates can provide support by helping survivors to navigate a complex system and to advocate on their behalf with child welfare caseworkers and others when requested by survivors via direct contact and attending meetings.

Using a broader social context lens, it's also important to know how children and families of color—Black, Indigenous, and people of color (BIPOC)—living in communities that may be over-surveilled by police and lack access to equitable resources are disproportionately represented in the child welfare system. Historically, Indigenous families in the United States were most severely affected with children being removed, placed in foster care, and for adoption with nonrelatives. In response, the Indian Child Welfare Act (ICWA), established in 1978, provides federal guidelines for protecting American Indian and Native Alaskan children from removal from their parents and tribal communities and guides policies across states related to child abuse and neglect of Native children. For more information, see links: <https://nicwa.org/about-icwa/>; <https://www.bia.gov/bia/ois/dhs/icwa>.

On occasion, domestic violence advocates may need to make a report to child protective services. State and county child abuse reporting mandates vary. It's important to know your state mandates and to follow your organization's policies. (*Refer also to "Issues of Confidentiality" in this section.*) For more information, see the link to state laws when needing to make reports to Child Protective Services: <https://www.childwelfare.gov/topics/systemwide/laws-policies/can/reporting/>.

Providing nonjudgmental support is essential to building trust and collaboration with survivors, as feelings of shame and embarrassment, anger, grief, and resentment may arise when there is involvement with the child welfare system.

Offering and encouraging family-centered services, required by the child welfare system, to take place at your organization may be another way to support the family. (*See Section 7 for additional recommendations on supporting caregivers and children when domestic violence advocates need to report child maltreatment.*)

COMMUNITY ORGANIZATIONS:

Consider collaborating with child and family-focused community organizations in your local area. These might be standalone organizations similar to Big Brothers and Big Sisters or the YMCA or YWCA that have services for the families and children you serve. Some organizations, like local cultural centers or religious youth groups, might offer programming for after-school childcare or low- to no-cost summer “camps.” Other organizations might work within the school district to support children through free tutoring, school supplies, and food. Check with local libraries for free reading, arts and crafts, and music programming for children and families.



Critical Conversations

Helpful Hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing compassionate policies within your program.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

- How does the intake process support the unique needs of the survivor and children?
- Do your safety planning template and guidelines reflect the work your organization actually does to support the unique needs of families with children?
- Does the safety planning include the survivor's children, address culture, accessibility issues, mental health issues, substance use, emotional support animals, visitation with other parent, and anything else specific to the unique needs of individual clients?
- How does our program support caregivers and families who are or who become involved with the child welfare system? What trends do we see emerging regarding separation of children from their caregivers (e.g., removals due to parental substance use or domestic violence)? What stance can we take to better support families?
- How can we further develop and maintain collaborative partnerships with other organizations?

Critical Conversations



What can a direct staff person do?

- Ensure that choices are provided to the survivor regarding intake process, specifically where the children will be while the intake is occurring.
- Make sure that you are familiar with how best to include the unique needs of families and children within the safety planning process.
- Maintain up-to-date resource lists for your community.

What can a supervisor do?

- Engage in conversations about intake protocols. Reflect on consistencies between intake guidelines and current practices. If there are any discrepancies, is there room to make changes to the intake protocols that more accurately reflect trauma-informed practices?
- Engage in conversations about safety planning. Reflect on consistencies between safety planning guidelines and current practices. If there are any discrepancies, is there room to make changes to the safety planning guidelines that more accurately reflect trauma-informed practices?
- Engage in conversations about supporting families involved with the child welfare system. Revisit current policies and protocols related to mandated reporting and partnering on behalf of families involved with the child welfare system. Review your state's mandated reporting requirements periodically and provide opportunities for up-to-date training and discussions with staff.
- Invite community partners to your organization to present on their services and learn about your program too.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Sue and her 7-year-old daughter, Janie, have made an appointment with you to receive services at your agency. While completing the intake documents, Sue shares with you her history of physical and emotional abuse that Janie witnessed. Janie has unsupervised visitation with her father (*Sue's abusive partner*) two weekends each month. Sue also shares that Janie tells Sue that she's "*scared*" of her father but hasn't shared anything specific. Sue tells you that she thinks Janie's father might be molesting her because Janie has started wetting the bed before and after these weekend visits. Sue says that her best friend told her that Janie's bedwetting is probably a sign of sexual abuse.



Things to consider:

- What does the intake process look like? Is there an opportunity to talk with Sue and Janie individually? It seems like it may be important to hear from both of them about these concerns.
- Sue's concerns and distress may be related to her own trauma reminders of past abuse with her partner or if she herself experienced child abuse.
- What does a safety plan need to include for this family?
- If there is continued concern regarding child sexual abuse, discuss possible family court or legal referrals to temporarily pause and address unsupervised visitation.
- Are there other community organizations that might benefit this family?

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin with empathizing with Sue's concerns and distress



- Initiate the dialogue. Tell me more about it:
 - When did you first notice this behavior?
 - What have you tried? What's worked in the past?
 - Have you sought support from anyone about this before?
 - What do you do when this happens? What do you feel like doing?
- When Sue is able to take in a more problem-solving mode with the advocate, explore what Janie's behavior is about. Is she distressed about the separation? Is she dysregulated?
- Discuss mandated reporting for child abuse and possible next steps, including forensic interviewing.
- Discuss establishing rituals as a way to anticipate separation and coming back together after visits. Caregivers like Sue might consider giving their children a reminder of them to take with them during visits (*see **Bedtime Beads activity and link to handout***).



Section 5: Resources and Links

Domesticshelters.org has a section that discusses safety planning based on children's varying developmental levels:

<https://www.domesticshelters.org/domestic-violence-articles-information/safety-planning-with-your-kids#.WvC-XmVMlEd>

<https://www.domesticshelters.org/domestic-violence-articles-information/fleeing-an-abuser-with-your-children#.WvC9qmVMlEd>

WomensLaw.org includes legal information regarding children and custody:

<https://www.womenslaw.org/safety-planning-children#1>

The National Domestic Violence Hotline talks about safety planning in different locations: <http://www.thehotline.org/2013/04/12/safety-planning-with-children/>

Futures Without Violence safety planning template: <http://promising.futureswithoutviolence.org/files/2012/08/Family-Safety-Plan-Template2.pdf>

ChildWelfare.gov for supporting parents involved with child protective services: <https://www.childwelfare.gov/topics/systemwide/domviolence/casework-practice/safety-planning/>

NCDVTMH ACRTI Focus Area 6 on community partnerships: <http://www.nationalcenterdvtraumamh.org/publications-products/tools-for-transformation-becoming-accessible-culturally-responsive-and-trauma-informed-organizations-an-organizational-reflection-toolkit/>



SECTION SIX

6. Incorporating Knowledge about Attachment, Child Development, Trauma, and Healing into Family-Centered Services

This section includes foundational knowledge about the importance of attachment relationships, understanding child development, the Adverse Childhood Experiences (ACEs) Study, and how traumatic stressors and experiences may impact ongoing development. We then introduce a resiliency-based framework for supporting children, caregivers, and families to heal from the traumatic effects of domestic violence. And, finally, we offer critical conversations and a vignette for team-based discussion and links to resources to support family-centered practice.

Attachment relationships

Our first relationships are formed with our primary caregivers. Depending on the caregiving environment, this may be the infant's mother, father, extended family, or communal relatives—whoever is responsible for the baby's care. Although caregiving practices vary from culture to culture, the foundation of the baby's and growing child's development is a predictable, and hopefully secure,

relationship with their primary caregivers. It is more than a loving bond between the baby and caregivers; it is a hardwired biological process between infants and their primary caregivers designed to meet the infant's and child's basic needs. John Bowlby, a British psychoanalyst who developed attachment theory, explains that attachment behaviors, such as a baby's crying, smiling, and reaching, are all hardwired, and the corresponding caregiving behaviors are hardwired into parents to keep the caregiver close to the baby and to protect the baby from danger.

Because attachment is so closely tied to protection for infants and very young children, the attachment relationship is the main organizer of the child's response to danger. Babies and young children are dependent on their caregivers to detect and decide what is safe and what is dangerous, and to take action for protection as necessary. Protection for a very young baby is about more than protecting the baby from predators or life-threatening experiences. It is about meeting the baby's needs for food, warmth, and human connection in a reasonably consistent and prompt way. When a young baby is distressed (*e.g., hungry, needing a diaper change, hearing loud noises*), they have no way of knowing that the distress will pass. With consistent attention from a protective and nurturing caregiver, the young baby develops a sense of

trust that someone will respond to their immediate distress. This builds a secure attachment between the baby or very young child and their caregivers. In the process of becoming attached, the baby and young child learn to trust that one is worthy of love and that others can be relied upon to help when help is needed. Attachment relationships provide young children with an internal model for future relationships. They determine how children see themselves in relation to others and whether children view the world as a trustworthy and helpful place.

Attachment relationships help scaffold children's ongoing development, including the capacity for self-regulation and resilience.

Built on the work of John Bowlby, Mary Ainsworth, and other pioneers in field of attachment theory and research, Kent Hoffman, Glen Cooper, and Bert Powell took this work and developed the Circle of Security © Parenting (COSP) approach. They also made attachment theory more accessible by creating the graphic (see below) to illustrate how caregivers provide a **secure base** for children to go out in the world and explore, and a **safe haven** to come back to when they are upset, feeling overwhelmed, and in need

of connection. The top of the circle illustrates what happens when the child ventures out from the secure base of the attachment relationship and how caregivers respond to meet the child's needs. The bottom of the circle illustrates what happens when the child comes "in" or back to the safe haven of the relationship with the caregiver for comfort and support. With a secure base, children are able to venture forth to explore, learn, and master age-related tasks—and their caregivers are able to "let go," tolerate the separation, and support their children's needs by acknowledging and delighting in their accomplishments. Within the safe haven of the relationship, children are able to come back to their caregivers when they are feeling upset, afraid, and in danger—and their caregivers are

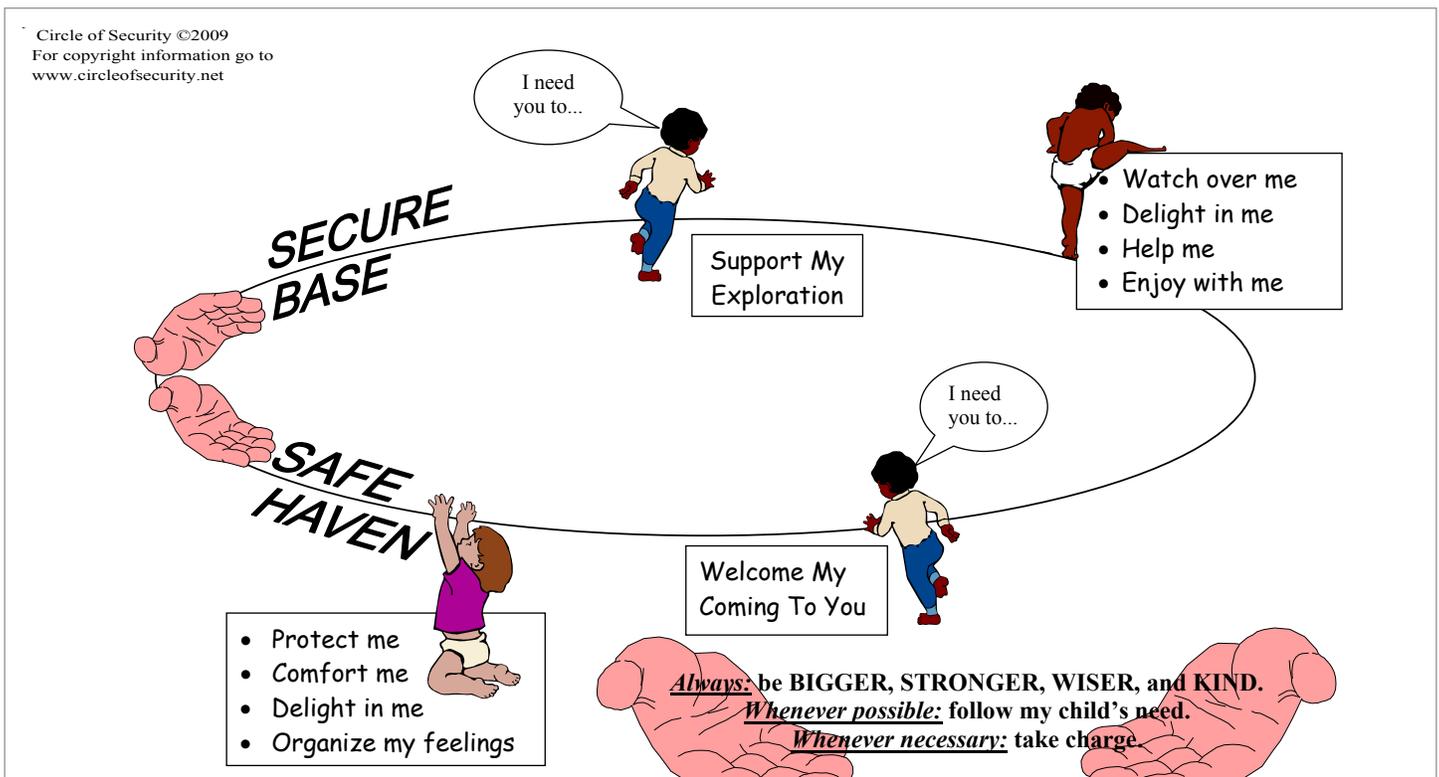
able to welcome them back "in" with a hug or lap when they are small, offer comfort and care, help organize and soothe strong feelings and upset, and provide safety. The Circle of Security © is applicable to all of us. When we are afraid or in danger, our "attachment system" (e.g., our primary relationships) is activated, and we are hardwired to seek safe haven.

For more information about the Circle of Security ©: <https://www.circleofsecurityinternational.com/>

Brief YouTube video introduction to the Circle of Security Parenting approach: <https://www.youtube.com/watch?v=cW2BfxsWguc>

CIRCLE OF SECURITY®

PARENT ATTENDING TO THE CHILD'S NEEDS



Basic principles of child development

We begin by introducing basic principles about child development that apply across the age spectrum:

1. The pace of development is more rapid during the first three years than at any other time of life.
2. Children are not “*blank slates*.” They are born with certain characteristics and genetic makeups. Both nurture and nature are intertwined and interact to affect all aspects of children’s ongoing development.
3. Every child is different, and each child’s development will unfold in a unique way. We can easily notice differences in children’s temperament. Some children are easygoing while others may be shy or more hesitant to approach new people and situations. Our temperament is about how we approach and react to the world around us. Understanding temperament helps us to identify children’s strengths and what supports they might need from their environment to succeed.
4. Family, home, culture, and community play an important role in development. Achievement of some milestones is as much about opportunity or access (*e.g., riding a bike*) as it is about innate capability. We can ask caregivers about what’s valued and important for their family. What’s encouraged and supported?
5. Development does not occur in a straight line or evenly. Although there are some predictable patterns, there is also great variation from child to child.
6. Mastery of developmental tasks at each stage builds on each other. Lack of achievement of key milestones at one stage may impact children’s ability to move forward as they get older. There may be a mismatch between the child’s chronological age and their developmental capacities. For example, if a child has difficulty in managing strong feelings and in self-regulation when stressors arise, as they grow older it may impact their ability to make friends and to navigate various learning demands.
7. Children’s development may unfold in atypical ways based on neurodevelopmental differences at birth, because of medical history or injury, and because of trauma and abuse. These differences add another layer of complexity in understanding children’s needs and finding the right resources to help them thrive.

Offering developmentally attuned, family-centered services

It's important to have a working knowledge of typical child development at various ages and stages when providing services for children, teens, and caregivers affected by domestic violence. This helps us assess whether or not children's development may be delayed or affected by traumatic experiences. Some children are developing typically despite their exposure to domestic violence. Others may have uneven development in certain areas; for example, a child may be meeting all of their motor development milestones (*crawling, standing, walking*) but may be delayed in their speech and language development.

Knowing about child development also allows us to engage in dialogue with parents about their children's developmental stage and capacities. Advocates can offer information about what to expect and can support caregivers to recognize and respond to their children's developmental needs. Of course, we need to understand child development in the context of the family's cultural values and norms and parenting practices. We can share and discuss print resources that explain age-typical developmental tasks and help

caregivers understand when their children may need outside resources and services to “catch up” and regain a healthy developmental momentum.

For more information on child development, see resources and links in this section. See also NCDVTMH's “*Developmental Tasks—Ages and Stages*” ([link to handout](#)) and “*Tips for Supporting Children and Youth Exposed to Domestic Violence: What You Might See and What You Can Do*” ([link to handout](#)). These handouts can be shared with caregivers. Also refer to NCDVTMH's “*Guide for Engaging and Supporting Parents Affected by Domestic Violence*.” The guide offers strategies for having sensitive dialogues with caregivers and may be helpful when offering developmental guidance. Click on the link:

<http://www.nationalcenterdvtraumamh.org/publications-products/guide-for-engaging-and-supporting-parents-affected-by-domestic-violence/>

When children's development is atypical and they are experiencing delays

Engage in a conversation with the child's primary caregiver about what you are observing. Do they seem to be delayed in their speech and language, motor development, social-emotional development, or in meeting major milestones (*e.g., toileting*)? Encourage the parent to share their observations with you (*e.g., What are they seeing? Do they have any concerns? If so, what are they?*). Ask how this particular child's development or experiences may be different from other siblings or their own expectations.

After gauging the parent's willingness to explore this topic with you, share information about what to expect within the range of typical behavior as children's development unfolds. If the caregiver holds a different view, explore that further and try to better understand their perspective. Recognize cultural differences and support culturally attuned experiences that promote healthy development. Keep in mind that parents may feel guilt, grief, shame, or blame about their child's developmental differences.

In the previous section, one of the child-and-family serving systems listed was early intervention. Be familiar with resources in your community and state that offer no or low-cost developmental assessment and home-based early intervention services for children from birth through age 3. After age 3, there is another network of school-based special education services for children who are in the 3- to 5-year-old range. For general information about early intervention services: <https://www.zerotothree.org/resources/2335-what-you-need-to-know-early-intervention>.

Understanding the impact of traumatic experiences on children's development

The role of stress in children's development

Children are exposed to a range of stressful experiences as they grow and develop. Stress in early childhood can be either growth enhancing or harmful to the developing brain. Different effects depend on the intensity and duration of the experience, differences among children in their body's stress reactions, and the extent to which a supportive adult is available to help the child cope with the adversity. These differences can be understood within the context of three types of stressful experiences that may lead to different outcomes. These types of stress: positive, tolerable, and traumatic or toxic stress is based on the work of Jack Shonkoff, a pediatrician at the Center on the Developing Child at Harvard University (www.developingchild.harvard.edu):

- **Positive stress** refers to the types of stress that are part of everyday life (*meeting new people, entry to school or day care, routine medical care, dealing with frustration, learning to ride a bike*). When adults help children manage their feelings, it keeps the physiological stress response manageable and helps the child to develop increasing mastery and self-control within the safety of a consistently nurturing and warm relationship. Positive stress is an important and necessary aspect of healthy development.
- **Tolerable stress** is associated with events that could trigger physiological responses large enough to disrupt the brain's architecture (*e.g., being hospitalized, the death of a family pet, a car accident, or a natural disaster*) but are relieved by supportive relationships that facilitate the child's adaptive coping and restore the stress response system to its normal baseline. What makes them tolerable rather than harmful is the presence of trusted and supportive adults whose actions protect the child by reducing the sense of being overwhelmed. The availability of caring adults literally turns down the child's stress response system, allowing the brain to recover and preventing

harm. When a stressful experience overwhelms the family's capacity to cope, outside assistance can make a difference.

- **Traumatic or toxic stress** is associated with strong and prolonged activation of the body's stress response systems in the absence of the buffering protection of adult support. Types of stressors include recurrent child abuse or neglect, severe maternal depression, parental substance use, or domestic violence. Under these circumstances, persistent elevations of stress hormones and altered levels of key brain chemicals can disrupt the architecture of the developing brain. Although responses vary among children, these reactions can affect learning and memory and can undermine health and well-being over time.

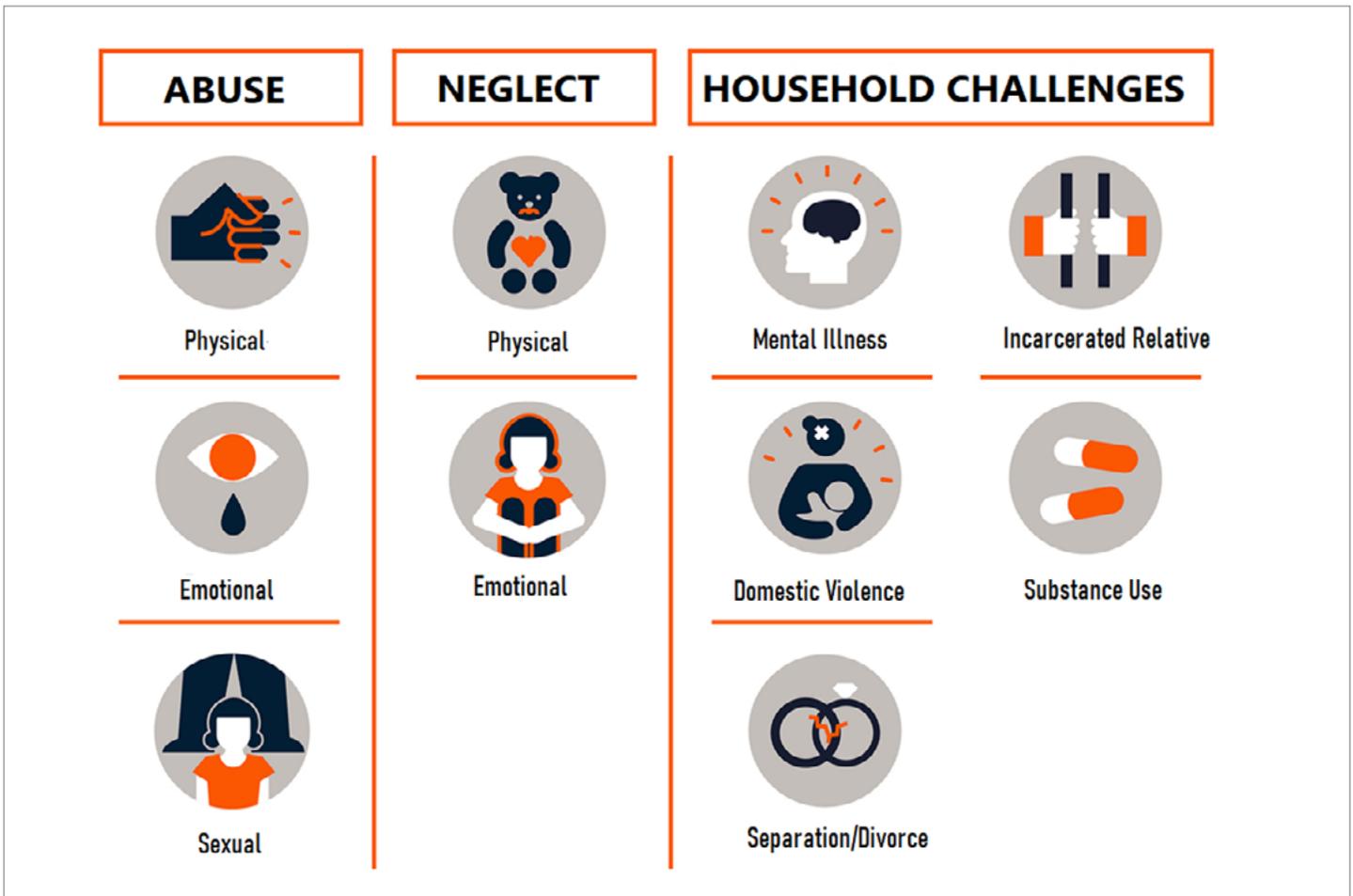
In thinking about the role of stress in children's development, it's important to consider not only the nature of the stressor but the availability of adult caregivers to help children manage the stress, and to use those coping skills to strengthen their own internal capacities to manage stress as they grow older.

Adverse Childhood Experiences (ACEs)

In 1995, the Centers for Disease Control and Prevention and the Kaiser Permanente health care organization in California conducted a groundbreaking study on how adverse experiences in childhood might affect health and mental health outcomes during our lifetime. In that study, “ACEs” referred to three specific kinds of adversity children faced in the home environment—various forms of physical and emotional abuse, neglect, and household challenges:

The key findings of dozens of studies using the original ACEs data are:

- (1) ACEs are quite common. More than two-thirds of the population report experiencing one ACE, and nearly a quarter experienced three or more.
- (2) There is a powerful, persistent correlation between the more ACEs experienced and the greater the chance of poor outcomes later in life, including dramatically increased risk of heart disease, diabetes, obesity, depression, substance use, smoking, poor academic achievement, time out of work, and early death.



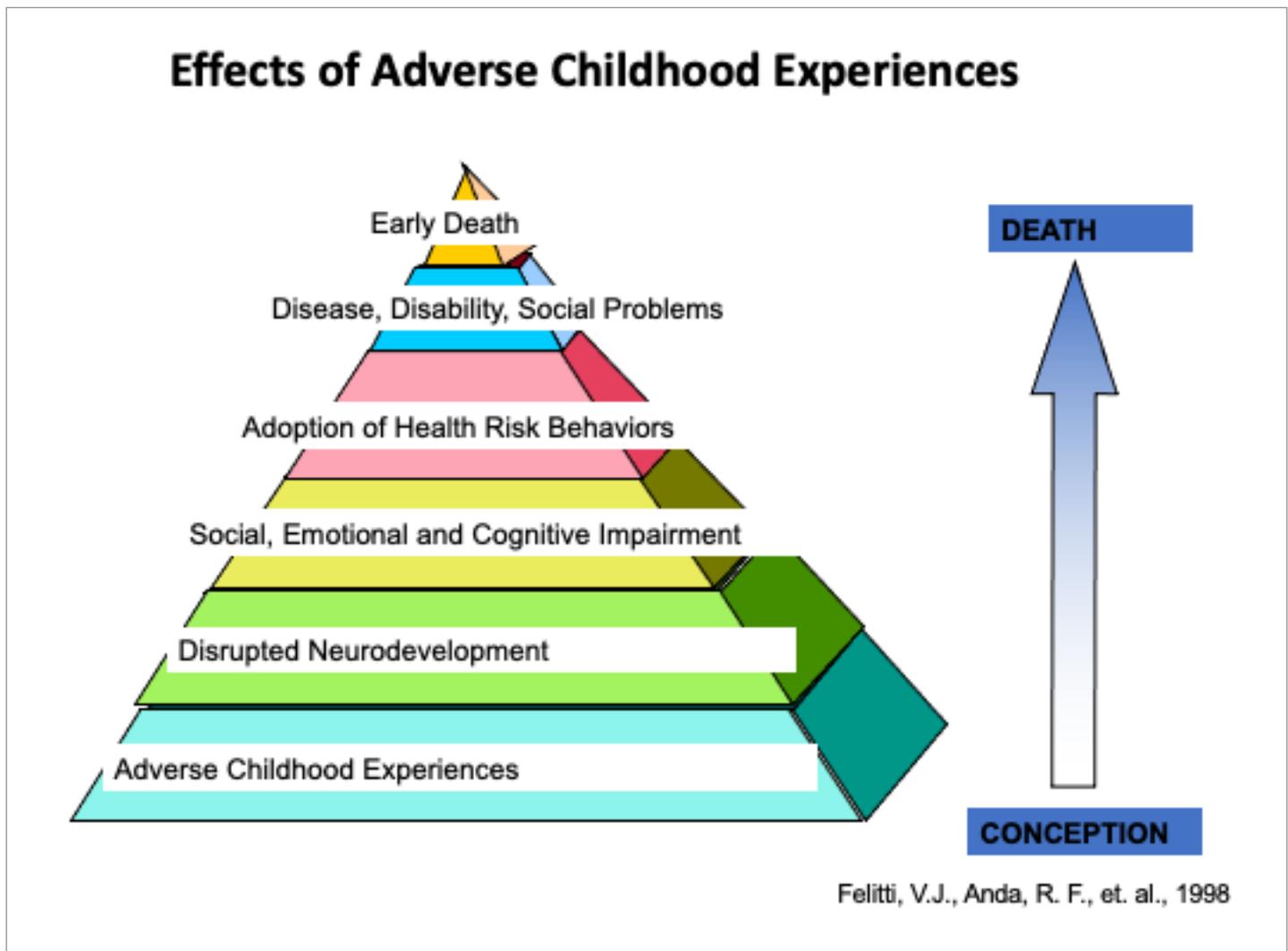
As the number of ACEs increases, so does the risk for negative health outcomes



Possible Risk Outcomes:

BEHAVIOR				
 Lack of physical activity	 Smoking	 Alcoholism	 Drug use	 Missed work
PHYSICAL & MENTAL HEALTH				
 Severe obesity	 Diabetes	 Depression	 Suicide attempts	 STDs
 Heart disease	 Cancer	 Stroke	 COPD	 Broken bones

The following pyramid graphic highlights the effects of ACEs on our brain development, health, mental health, and well-being during our lifetime.



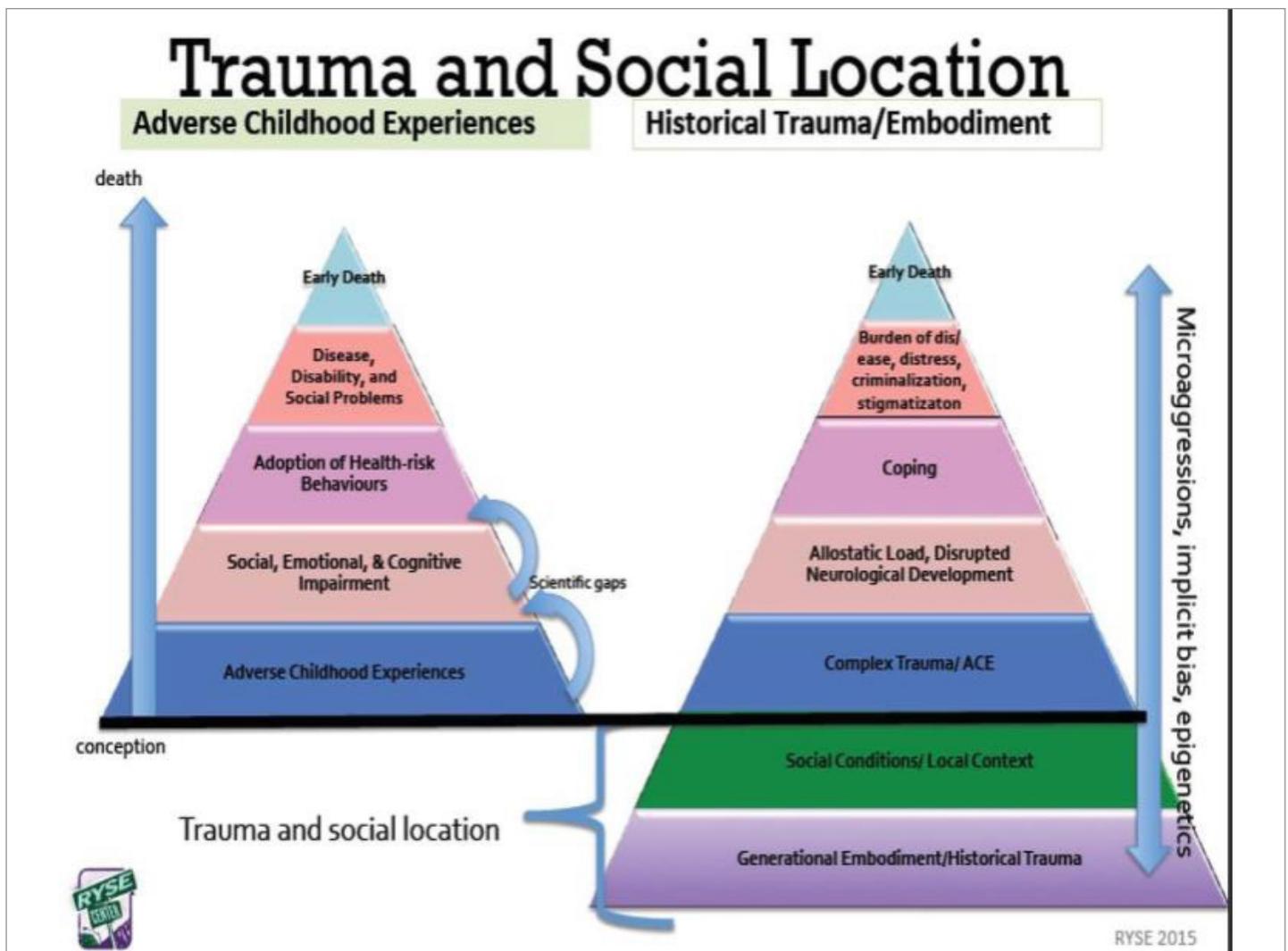
Pediatrician Dr. Nadine Burke Harris has given an informative TED Talk called “*How childhood trauma affects health across a lifetime*”:

https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

A recent large-scale study of approximately 250,000 adults, representing the most racially and ethnically diverse sample to date, across 23 states, reconfirmed that childhood adversity is common across all sociodemographic categories. However, some individuals are at higher risk of experiencing ACEs than others. The study

found statistically significant higher scores for people of color and those identifying as LGBTQ+. They concluded that we need to prioritize primary prevention of ACEs to improve health and life outcomes throughout the lifespan and across generations. The graphic below expands our understanding of how ACEs may affect our health outcomes during our lifespan and broadens our definition of what affects stress, well-being,

and parenting in the next generation by adding the pyramid of trauma and social location. Seeing both side by side allows us to understand the additional burden of microaggressions, implicit bias, discrimination, racism, and oppressive practices in the context of historical, collective, and ongoing trauma and how that affects individual outcomes throughout the lifespan and across generations:



In another ACEs study that focused on childhood exposure to domestic violence, the authors found that those individuals who experienced domestic violence in childhood were two to six times more likely to have experienced other childhood adversities. Experiencing domestic violence in childhood was also associated with a higher risk for alcohol use disorder, illicit and IV drug use, and depression in adulthood. This highlights the importance of talking with caregivers about how their own adverse childhood experiences might be impacting their health and well-being and their children's health and well-being. A resource that incorporates an understanding of ACEs was created for home visitors in the Maternal, Infant, and Early Childhood Home Visiting health sector. This trauma-sensitive approach is titled NEAR, which stands for Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience, and might be readily adapted within domestic violence program settings. The resource can be downloaded at Near@Home: <https://startearly.org/where-we-work/washington/nearathome/>

(See resources in this section for additional information and links on ACEs.)

Supporting children, caregivers, and families to heal from the traumatic effects of domestic violence

The SASS framework is a resiliency-based approach to help guide our practice and to support protective caregivers in fostering resilience and healing for their children and themselves.

SASS is an acronym that stands for: **S**afety, **A**ttachment, **S**elf-regulation, and **S**elf-esteem/**S**elf-agency (Blumenfeld, 2014). Each of these interrelated components are summarized below:

SAFETY is the first component:

With any behavior or concern, we begin by establishing a sense of **safety** that includes being physically safe and feeling emotionally secure. Domestic violence can affect children's sources of safety and security. The quality of the caregiving environment may be compromised by the abusive partner's actions and behavior. This may include undermining the non-abusive parent's role and authority within the family. The abusive partner's behavior may also be confusing and frightening for children, and their parenting

may not be responsive to their children's needs for nurturance and protection (*both directly and indirectly through what they experience as a result of domestic violence within the home*). The protective parent may be unable to keep their children safe from physical and emotional harm, despite their efforts, due to the pattern of power and coercive control established by their abusive partner.

Establishing a sense of safety and security is the first step toward fostering resilience and healing for survivors and their children. Reestablishing a sense of safety and security may need to happen over and over again as new events or traumatic reminders and memories of past experiences related to domestic violence unfold. Some examples include when contact is resumed with the child's parent who has court-ordered, unsupervised visits or when the abusive partner violates an order of protection. If children are not feeling safe at any point in time, then it's difficult to address problems or concerns.

We can be supportive to caregivers by encouraging them to help their children feel safer and more secure by: (1) establishing predictable routines (*including daily routines at home, drop-off and pickup*); (2) providing reassurances about how they are keeping their children safe (*changing locks on the door*

after safety was breached, etc.); (3) helping children navigate transitions (*e.g., change in routine, custody arrangement, teachers, etc.*); (4) offering choices that help children regain a sense of control; and (5) setting limits and boundaries with kindness and consistency (*reestablishing the parent's or caregiver's authority, post-separation from the abusive partner*).

ATTACHMENT is the second component:

The single most important resource for children's healing and resilience can be their relationship with the non-abusive parent.

The parent-child relationship may be altered or disrupted, however, as a result of experiencing domestic violence. Building or reestablishing a secure attachment relationship helps children gain or regain a sense of safety and security. The protective parent is a "secure base" from which to explore the world and a "safe haven" when children experience scary or overwhelming feelings or events. Protective adults can be counted on to be "bigger, stronger, wiser, and kind" and can take actions to protect and comfort children when needed. (*See previous information on Circle of Security* ©.)

We can support protective parents to build secure attachments by engaging in interactions and activities that promote bonding and closeness and by responding to their children’s needs at the “top” and “bottom” of the Circle of Security ©. Young children may enjoy simple games such as “hide and seek” and other reciprocal interactions that promote pleasure and bonding with parents and other adult caregivers. We might ask: What positive memories do you have of doing things together as a family that were fun? We can encourage parents to find ways to engage in enjoyable activities with their children of all ages to strengthen bonding and closeness (such as dancing, watching movies together, reading, playing games online, making popcorn, having special times to play and cuddle).

SELF-REGULATION is the third component:

Self-regulation is an important part of the healing process, as children and teens learn to cope with overwhelming feelings, thoughts, sensations, trauma reminders, and memories in ways that are more adaptive.

When we are young, primary caregivers help us regulate overwhelming feelings and sensations and help to buffer stressful experiences. Parents have to be calm enough themselves and able to reflect on their children’s needs in the moment in order to help their children re-regulate when they are

upset. As children become older and more independent, they are better able to manage strong feelings and stressful situations over time on their own. When children have experienced domestic violence and other adversities from an early age, they may not have had the same support to develop this capacity for self-soothing and self-regulation.

We can help children and support parents by offering strategies for self-regulation. These include relaxation techniques, such as deep breathing, positive affirmations, progressive muscle relaxation, yoga, mindfulness, and meditation. (See Section 12 for resources.)

SELF-ESTEEM (and having a sense of self-agency) is the final component of the framework:

Self-esteem and how we view ourselves begins with positive mirroring from our parents and other important adults in our lives. Our sense of self-agency in the world comes from knowing that our needs and feelings are understood and matter! Through our relationships with parents and other caring adults who can sensitively attune to and respond to our needs, we learn how to articulate what we want and need. We learn how to trust others to help meet our needs and to gain skills in negotiating and solving problems when we have conflicts. Children who experience domestic violence may feel very alone and that their needs

are not important. We can encourage adult caregivers to help repair and strengthen these relationships that may have been affected and challenged by the ongoing stressors of intimate partner violence. In the process, this restores protective parents' capacity to respond sensitively to their children's needs

Mastering developmental tasks at each stage makes us feel proud and capable. Having an opportunity to develop our individual talents and abilities, such as excelling in sports, the arts, and other pursuits, contributes to positive self-esteem.

When children experience domestic violence or other forms of interpersonal violence, this may affect their view of themselves and how they see the world around them. They may feel that they are "bad" or unworthy of love and care or to blame for what's going on. Children need reassurance that the violence they have experienced is not their fault. Building positive connections with caring adults and peers can be reparative to children's self-esteem.

We can help children and support parents to build children's self-esteem based on the individual child's developmental capacities and interests. Infants and young children develop self-esteem through their attachment relationships and when primary caregivers can "delight in me" as they explore my world and try new things. With school-age children

and teens, parents can help support the discovery of what their child enjoys doing and is interested in mastering through activities, classes, and participation in sports, clubs, and through other community events such as tutoring younger children or "giving back" to others. When children feel a sense of belonging within family, cultural, and community groups, this also contributes to positive self-esteem. Children's sense of self-agency is fostered when parents can acknowledge and hold their children's needs in mind, while offering choices that are developmentally sensitive and providing reasonable limits and boundaries.

All of the SASS components are interrelated. They help children to become more resilient, to cope more adaptively with their life experiences, and to experience a greater sense of well-being and security through their connections with nurturing parents, other caring adults, family, and community.

The well-being and resilience of domestic violence survivors is intertwined with their children.

Through our relationships with families affected by domestic violence, we can support protective parents and children to heal together and to thrive.



Critical Conversations

Helpful hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing compassionate policies within your program.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

- Consider how you and others in your organization can increase your understanding of child development and the impact trauma can have on the development of children.
- How does the Circle of Security[®] approach resonate for you and your team in supporting families experiencing domestic violence? How would you adapt the graphic when supporting families who are living in multigenerational and more communal settings? Consider how historical and cultural trauma, multigenerational abuse, societal racism, and oppression may influence caregivers' responses to safety, danger, and parenting practices for their children.
- Consider how an increased understanding of ACEs might benefit domestic violence survivors and their children that your organization serves.
- How would you go about offering developmental guidance to survivors who are parenting? How might you use the handouts on *“Developmental Tasks—Ages and Stages”* and *“Tips for Supporting Children and Youth Exposed to Domestic Violence”*?
- Consider how the SASS framework might be applied to families you are supporting in your program during team meetings.

Critical Conversations



What can a direct staff person do?

- Seek out information and trainings on child development and childhood trauma.
- Consider collaborating with infant mental health and early childhood programs in your community to improve future referrals.
- Think about how you might apply the SASS framework to a specific family and bring that into individual and team-based supervision meetings.

What can a supervisor do?

- Build relationships with community partners who specialize in infant mental health or early childhood programming.
- Create training opportunities for staff regarding issues of child development, ACEs, and trauma.
- Help facilitate individual and team-based reflective supervision using the SASS framework.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Sally attends a parenting support group that you facilitate. She talks about Sammy *“acting just like his father.”* After group she tells you that Sammy is a bad kid. The other day, she discovered him trying to choke his 2-year-old sister. She says, *“He will end up being an abuser like his dad. Maybe he should go live with him. I can’t take it anymore!”*



Things to consider:

- How might you apply the SASS framework to support this family?
- How might teaching ways to calm and soothe (when not in the moment) help both Sally and Sammy in the future?
- It can be normal for survivors to experience their children's behaviors as trauma reminders. It can be helpful to support survivors in recognizing their unique and individual trauma reminders and how to manage those.

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin with empathizing with Sally's distress and talk about what she may be feeling, including panic, helplessness, anger, and blaming Sammy.
- Explore the possibility that she may be experiencing trauma reminders of when she herself was choked by her intimate partner.



- Initiate the dialogue. Tell me more about it:
 - Is this recent? When did you first notice this behavior?
 - What have you tried? What's worked in the past?
 - Have you sought support from anyone about this before?
 - What do you do when this happens? What do you feel like doing?
- When she's able to engage in a problem-solving mode with you, think together about ways to protect her 2-year-old from harm. Safety first.
- Then explore what Sammy's behavior is about. When does this happen? Is Sammy feeling overwhelmed and dysregulated? Is he imitating something he's seen? Can she set limits in a way that helps Sammy understand that what daddy did was wrong?
- Teach ways to calm and soothe for both of them (*when not in the moment*), etc.



Section 6: Resources and Links

See NCDVTMH handout on “Developmental Tasks—Ages and Stages” and selected links for more specific information on child development.

(Link to “Developmental Tasks—Ages and Stages”)

Bright Futures from the American Academy of Pediatrics. Bright Futures is a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community. Bright Futures offers many different resources for your use in improving and maintaining the health of all children and adolescents, including tip sheets, resources on typical and atypical child development, information about medical and dental needs, and more: <https://brightfutures.aap.org>

Center on the Developing Child at Harvard University. The mission of the Center on the Developing Child at Harvard University is to drive science-based innovation that achieves breakthrough outcomes for children facing adversity. The website includes videos, tip sheets, and information on scientific research: <https://developingchild.harvard.edu/>

Child development information from the Centers for Disease Control and Prevention. Information, tip sheets, and resources related to children's development from birth to age 18; topics include developmental milestones, children's mental health, positive parenting tips, and more: <https://www.cdc.gov/ncbddd/childdevelopment/>

Child Mind Institute. Parents Guide to Developmental Milestones (*in English and Spanish*) (2017). This guide provides developmental milestones from birth through age 5 with sections called “Developmental health watch” for possible delays that may signal discussion with pediatrician: <https://childmind.org/guide/developmental-milestones/>

Section 6: Resources and Links



Talaris Institute’s Parenting Counts. Parenting Counts offers information for professionals, parents, and caregivers about raising socially and emotionally healthy children. Parenting Counts has easy-to-use tools and materials that are based on research. Free resources include a developmental timeline that explores children’s physical, social, learning, and communication milestones for children between birth and age 5: <https://www.parentingcounts.org/developmental-timeline/>.
<http://www.parentingcounts.org/>

Zero To Three. Zero To Three offers a comprehensive interactive resource for parents/caregivers and professionals on healthy development of children from birth to age 3: <https://www.zerotothree.org/>

Selected print resources on childhood development:

Davies, D. (2004). *Child Development: A Practitioner’s Guide* (2nd ed.). Guilford Press.

Fraiberg, S. (1959). *The Magic Years*. Fireside (paperback, 1996). Birth to age 6.

Kopp, C. (2003). *Baby Steps* (2nd ed.). Holt Press (paperback). Development during the first two years of life.

Lieberman, A. (1993). *The Emotional Life of the Toddler*. The Free Press: NY (paperback)



Section 6: Resources and Links

Parent or caregiver resource:

Michigan Association of Infant Mental Health. You can order “wheels,” available in multiple languages, on children’s social and emotional development from birth to age 5: <https://mi-aimh.org/?s=wheels>

Links on ACEs:

The Centers for Disease Control and Prevention has background information and graphics: <https://www.cdc.gov/violenceprevention/acestudy/> https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html

Center on the Developing Child at Harvard University:

<https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/>

PACEs Connection (formerly ACEs Connection). PACEs (Positive & Adverse Childhood Experiences) provides a community forum, up-to-date resources, and blogs: <https://www.pacesconnection.com/>

ACES Too High is the companion site to PACEs Connection and is a news site that reports on research about Adverse Childhood Experiences, including developments in epidemiology, neurobiology, and the biomedical and epigenetic consequences of toxic stress. It also covers how people, organizations, agencies, and communities are implementing practices based on the research. This includes related developments in education, juvenile justice, criminal justice, public health, medicine, mental health, and social services: <https://acestoohigh.com/>



7. Responding to Children’s and Teens’ Behavioral Challenges and Mental Health Concerns

In the previous section, we explored how children develop and thrive in the context of their caregiving relationships and how traumatic experiences may impact children’s development and well-being. A resiliency-based framework to support children’s ongoing development and help families heal from the traumatic effects of domestic violence (SASS) was also introduced. Yet, we may find ourselves without clear guidance on how to respond to emotional distress, crisis, and the full range of mental health-related issues that may arise as we seek to support the unique needs of children, teens, and their families. This section provides best practice guidance for offering direct services, supports, and ways to partner with parents and other primary caregivers to address and respond to their children’s needs. In addition, more detailed information and guidance on responding to children’s and teen’s behavioral challenges and mental health concerns is provided with helpful resources and links.

Children’s experiences of domestic violence and their needs are unique and varied.

Depending on the protective relationships and other supports in children’s

lives, they may be doing well despite experiencing domestic violence. Some children appear to be functioning well—they are high achievers

in school and may excel in other activities—but at the same time, they may be carrying significant feelings of depression, anxiety, and isolation. These children can be easily overlooked. Sometimes a child’s functioning can deteriorate because of a new situation that affects the family. For instance, the child or youth was doing well in school and at home, and then the family entered shelter; or the visitation and custody order changes and contact resumes in a different way; or the parent or caregiver has lost a job; or the former abusive partner and non-protective parent is being released from prison, and there are resulting new fears about the safety and well-being of both themselves and their protective parent.

The health and well-being of the protective parent or caregiver is closely intertwined with how children are faring and vice versa. Children may have different needs at different points in time. Healing from the traumatic effects of domestic violence is not a linear process.

Responding to concerns and the unique needs of children and teens

When concerns arise, it’s important to build a collaborative connection and rapport with the primary caregiver or protective parent

who will be supporting their child’s services and engaging as a participant in the process. It’s helpful to begin by exploring who is experiencing the distress and who’s holding the concern about the child’s well-being. Is it the child or teen, the parent or family member, a caregiver, teacher, or other caring person in the child’s life? Or does the domestic violence advocate or mental health counselor hold the concern?

If the parent identifies concerns, how are they feeling right now? Parents might be feeling overwhelmed, angry, helpless, or scared by their child’s behavior. Parents may also perceive their children’s behavior through the lens of their own trauma-related experiences (e.g., *seeing the child as their abusive partner*) or interpret behavior that is age-typical as cause for alarm.

Some of the concerns may be related to ongoing contact between the child and their former abusive partner as they continue to share parenting arrangements.

If the parent is not identifying the concern, then it’s important to talk about what the advocate or others have noticed and are concerned about. We can ask the parent directly: “*Have you seen this?*” “*Does this worry you?*” Sometimes parents may seem dismissive of these concerns. It’s important to hear, respect, and reflect on their perceptions,

while continuing to understand more about their perspective. You can bring a trauma-informed, culturally responsive lens to this conversation. You may have different perspectives and that's OK. This too is a process.

Each situation is unique. We can help children, teens, and caregivers begin to understand and respond to these behaviors by stepping back to further explore their meaning. To understand the meaning of the child's behavior, we can be guided by taking a curious, open, and nonjudgmental stance as we look for clues. This can apply to any concern you encounter.

We can begin by asking and then further exploring the concerns with caregivers:

- When did the behavior begin? Has it been continuous, or has it gotten worse at any point?
- Has the child or family been through any significant change or transition recently that coincides with when the behaviors began or got worse? Remember that protective caregivers may not immediately identify a change that may be having a profound effect on their children (such as a parent's return to work, a move, changes in childcare arrangements, etc.).
- How does the parent understand the concern? What have they tried to do in response to the behavior, and what was the result? What have they been feeling? It's not uncommon for parents to feel overwhelmed and distressed, and their children's behavior may elicit feelings of helplessness, fear, anger, blame, and hopelessness. As advocates, we can acknowledge and hold those feelings together with caregivers as we continue to see ways to address the issues.

We can also explore needs and concerns from the child's or teen's perspective:

Quite often, when we ask children and teens directly about their experiences, we get new information about how they are feeling and insights into what's going on at home, with the family, at school, with peers, in the community, and how this may be affecting their mood and behavior. Research has shown that caregivers are generally more aware of externalizing behaviors (*such as aggression and non-prosocial behaviors*) than they are of internalizing issues (*such as anxiety and depression*).

We can also do a self-awareness check-in before responding to the concern. What am I aware of feeling within my body right now (*such as heart racing, sick to my stomach, etc.*)? What thoughts and feelings do I have about this? These might include identifying with a particular family member's distress or the child's response, or feeling confused and uncertain about what would be helpful and supportive, etc. This can help prepare us to be grounded and more present while also being aware of any strong feelings or biases we may be holding.

With any concerns that are presented, we can be attuned to power and control issues that come up for parents and their children when and after experiencing domestic violence. Often the parent's authority and their sense of themselves as capable caregivers has been diminished over time within the family system by the abusive behaviors and actions of their partner. The family may have adjusted to living within an atmosphere of tension, unpredictability, and fear. Parents' and children's stress response systems are dysregulated by ongoing trauma. This can lead to strained communication, ineffective ways of negotiating and handling problems and conflicts, and feeling depleted.

In understanding and responding to the unique needs of children and teens, we can apply various lenses, which include age and developmental capacity, culture and identity, trauma and healing—all in the context of family, community, and the broader society. What are the social supports, services, and resources available to the family? What do they draw on as sources of comfort, resilience, and healing in their lives?

Identifying mental health needs of children and teens affected by domestic violence

Domestic violence agencies may have access within their programs to in-house mental health services or they may refer out. Mental health services can include diagnostic assessment, trauma-informed treatment services, and psychiatric evaluation.

It's important to explore parents' beliefs about mental health services. Be aware of and explore cultural practices and beliefs related to wellness and mental health.

What, if any, past experiences have they had with the mental health system, either directly for themselves or for family members? What were those experiences like? In general, our society views mental health issues as stigmatizing, and parents may be afraid that their children will be labeled in a way that is deficit-based, damaging, and potentially retraumatizing.

We can ask the parent: What are your expectations for receiving mental health services?

Some parents may express the wish for the therapist to “fix” their child and resolve the behavior. We can talk realistically about what to expect and how important it will be for the parent or caregiver to be engaged in the process.

This alliance can be further developed when advocates can anticipate parents' issues of mistrust with the mental health system and services, and any fears of being coerced into making this choice on behalf of their children. If that comes up, advocates can actively reassure parents about their unconditional respect and belief in their capacity for healing. This trauma-informed working alliance enhances the self-esteem and resiliency of parents who have experienced domestic violence and creates opportunities to build on strengths. It can be empowering for domestic violence survivors to have an understanding of their own trauma reactions and coping skills along with their children's trauma reactions and coping skills.

Mental health services might be considered when:

- Children are experiencing challenges that affect mastery of age-related developmental tasks, including delays in social-emotional development. Some children may also benefit from a coordinated plan that includes early intervention services and speech and language or occupational therapy services with mental health care.
- Children are having severe difficulties with daily functioning over a period of time, at home or in other settings such as day care, school, after school, or community programs. For example, they may be unable to sleep at night, may be highly aggressive toward a younger sibling, may demonstrate repetitive, post-traumatic play without resolution, or are having difficulty relating to peers or concentrating in school.
- Children and teens may be expressing suicidal thoughts or intent or are self-harming or harming others.
- Youth are dissociated, or “*losing time*” over the course of a regular day, which may put the youth at risk for harm.
- There are issues with the attachment relationship between children and their primary caregivers. Parenting capacities may be strained as a result of experiencing ongoing domestic violence, and children may not feel safe and protected. Parent and child may hold views of each other that are negative and inaccurate, based on traumatic experiences.

When a child, domestic violence survivor, or family may need to be referred to a mental health therapist within your program or agency, or to other mental health services outside of your organization, it can be helpful to anticipate that need and make connections in your community and surrounding communities with services that provide trauma-informed mental health interventions for adults, children, and families. Make sure to let the adult caregiver know how and what specific information will be shared as part of the referral process. Ensuring adherence to strict confidentiality supports a trusting relationship between caregivers and their children and staff.

In finding qualified mental health providers, it's important to consider the following questions:

- Are the mental health providers domestic violence informed?
- How much information about any individually based therapy for children or teens will they share with the parent or caregiver?
- Do they routinely include protective parents in the process?

- Do they have experience in conducting trauma-informed and trauma-specific therapy? If so, let them tell you about their training, treatment philosophy, and approach, and what families can expect.
- Do these providers consider a range of options, such as community-based programs, in addition to therapy? Are they thinking holistically about child and family needs?

Trauma-informed treatment approaches:

Mental health practitioners should be well versed in a phase-based approach to trauma-informed treatment. **The core components include:**

- Establishing safety (*both physical and emotional*)
- Regulating emotions
- Building interpersonal skills and adaptive coping strategies
- Making sense of what happened (*by incorporating play, talk, and expressive arts*) or using mind-body centered approaches, such as yoga-sensitive treatment, or culturally specific approaches to wellness and healing

- Regaining a sense of hope and finding perspective (e.g., “I am more than what happened to me”). Children are able to regain developmental momentum that may have been stalled due to trauma.

It is important to provide interventions jointly for domestic violence survivors and their children.



Often, treatment services are directed for the survivor and child separately, for example, separate groups for parents and children on understanding domestic violence. While these groups and others can be beneficial, it is also important that there are opportunities for family work and relationship-enhancing interventions to occur. Some domestic violence organizations are able to team an advocate with a mental health therapist (in-house) to offer some of these services. The treatment of choice for young children, ages 5 and younger, is parent-child work. Crisis intervention, individual counseling, groups, and family sessions can all benefit children, teens, and domestic violence survivors.

There are a number of researched treatment interventions, considered best practices that may benefit domestic violence survivors and their children. Interventions found within the literature include simultaneously occurring groups for parents and children,

and family sessions with mothers and children to support relationship skills. Many of the researched interventions occur with a licensed mental health therapist. Some of the following programs may be of interest if your organization has the funding and capacity for increasing therapeutic services.

- Child-Parent Psychotherapy
- Circle of Security Parenting
- Kids Club and Moms Empowerment Program
- The Nurtured Heart Institute
- Parent-Child Interaction Therapy

Occasionally other systems may not respond to survivors and their children in a trauma-informed way and some advocacy on our part is required. If the parent is interested, encourage their participation in facilitated

conversations so that you can support them while the other service provider is able to hear directly about the system breakdown. If the parent or caregiver is not interested, or just overwhelmed, make sure to still follow up and share the concern. Try assuming that all programs want to provide the best services that they can and that they want to improve their services.

Preventing ineffective system responses (*that may also be retraumatizing*) is most helpful in supporting families. Collaborating with other systems can be preventative and also informative. Invite other agencies to your programs in order to learn about them and their resources. Offer to provide presentations and trainings regarding your organization to help increase their understanding of domestic violence and its impact on children and families.

Resources and links:



Child-Parent Psychotherapy:

<https://www.nctsn.org/interventions/child-parent-psychotherapy>

Circle of Security:

<https://www.circleofsecurityinternational.com/resources-for-parents/>

Kids Club & Moms Empowerment:

<https://www.cebc4cw.org/program/kids-club-moms-empowerment/detailed>

The Nurtured Heart Institute:

<https://nurturedheartinstitute.com/>

Parent-Child Interaction Therapy (PCIT):

<https://www.cebc4cw.org/program/parent-child-interaction-therapy/>

In this next part, we will examine behaviors, issues, and concerns that come up frequently in our work with children, teens, and families affected by domestic violence. These include aggressive and destructive behavior; depression, anxiety, and self-harming behaviors; responding to suicidal thoughts, intent, and risks; and child sexual abuse and problematic sexual behaviors in children and teens. Many helpful resources and links are provided. We'll talk about how we can be helpful as domestic violence advocates and when we might consider referrals for mental health services to address issues and needs.

Aggressive and Destructive Behaviors in Children and Teens

We commonly hear concerns about **aggressive behavior in children and teens**. Parents and caregivers who have experienced domestic violence may express fears about their children's aggressive behavior toward themselves, other members of the immediate and extended family, peers in school or in community-based activities, pets or other animals, or other people's things or property. Parents may tell us that they are afraid to leave their younger children in the care of an older sibling who acts aggressively and are also sometimes afraid for their own safety with that older child.

There are a few guiding principles for responding to aggressive behavior in children and teens.

First, take steps to stop the unsafe behaviors toward others. Having limits is ultimately reassuring to children and adolescents who may feel *"out of control."*

Second, help caregivers to *"lower the temperature"* in the room by being aware of their own responses and *"cooling off"* (before escalating the situation by their own anger, fear, or sense of being overwhelmed) before trying to resolve the situation or behavior with their children. When caregivers are feeling immobilized, we can support their ability to take action and regain their parental authority within the family. In some instances, domestic violence survivors may act aggressively toward their children, who are then retaliating in kind.

Third, engage with families to understand the meaning of the behavior and what would be helpful and supportive to all.

Finally, caregivers can respond with kindness and remain steadfast in setting boundaries while helping their children express and process the feelings and thoughts that may have led to the aggressive behavior.

Using a trauma-informed lens and the SASS framework, we can wonder: Is the child's or teen's behavior covering over fear, or is it part of having a dysregulated stress response system, where another person's intent or actions are misperceived as dangerous, when they're not? For instance, children report having another child brush into them in the hallway at school and they mobilize to defend themselves by striking out. The child with the aggressive behavior is mobilizing with an instinctive, automatic "fight" response for survival. Often, the other child has no intent to hurt or harm. In this example and other situations, children and teens may be feeling powerless or threatened in some way and use aggression to regain a sense of control. We understand that hypervigilance and defensive responses are self-protective strategies based on prior experiences of being physically and emotionally unsafe or unprotected by others in their caregiving system and in the broader community and social system at large. We can support children and caregivers to understand these automatic stress responses as part of their lived experiences with trauma. We can provide support by helping children and teens, and supporting caregivers to help their children and themselves, to build skills for self-regulation and managing their own stress responses.

Using a developmental and family-contextual lens, we can wonder: Is the younger child's aggressive behavior mimicking what they saw during experiences of domestic violence in the home? Is the child now hitting or throwing an object at the family pet or squeezing a younger sibling around the neck? Children's and teens' behaviors can include aggression toward the victimized parent and other family members (*e.g., hitting, swearing, verbally and psychologically abusing family members, destroying things and other people's possessions, and defying the parent's authority*). We sometimes see or hear about a child or teen intimidating and controlling others, including the victimized parent, with threats and violence (*during or after the abusive partner has left*). These kinds of reenactments are scary and potentially dangerous. Caregivers who have experienced domestic violence may feel terrorized by one of their children whom they see as turning out to be just like their abusive partner. In those instances that are potentially dangerous, we can support caregivers to take steps to protect themselves and younger family members. Sometimes caregivers' perceptions are affected by their own lived experiences with domestic violence, and they don't see the child who is in front of them, but instead see their abusive partner. Parents may tell us that their child is "bad" or "being a brat." In the process, we may find that both parents and children hold views of each

other that may not be accurate and that have their origin in traumatic experiences.

With children who may need help from their caregivers in organizing their feelings at the bottom of the Circle of Security ©, we can introduce the concept of providing a “*time-in*” between parent and child to repair the relationship and to be with the child’s feelings rather than punishing the child with a time-out. ([Link to "Repairing Relationships with a Time-In" Handout](#))

When to consider mental health referrals for aggressive behavior (*also see section above on mental health referrals*): A referral is recommended when the situation does not resolve after following some of the guidance suggested above and when the child’s or teen’s behavior continues to pose

We can support parents and their children by uncovering the meaning of children’s or teenagers’ aggressive behavior and their own responses and helping to make emotional repairs within the relationship.

a danger to others. We hear from primary caregivers that no one feels safe in the family because of the aggressive or bullying behaviors of one of the children toward themselves and their siblings. Mental health

referrals are appropriate when parents are unable to set effective limits or unable to be watchful 24/7 based on their work and school schedules. Mental health services combining individual and family treatment to address the issues and to reestablish family bonds can be very helpful. In some instances, inpatient hospitalization and intensive outpatient programs may also be considered to stabilize the situation and provide respite for caregivers and other family members. The latter should only be considered as a prelude to engaging in therapy and when alternative means are not deemed effective due to the severity of the situation and when natural supports, including respite care, are not available to the family.

Anxiety, Depression, and Self-Harming Behaviors

All children experience fears and worries and may feel sad, and even hopeless, at times during the course of their development. In Section 6, we talked about the importance of children’s attachment relationships and receiving consistent support from responsive caregivers to help children and teens express and regulate their full range of feelings and to master new experiences. This may be more challenging when children and teens are growing up with domestic violence. We hear directly from children and adolescents that they feel alone, afraid, and disconnected from sources of comfort and support within their families. Sometimes these concerns are hidden from their parents or adult caregivers. Communication may be strained. Often, there is silence about the current or past history of violence in the home—out of fear, shame, and guilt. Some children and teens may try to protect their victimized parent by not “*making waves*” or by being attuned to their parents’ needs and concerns and trying to comfort and support them. All of this may take a toll on children’s mental health and well-being.

Anxiety disorders³ are the most common mental health condition diagnosed for children and youth in the United States, affecting more than 7 percent of children between ages 3 to 17 years. The median age of onset is 6 years. Symptoms of anxiety include irritability, difficulty sleeping, anger, trouble concentrating, fatigue, and other physical complaints like headaches and stomachaches. Types of anxiety disorders include:

- Being very afraid when away from parents and caregivers (*separation anxiety*)
- Having extreme fear about a specific thing or situation, such as dogs, insects, or going to the doctor (*phobias*)
- Being very afraid of school and other places where there are people (*social anxiety*)
- Being very worried about the future and about bad things happening (*general anxiety*)

³ <https://www.cdc.gov/childrensmentalhealth/features/anxiety-depression-children.html>; <https://childmind.org/guide/anxiety-basics/>; <https://www.psychiatrytimes.com/view/anxiety-disorders-children-and-adolescents-new-findings>

- Having repeated episodes of sudden, unexpected, intense fear that come with symptoms like heart pounding, having trouble breathing, or feeling dizzy, shaky, or sweaty (*panic disorder*)

Each of these should be thought about in the context of the child's or teen's age and developmental stage and their life experiences, including the traumatic effects of domestic violence (*ongoing and past*).

In the United States, about 1 percent of preschoolers, 2 percent of school-age children, and about 5 to 8 percent of adolescents are affected by **major depression**⁴. By adolescence, girls are twice as likely as boys to be affected by depression. In addition to gender, other risk factors include a family history of depression, family conflict, co-occurring anxiety, and substance use. It's important for caregivers and children to know that depression is highly treatable.

Some or all of these symptoms may signal depression in children and teens:

- Irritability or anger
- Continuous feelings of sadness and hopelessness
- Social withdrawal

4 <https://www.aafp.org/afp/2000/1115/p2297.html>

- Increased sensitivity to rejection
- Changes in appetite—either increased or decreased
- Changes in sleep—sleeplessness or sleeping too much
- Vocal outbursts or crying
- Difficulty concentrating
- Fatigue and low energy
- Physical complaints (*such as stomachaches, headaches*)
- Reduced ability to function during events and activities at home or with friends, in school, or during after-school activities
- Feelings of worthlessness or guilt
- Impaired ability to concentrate
- Thoughts of death or suicide



In understanding depression in children and adolescents, it's helpful to use a developmental lens. **With very young children**, they won't be able to use language to report what's going on, so we're more reliant on what we might see, and what caregivers, teachers, and other care providers may observe. Young children who seem withdrawn or apathetic in mood, have no interest in exploring their immediate environment, or are not eating or sleeping well and may be crying without being able to be soothed or comforted might be experiencing depression. **With school-age children**, they may be irritable, sad, have tantrums or other behavioral issues, have low self-esteem and guilt. They may also have somatic complaints such as headaches and stomachaches, have difficulty concentrating in school, and may withdraw from activities. Some children may try to please their teachers and other adults, may excel in school, and go undetected. **With adolescents**, they are in the midst of figuring out who they are, forming their own identities, and separating from their caregivers to become increasingly more autonomous in the world. They are also more dependent on their peers for their self-esteem. With teens who have grown up with violence in their homes, this may be a particularly vulnerable time with some adolescents having difficulty separating from their family, while others may leave home early, especially if there has been ongoing abuse, neglect, or rejection.

Our task as domestic violence advocates will be to sort through the concerns and to decide with the family what kinds of services and supports will be helpful. When struggles with anxiety and depression interfere with a child's or teen's day-to-day functioning at home, with peers, and in school, then a more thorough assessment by a mental health professional may be helpful.

Children and adolescents may engage in **self-harming behaviors and self-injury** that can look different depending on their age and developmental capacities. **For younger and school-age children**, we may see a pattern of being accident-prone; being impulsive; scratching, biting, hairpulling, hitting, or pinching themselves; and doing things that may put themselves in danger, such as running out into traffic or climbing into areas that are unsafe. This signals to us that some kind of adult intervention with parents and caregivers is needed. Sometimes this is a way for children to tell us that they need more structure, limits, and responsive caregiving. Domestic violence advocates may see some of this in shelter-based settings. We can be helpful in enlisting parents to observe, understand, and respond to their children's needs for emotional and physical safety, attention, and connection within the parent-child relationship. **For older school-age children and adolescents**, we may see some of the behaviors listed above in

addition to cutting and burning themselves. Regardless of children's developmental stage, it is important to understand self-harming behaviors and self-injury in the context of their caregiving environment. Some children and teens who self-harm may be experiencing current or past abuse, neglect, or trauma involving a primary caregiver, but not all.

Prevalence of non-suicidal self-injury is between 7-24 percent in samples of young and older adolescents. Although younger children have been identified as engaging in self-injury, the most common age is amongst ninth-grade girls who use cutting.

Warning signs of self-injury may include⁵:

- Cut or burn marks on arms, legs, abdomen
- Discovery of hidden razors, knives, other sharp objects, and rubber bands (*which may be used to increase blood flow or numb the area*)
- Spending long periods of time alone, particularly in the bathroom or bedroom

- Wearing clothing inappropriate for the weather, such as long sleeves or pants in hot weather.

A **couple of tips** are helpful to keep in mind when older children and teens tell us directly, or parents share concerns, or we observe the results of their self-injury. **First**, the reasons for self-injury vary and may be unique to each person. There is a common misconception that self-injury is a suicide attempt or failed attempt. Most studies find that self-injury is a means of avoiding suicide. Sometimes the act of self-injury releases tension and anxiety, and some children and teens remark that it helps them to feel better. **Second**, self-injury is usually hidden by children and teens. It's helpful to approach a conversation in an open, nonjudgmental manner and not rush in to fix or stop the behaviors.

5 <http://www.selfinjury.bctr.cornell.edu/resources.html>; <http://www.selfinjury.bctr.cornell.edu/perch/resources/parenting-2.pdf>; <http://www.selfinjury.bctr.cornell.edu/perch/resources/15-misconceptionse-english-7.pdf>; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3382916/>

The following questions may be helpful lead-ins for a conversation:

How do you feel before you self-injure? After?

How does self-injury help you feel better? (*Does it help release emotional pain, combat numbness, etc.?*)

What is it like for you to talk with me about hurting yourself?

Is there anything that is really stressing you out right now that I can help you with?

If you don't wish to talk to me about this now, I understand. I just want you to know that I am here for you when you decide you are ready to talk. Is it OK if I check in with you about this or would you prefer to come to me?

Depending on the receptivity of the child or teen, you can explore supports and resources that might be helpful in better understanding self-injury (*through books, movies, or online resources*). **Third**, involving the child and their primary caregiver (*when appropriate*) can support more adaptive coping as an alternative to self-injury. If they are interested in stopping the behavior, you can brainstorm other less harmful ways of achieving the same effects. If there are consequences for self-injuring behaviors, such as the risk of infection, you might use harm-reduction strategies. For older adolescents, this might involve more socially acceptable ways such as getting tattoos or body piercing. **Finally**, it is best practice to involve a non-abusive parent or guardian or adult in considering any life-threatening behavior that is associated with self-injury.

Suicidal ideation, intent, and responding to suicidal risks

In offering domestic violence services to families, we may be hearing more frequently about children's and youths' suicidal thoughts and intentions. This section provides practical guidance on how to respond to suicidal risks to prevent potential attempts and suicide.



Suicide is the second leading cause of death in children and young adults ages 10 to 24⁶ and has increased by more than 50 percent from 2007 through 2017. Girls are more likely to attempt suicide, but boys are more likely than girls to die by suicide. Of these attempts or deaths by suicide, 90 percent are with gunshots, overdose, poisoning, and jumping from heights. Based on reporting through 2017, the highest suicide rates are among American Indian and Alaskan Native youth followed by White youth in the United States. LGBTQ+ youth are three times more likely than heterosexual youth to attempt suicide at some point in their lives. LGBTQ+ youth from families who reject them based on their identity are eight times more likely to attempt suicide. More than 6,000 children and youth take their own lives in this country each year.

Initial studies are emerging about the impact of COVID-19. Although there isn't a rise in suicides attributable to the pandemic, more children and teens have been expressing suicidal thoughts and intent. For the families we serve, this may be part of the cumulative effects of social isolation, hardship, lack of grounding in normal routines and activities

6 <https://www.nytimes.com/2019/12/02/well/mind/the-crisis-in-youth-suicide.html>; <https://www.nimh.nih.gov/health/statistics/suicide.shtml>; <https://save.org/about-suicide/suicide-facts/>; https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx#

(such as school and outside activities that bolster self-esteem), increased violence at home and in the community, and grief and loss of loved ones without the usual communal rituals to support mourning.

Suicidal thoughts and intent can arise when our lives feel unbearable, when we are experiencing overwhelming emotional pain and distress, when we are isolated from others, and when we can't envision a future for ourselves.

These factors may increase the risk of suicidality for children and teens:

- Recent exposure to suicide
- Family history of suicide attempts or suicide
- Signs of depression (*ongoing, persistent, and lasting for more than several weeks*)
- Lack of meaningful social connections
- Exposure to violence, abuse, or maltreatment including bullying
- Impulsivity (*brain development that puts the "brakes" on impulsivity is not fully formed in children and teens*)
- Acute loss or rejection
- Increased substance use
- Experiences of bias and marginalization
- Access to firearms

These are potential warning signs that would lead us to respond with a sense of urgency:

- Talking about wanting to die by suicide or talking about no longer being a burden to others.
- Preoccupation with death. Children and teens may also express these thoughts and feelings through drawings, writing, social media posts, and selected video games.
- Searching for ways or making a suicide plan.
- Social isolation and withdrawing from friends, family, and regular activities.
- Sleeping too much or too little and changes in eating habits.
- Acting agitated and taking risks that are potentially self-endangering (for example, teens driving too fast while under the influence of drugs or alcohol).
- Feeling hopeless, helpless, or rageful and having thoughts of revenge.
- Feelings of pervasive sadness, including crying spells, or lack of emotional expression.
- Extreme mood swings or having an elevated mood after a period of prolonged depression.



The risks and warning signs should all be considered within the context of the child’s or youth’s current situation, family, and developmental age and capacity. It’s important to approach this concern by getting a good picture for what might be going on, when the suicidal thoughts began, how long the child or youth might have been depressed, whether help was sought previously, and what the results of help-seeking might have been. Are there any recent changes or events that are significant (*such as a recent break-up with a partner*), or are there cumulative effects of stress related to COVID-19? Adolescents and young adults may also feel stressed out and pressured to succeed or may be facing financial uncertainty, disappointment, rejection, and loss.

Young children may express suicidal thoughts that reflect the state of mind of their primary caregiver. They may be repeating what they

have heard from adults in their environment without an intent to truly harm themselves. Or they may be frightened and preoccupied with a recent suicide attempt by a caregiver or death of a loved one. It’s important to explore and make this distinction.

On the other hand, we may see young children who express the wish to die and impulsively take actions that are potentially self-endangering, such as darting away from an adult, running into ongoing traffic, or climbing onto areas that are potentially self-endangering. In these instances, the attachment relationship with the protective caregiver may have been disrupted or never consistently established. We can support the attachment relationship by referring the parent or caregiver and child to mental health treatment, such as Child-Parent Psychotherapy.

There are **several myths about how to respond to potential suicide risks in children and youth.** The first is that asking or talking about suicidal thoughts, intent, and plans will make it happen. It’s actually beneficial to ask about it (*see screening questions*). The second misconception is that once we have identified the risk of suicide, we should make a “*no-suicide contract*” with the child or youth. There is little evidence that these contracts help, and in fact, may give caregivers, advocates, and mental health practitioners a false sense of

security. Instead, we can ask for a commitment to treatment statement rather than having someone pledge that they will not harm themselves. This includes developing a safety or crisis-response plan that lists coping and self-regulation skills and sources of support to use when feeling distressed and what to do if the child or youth is in imminent danger (e.g., *let someone know that you're in distress, call 911*). The plan can be made into a written card to carry with them or to put on their phone. As we've discussed before, engage the child's or teen's protective caregiver as an ally in this process and provide them with support and information too.

Suicide can be preventable with the right resources and supports⁷. Knowing the risks and warning signs is an important first step. Next, trust your own intuition and show your care and concern. You might say: "I'm concerned about you, and about how you're feeling." "I've noticed you've been really sad (or upset, etc.) lately." "I'd like to hear about what you're thinking and how you've been feeling." Then, it's important to talk about it. When entering into a dialogue about suicide, it should be **tailored to the child's or teen's age and developmental capacity**.

With young children, you can also engage in play by using hand puppets and stuffed animals to express feelings that pick up on what you're intuiting or hearing from the child or their caregiver.

The National Suicide Prevention

Lifeline provides the following guidance on opening a dialogue and providing support to school-age children and teens at risk:

- **ASK:** "Are you thinking about suicide?" in an open, nonjudgmental manner. You can also ask, "How are you hurting?" "How can I help?" Acknowledging and talking about suicide has shown to reduce rather than increase suicidal thoughts.
- **LISTEN:** Listen intently about their pain, their reasons without trying to fix or falsely reassure. Don't try to talk them out of their reasons. You can also gently inquire if there is anything in their life that makes them feel hopeful and gives their life meaning right now. Remember not to promise to keep their disclosure of suicidal thoughts or intent a secret.
- **BE THERE:** Being physically present or connected via the phone or virtually can be helpful. Whatever support you are offering, be sure not to promise anything that you can't deliver on over time. Begin to explore sources of help

⁷ <https://www.speakingofsuicide.com/resources>; <http://dx.doi.org/10.15585/mmwr.mm6708a1>; The Sky Center: New Mexico Suicide Intervention Project, <https://skycenter.nmsip.org/> (2019 presentation)

with the child or teen in the lead. This supports connection to others, which is an antidote to isolation and despair.

- **KEEP THEM SAFE:** After talking and listening together, find out about whether or not they have a plan, when they might do it (tomorrow, in a week, etc.), how they might do it, or if they have attempted in the past. This helps us gauge the severity of the risk and whether the child or teen is in immediate danger.

Parents and primary caregivers can also take safety precautions by removing access to firearms, knives, putting prescription medications and over-the-counter drugs such as aspirin, etc. in lock boxes, and securing health or household cleaning products that are potentially lethal poisons. Caregivers can have a conversation about why they are doing this and can anticipate that they will be administering the prescription medications until and unless it's safe for their older child or teenager to self-administer.

When suicide is a concern, regardless of whether you are referring in-house for mental health services and supports, to a community provider, or to online crisis lines, it's still helpful to maintain continuity and connection if you have an established relationship with the child, teen, and caregiver.

You can remain one of the supports to the family and avoid inadvertently signaling “rejection” by explaining that you’re taking this situation seriously and want the child and family to have what they need to start to feel better and more hopeful, while you’ll continue to be available and part of their support network. You can then link to specific suicide prevention resources by providing information, making a warm referral to a local provider or in-house therapist, or making a first call together. Be prepared by knowing your local resources for suicide prevention support and mental health treatment services.

National resources that can offer immediate crisis support and other information for youth, caregivers, and families:

- **National Suicide Prevention Lifeline** (open 24/7) (English and Spanish): 1-800-273-8255; 1-800-273-TALK
www.suicidepreventionlifeline.org;
www.suicidepreventionlifeline.org/help-youthself/youth/
- **Anonymous Crisis Counselor Text Line:** Text HOME to 741741
<https://www.crisistextline.org/>
- **The Trevor Project** (a national organization providing crisis and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning youth): 1-866-488-7386
<https://www.thetrevorproject.org/>
- **Suicide Prevention Resource Center:** <https://www.sprc.org/>
- **National Institute of Mental Health:** <https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>
- **10 Things Parents Can Do to Prevent Suicide:** <https://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Ten-Things-Parents-Can-Do-to-Prevent-Suicide.aspx>
- **Child Mind Institute:** A parent's guide to helping a child in distress: <https://childmind.org/article/youre-worried-suicide/>
- **Speaking of Suicide:** A site for suicidal individuals and their loved ones, survivors, mental health professionals, and others who care: <https://www.speakingofsuicide.com/resources>
- **Suicide and Refugee Children and Adolescents:** https://www.nctsn.org/sites/default/files/resources/fact-sheet/suicide_and_refugee_children_and_adolescents.pdf

Cautionary notes on the use of psychiatric medications for children

The prescription and use of psychiatric medications for children, including young children, has grown exponentially during the past 20 years. Some children and teens may be carrying a mental health diagnosis or multiple mental health diagnoses, starting in preschool and throughout their teenage years. Often what's missing is an understanding of how traumatic experiences and adversities affect children's behavior.

As a society, we have become overly reliant on medications, seeking a quick fix for our problems. This is often in opposition to the slower process of investing in children's primary relationships, which hold the potential for restorative healing from traumatic experiences, including domestic violence.

Pediatricians and psychiatrists are medicating children to manage behaviors that may concern parents and caregivers, or via referrals from schools and day care programs. Young children who have experienced instability and trauma in their lives are increasingly at risk of expulsion from day care settings because they can't conform to what is deemed to be age-appropriate behavior.

Children may become "*compliant*" on meds, but often that comes with a price. Many children and teens seem "*drugged out*" or "*flat*" in terms of their feelings; they may also have other side effects such as sleeping too much or fluctuations in weight gain or loss. In addition, we don't know how the long-term effects of psychiatric medication use may affect children's developing brains. Finally, the use of psychiatric medication may inhibit children's ability to process and work through current or past traumatic experiences and daily life stressors.

In concluding, we are endorsing a thoughtful approach to the use of psychiatric medications, particularly with older children and teenagers. When considering the use of medication, children and teens should receive a thorough assessment by a qualified mental health practitioner who is domestic violence-informed and trauma-sensitive: This includes taking a developmental history, gathering observations across settings (home, school, and community), and gaining a beginning understanding of children's and youth's life experiences, including exposure to trauma, current circumstances, and other adversities and stressors, such as racial injustice, health and educational inequities, bullying, and exposure to discriminatory systems. This also includes ongoing stressors experienced by children and teens who may be LGBTQ+

identified or gender non-conforming. For young children, we believe that parent-child mental health treatment is most beneficial (rather than prescribing medications). With older children and teenagers, sometimes their symptomatic behavior is so severe that it limits their ability to function. Under those circumstances and with proper assessment, psychiatric medications may be beneficial. Of course, best practice includes ongoing monitoring of side effects, adjustments to medications, and evaluating the need to remain on medications. Under those conditions, many older children and teens can then benefit from other sources of help and engagement in activities that promote growth and healing.

For example, a child may be having trouble concentrating in school, completing assignments, sitting still, or self-regulating in other social situations. Children who are having these difficulties are often given the mental health diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and may be taking medications to “*manage*” the behavior. School personnel, psychiatrists, and caregivers may see this as a solution without considering if the child’s behaviors may be trauma-related responses to past or ongoing trauma and adversity, such as experiencing domestic violence, housing insecurity, or sexual abuse.



Child Sexual Abuse and Problematic Sexual Behaviors in Children and Teens

Child sexual abuse⁸ is widespread in the United States. One in four girls and one in six boys under the age of 18 is sexually abused. According to child protective services records, most alleged perpetrators are male. In substantiated cases, 88 percent of the perpetrators are male, 9 percent are female, and 3 percent are classified as unknown.

When children experience domestic violence in their homes, they are also more likely to be victims of child maltreatment, including physical and sexual abuse.

The co-occurrence of physical abuse of a child is estimated to be 45 to 70 percent greater than in homes without intimate partner violence. There are very few studies on the co-occurrence of domestic violence and child sexual abuse. What we've learned from the

existing studies is that there is a significant increased risk of being sexually abused by a biological father, stepfather, or male partner of the child's mother who experiences domestic violence.

Let's start with a common understanding of the definition of child sexual abuse from the National Child Traumatic Stress Network (NCTSN)'s *Caring for Kids: What Parents Need to Know About Sexual Abuse*, 2009, p.6:

“Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer. Sexual abuse can include both touching and non-touching behaviors. Touching behaviors may involve touching of the vagina, penis, breasts or buttocks, oral-genital contact, or sexual intercourse. Non-touching behaviors can include voyeurism (trying to look at a child's naked body), exhibitionism, or exposing the child to pornography. Abusers often do not use physical force, but may use play, deception, threats, or other forms of coercion to engage children and maintain their silence. Abusers frequently employ persuasive and manipulative tactics to keep the child engaged. These tactics—referred to as ‘grooming’—may include buying gifts or arranging special activities, which can further confuse the victim.”

8 <https://www.rainn.org/about-rainn>; <https://victimsof-crime.org/child-sexual-abuse-statistics/>; <https://www.nsvrc.org/statistics>; https://www.nctsn.org/sites/default/files/resources/fact-sheet/caring_for_kids_what_parents_need_know_about_sexual_abuse.pdf

About 75 percent of all child sexual abuse is perpetrated by a family member or person known and trusted by the child (*neighbor, babysitter, family friend, community mentor, older peers*). Adult sex offenders don't fit a single profile; some were sexually abused as children, others were not. Some can't function sexually with adult partners, while others also have sexual relationships with adults. Although state statutes vary, child sexual abuse can occur between an older peer or sibling with a clear power differential in which the older child coerces the younger into engaging in adult-like sexual behavior.

Children who have been sexually abused may have some of the same symptoms that we see with children experiencing domestic violence and other kinds of trauma. These include nightmares and sleep difficulties; angry outbursts and tantrums; withdrawing from others and activities; heightened anxiety and depression; regression in younger children (*bedwetting and thumb sucking*); and not wanting to separate from the protective parent or be left alone. Children may also use language and express knowledge about adult sexual behaviors that are not age appropriate. Some children do not show any of these signs or behaviors. Teaching about body safety and healthy body boundaries can be both preventative and protective in the future.

Children may not disclose the abuse directly for a number of reasons: They are afraid that the abuser may hurt them or other family members, or they have been threatened by their abuser; they may fear that they won't be believed or will be blamed, upset their parent, and get in trouble; they may fear that they will be removed from their home and separated from their protective parent and family; they may feel shame and guilt and that the abuse is their fault; or they may fear getting the family member or trusted friend in trouble. Young children may be confused because of their more limited cognitive capacities, believing explanations given by the abuser and not identifying the experience as abuse if the grooming process involved games, etc.

When there is a disclosure of abuse, it's important for adults to listen, be calm, never blame the child, and reassure them that it's not their fault and you're here to support them.

Domestic violence advocates and mental health counselors working in domestic violence settings may get direct disclosures from children and teens in group or individual counseling sessions. If the disclosure is made in a group setting, be sure to follow up after the meeting with individual support and a



plan for how to involve a protective caregiver (if possible). Call a child abuse hotline or child protective services to report. (**See Section 9 on supporting parents and caregivers for more information.**) If the family is receiving services through your domestic violence agency, parents may need your support in processing their feelings and may opt to have you there when the call is made. We also know that some children and teens are more likely to tell a peer than a family member or an adult caregiver. Most communities have child advocacy centers that function as a “one-stop shop” to coordinate legal and social services, including trauma-specific therapy, for the child and family. They are specially trained to offer victim-sensitive forensic interviews so that the child does not have to repeat their story over and over again, and the child’s testimony can stand up in court.

It’s important to note that children frequently take back or “recant” their initial disclosure. Most children who recant were telling the truth but may later feel fear, feel pressured to keep the abuse a secret, or have mixed feelings toward their abuser after what happens as a result of their disclosure. Some children may feel pressured by their family as a result of the ruptures in family relationships following their disclosure. Because the legal process can be intimidating and is often retraumatizing, children may also want to avoid continuing with the prosecution of the abuser.

Domestic violence survivors who are parenting may express fear and concerns about the safety of their children and want to know *if* child sexual abuse is occurring when custody is shared or unsupervised visitation is court-ordered. As domestic violence advocates, we can be supportive by listening to these concerns, finding out what worries them about their child’s behavior, and learning more about the context in which these behaviors are happening. For instance, are there tears, heightened anxiety, meltdowns, and refusals to go on weekend or overnight visits with the noncustodial parent? What is the child’s behavior like after returning home from a visit? We can also offer general information about children’s healthy sexuality across developmental ages

and stages as differentiated from child sexual abuse, and we can provide resources on child sexual abuse that educate and address their concerns. It can also be helpful to explore the parent's reactions based on their own lived experiences, including past childhood abuse, as well as how they were raised and any relevant cultural beliefs and practices about sexual abuse and intrafamilial abuse in particular.

As domestic violence advocates, we know that the stakes are high as parents are faced with a legal system that may not believe their claims; may accuse them falsely of “*parental alienation*” and coaching their children; or may leave them fearful that they will lose full-time custody of their children to their former abusive partner who is harming their children. This can create an untenable dilemma regarding the safety of their children and family versus their own safety.

Following their lead, we can support caregivers to come up with next steps and a plan of action to protect their children from further harm. The plan may include reading books about body safety and healthy boundaries, making a call to authorities, getting legal representation, and getting therapy for their children and themselves.

In our work with families affected by domestic violence, **we may also encounter**



children and teens with problematic sexual behaviors. It's important to note that many children and teens with problematic sexual behaviors have not been victims of child sexual abuse themselves. Research shows that other factors, such as exposure to domestic violence, adult sexuality, sexual materials, and physical abuse, may contribute to the behaviors.

With that in mind, sexualized behaviors in children can be particularly frightening for caregivers affected by domestic violence because of the fear that their abusive partner may have been abusive to their children as well. We know that many children may have been exposed to overstimulating adult nudity or sexuality and may have witnessed sexual assaults on the victimized parent, and some may have been inadvertently exposed to online pornography or other adult sexual materials while being cared for by an adult

caregiver (who may also be an abusive partner). All of these situations may contribute to children or teens acting out sexual behaviors (even though they were not direct victims of child sexual abuse). One important step that domestic violence advocates can take is to help the parent sort through what is normative sexual play or exploration given the child's age and developmental stage and what may be problematic.

The National Center on the Sexual Behavior of Youth (NCSBY) (<http://www.ncsby.org>; <http://www.ncsby.org/content/problematic-sexual-behavior>) informs us that there is a continuum of sexual behavior in children and teens from normative to concerning to problematic. They include the following:

- *Problematic self-touch or self-stimulation (such that it causes physical harm or damage, is excessive, and/or occurs in public in spite of interventions),*
- *Non-intrusive and repetitive sexual behaviors (such as preoccupation with nudity, surreptitiously looking at others when they are naked, frequently showing private parts to others, preoccupation with pornography, especially child or violent media, sexting, offensive sexualized language),*

- *Sexual touching without permission or consent, such as poking, rubbing or squeezing,*
- *Sexual interactions with others (such as, digital-genital contact, oral-genital contact, sexual behavior that involves penetration) which are developmentally inappropriate or illegal,*
- *Distributing youth produced sexual images, such as through texting,*
- *Sexual contact with animals, and*
- *Coercive or aggressive sexual contact or penetration.*

In responding to situations that we might encounter directly, especially in domestic violence residential settings, the NCSBY provides guidelines on how to distinguish sexually problematic behaviors from normative sex play. Problematic behaviors:

- *Take place between children of widely different ages or developmental stages (such as a 12-year-old who acts out with a 4-year-old, or a 15-year-old with a 10-year-old)*
- *Occur between children of different capacity, for example, disparate physical size and strength or intellectual abilities or a position of authority*

- *Are associated with strong, upset feelings, such as anger or anxiety/fear*
- *Cause harm or potential harm (physical or emotional) to any child*
- *Do not respond to typical parenting strategies (such as, instruction and supervision)*
- *Involve coercion, force, or aggression, or threats thereof, of any kind.*

The following tips may help guide your actions in these situations:

Domestic violence shelters and residential settings can **proactively establish clear standards about sexual touching and behavior** that gets communicated to family caregivers and children in a way that fits for children's age and developmental stage. Discuss privacy and how that will be honored within your setting. **Know your state's current laws about child sexual abuse reporting.** Many states require you to report any sexual behavior that is coercive, no matter how young the child is who initiates the coercive contact. The Child Welfare Information Gateway at <https://www.childwelfare.gov/pubPDFs/manda.pdf> lists all of the mandatory reporter statutes for all states and territories (2019). *With any disclosures of child sexual abuse and when*

determining what is considered to be problematic sexual behaviors, it's important to involve a supervisor in making decisions around mandatory reporting before taking action.

If you're in a shelter or residential setting and you observe intrusive or coercive sexual behaviors, it's important to intervene to stop the behavior in a way that is calm but firm and that restores safety and protection. Remind the child or teen that the other child has the right not to be touched. Let both know that you'll be talking separately to each while involving their parents. With younger children who have experienced intrusive or coercive sexual behaviors, reunite them with their protective caregiver and reassure them that they are not in trouble. Acknowledge any feelings they may have about what happened (*that was scary or that hurt, etc.*), calmly review what you observed, and involve the parent in a plan to keep them safe in the future.

In responding to the child or teen with problematic sexual behaviors and their caregiver, calmly review what you observed in a nonjudgmental manner and what you did to intervene. Reiterate your policy around sexual touching and behaviors. Let the caregiver know that you'll be consulting with a supervisor and, if appropriate, that you will be following your state protocols for mandatory reporting in these situations. You can provide information about what sexual

behaviors may be problematic and what is considered a sexual offense with legal and criminal repercussions. Let them know that help is available to address problematic sexual behaviors.

It's also important to take a moment to pause and do a self-awareness check-in: What am I aware of feeling within my body right now (*such as heart racing, sick to my stomach, etc.*)? What thoughts and feelings do I have about this? Who am I identifying with? Am I feeling confused and uncertain about what would be helpful and supportive, etc.? This can help prepare us to be grounded and more present before intervening. It also allows us to be aware of any strong feelings, reactions, or biases we may be holding. Reflective supervision can be helpful in processing and sorting through your responses to the situation.





Section 7: Resources and Links

RAINN (Rape, Abuse & Incest National Network) operates a hotline (1-800-656-HOPE) and provides resources for adult and child victims:

<https://www.rainn.org/about-rainn>

The National Child Traumatic Stress Network (NCTSN) has excellent resources for professionals and parents and caregivers about child sexual abuse. This resource provides facts, guidance around parents responding to their child's sexual abuse, handling disclosure, info on intrafamilial sexual abuse (incest), date rape, and problematic sexual behaviors:

https://www.nctsn.org/sites/default/files/resources/fact-sheet/caring_for_kids_what_parents_need_to_know_about_sexual_abuse.pdf

Statistics on child sexual abuse and sexual assault:

<https://victimsofcrime.org/child-sexual-abuse-statistics/>

<https://www.nsvrc.org/statistics>

National Center on the Sexual Behavior of Youth (NCSBY) provides guidance and resources on problematic sexual behaviors in children and teens: <http://www.ncsby.org>

<http://www.ncsby.org/content/problematic-sexual-behavior>

National Runaway Safeline provides 24/7 crisis support to youth and teens:

<https://www.1800runaway.org/> or call 1-800-runaway

State statutes on child abuse reporting: Child Welfare Information Gateway:

<https://www.childwelfare.gov/pubPDFs/manda.pdf> lists all of the mandatory reporter statutes for all states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands (2019).



Critical Conversations

Helpful Hint:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing compassionate policies within your program.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

- What supports are in place for staff to be able to access reflective supervision and manage personal reactions in responding to child abuse issues?
- Begin by examining our own biases and experiences related to child abuse, mental health issues, and psychiatric medication.
- Engage in conversations regarding mandated reporting of suspected child abuse.

Critical Conversations



What can a direct staff person do?

- Ensure that survivors understand your organization's policies on reporting suspected child abuse.
- Make sure you are knowledgeable about mandated reporting laws in your state.
- Engage in conversations with parents and caregivers about their understanding and definitions of child maltreatment.
- Engage in a conversation with parents or caregivers about their beliefs related to psychiatric medication. We can provide resources on the pros and cons of medication use that is specific to their situation based on:
 - The child's age
 - The severity and duration of the symptoms and how they are affecting the child's overall functioning (*at home, school, and in the community*)
 - The diagnosis and medications being recommended and what to expect.



What can a supervisor do?

- Provide trainings and support staff in recognizing and reporting child abuse based on state specific guidelines.
- Offer opportunities for staff to debrief and discuss general challenges as well as more personal reactions that may arise when working with families experiencing child abuse.
- Lead a team discussion about the use of psychiatric medications for children and teens and help support staff in having conversations with parents or caregivers and their children.
- Talk with mental health professionals in your community to find child psychiatrists (*preferably*) who understand domestic violence and how trauma affects behavior. You can ask about their views on medication use in children before establishing a relationship to help facilitate referrals.
- Consider doing cross-training for ongoing professional development.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Marcus, age 12, and his mother receive services through your program. Marcus talks frequently about being lonely and dying. He has recently started threatening suicide “to get what he wants,” according to his mother. Yesterday he refused to log into his online school, and his mother tells you that she didn’t argue with him this time because she is wondering if he might follow through with his threats.



Things to consider:

- Have Marcus and his mother talked about this? What does he say when he threatens suicide? Is he telegraphing his distress OR trying to get what he wants? How can he be supported?
- Get a better sense of Marcus' daily life. How has this changed with COVID and the increased isolation?
- Was he lonely and depressed before? When did he start having thoughts about dying? How does he cope when these thoughts or feelings arise?
- Is there any familial or community context with someone who has threatened suicide, made an attempt, or died by suicide? Did a close family member or peer die recently?
- Learn more about the relationship between Marcus and his mother. Are they in a power struggle? Is any of Marcus' behavior related to his developmental stage as a "tween"? How can you support ways for both to identify and communicate needs (*when not in the moment*)?

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin by empathizing with the mother's distress—further explore her reaction and any personal history of suicide. Provide some psychoeducational information about suicide, risks, and the importance of parents and children talking about it.



- Initiate a dialogue directly with Marcus and his mother about his expression of suicidal thoughts and explore further to find out if there is also intent or any prior attempts.
- Acknowledge your concern and share your observations.
- Provide information to Marcus and his mother about suicide and responding to suicidal risks, and offer crisis line information, as needed (*see “Suicidal ideation, intent, and responding to suicidal risks” in this section*).
- Ask Marcus if it would be helpful for you (*or another co-worker who has an established relationship with Marcus*) to meet with him privately. This can occur after your joint meeting.
- Depending on what is shared, discuss the possibility of getting a mental health evaluation.
- Consult with your supervisor and trusted peers to share concerns about potential risks, review any planning steps, and follow program policies and protocols.



8. Inclusive Services for Children, Teens, and Families

This section provides additional information for understanding and supporting children and teens who may be dealing with challenges or issues in addition to experiencing domestic violence. The topics covered are:

- Alcohol and drug use
- Teen dating violence
- Neurodiversity
- LGBTQ+, sexuality, and gender identity
- Grief and loss

This is an initial look at issues that advocates may encounter but is by no means an exhaustive list. Helpful resources and links are provided following most of the topics. In addition, we offer critical conversations and guidance related to providing inclusive services and a vignette to further staff discussion.

Alcohol and Drug Use

Experimenting with drugs and alcohol is a common experience in adolescence. In addition to experimenting, some children and teens who are dealing with the stress of violence in their homes may turn to drugs and alcohol as a way of coping. Alcohol is the most commonly used drug by teens in the United States (*Fact sheet on underage drinking. Centers for Disease Control and Prevention. U.S. Department*



of Health and Human Services, 12 Nov. 2015). While using drugs and alcohol may provide some temporary relief from painful emotions, the potential risk of experiencing adverse health outcomes exists, especially for teens who begin using substances or alcohol at a younger age and those who may also have family histories of substance use disorders.

Children and teens may also be influenced by many other factors when deciding to use drugs or alcohol. They may be dealing with issues of loneliness or social isolation. They may have witnessed drug and alcohol use in their homes, by relatives, and by their friends. Some children and teens may use substances and alcohol with family members. Others may have been introduced to using by an abusive partner as a way to threaten and harm survivors and children. Coerced use may develop into a substance use disorder. Teens

and children then may choose to maintain contact with the abusive partner for easier access to substances. Whatever the factors, it is important to initiate a dialogue with children and teens to better understand their unique situation with substance use.

When children and teens are using drugs and alcohol, it is important to engage them in conversations that actively avoid scare tactics or focus too heavily on the long-term consequences of substance use.

Teens and children are more likely to participate in open dialogue that doesn't involve lecturing and judgment, but instead is honest and engaging. Children and teens may be more interested in these discussions while spending one-on-one time engaged in activities while talking, or maybe there is an opportunity for group work to further explore this issue with peers.

For younger children who are experimenting with substances, the following questions may be important to consider to further understand their use:

Where are the substances coming from? How is there access?

Where is the pain coming from? What is happening in this child's life that this kind of instant soothing is needed?

Where are the trusted and safe adults for this child? Where are the sources of safe connection as well as protective monitoring?

For children and teens whose parents are currently using drugs and alcohol, it can be helpful for advocates and supportive caregivers to convey the ideas from the **three C's of Al-anon**: the children and teens did not **cause** their parent to drink or use drugs; they cannot **control** their parents' drinking or drug use; and they cannot **cure** it. Some domestic violence prevention programs collaborate with substance use prevention efforts as there is overlap between teen dating violence and teen substance use. Advocates can search for local programs and create opportunities to collaborate in addressing substance use prevention as a way to support teens.

Resources and links:



For teens who may be drinking or using drugs:

SAMHSA Too Smart to Start:

<https://www.samhsa.gov/too-smart-start>

NIDA National Institute on Drug Abuse for Teens:

<https://teens.drugabuse.gov>

NIAAA National Institute on Alcohol Abuse and Alcoholism:

<https://www.niaaa.nih.gov>

Drug Abuse Hotline:
1-877-901-6499

American Addiction Centers:

<https://drugabuse.com/11-real-reasons-teenagers-experiment-drugs/>

SMART Recovery Teen & Youth Support Program:

<https://www.smartrecovery.org/teens/>

Operation Prevention:

<https://www.operationprevention.com/culture-based-resources>

For parents and siblings of those teens:

Al-Anon Family Groups:

<https://al-anon.org>

Partnership to End Addiction:

<https://drugfree.org/parent-blog/why-do-teens-drink-and-use-drugs/>

Centers for Disease Control and Prevention (CDC): <https://www.cdc.gov/alcohol/fact-sheets/underage-drinking.htm>

For teens whose parents may be drinking or using drugs:

SAMHSA National Helpline. Provides support to teens whose parents may have alcohol or substance use issues:

1-800-662-HELP

<https://www.samhsa.gov/find-help/national-helpline>

Alateen support group information:

<https://al-anon.org/for-members/group-resources/alateen/>

SMART Recovery Family & Friends:

<https://www.smartrecovery.org/family/>

Teen Dating Violence

Adolescents experience abuse in their dating relationships at similar rates to adult intimate partner violence. Up to 1.5 million high school students experience physical abuse from a boyfriend or girlfriend each year (Centers for Disease Control and Prevention, Physical Dating Violence Among High School Students—United States, 2003, Morbidity and Mortality Weekly Report, May 19, 2006, Vol. 55, No. 19). Teens in abusive relationships experience psychological, verbal, physical, and sexual violence. Teens may also be at

increased risk of being abused through various forms of technology, including social media harassment, sexting, threatening texts, and release of personal, intimate photos.

Some signs that teens may be experiencing dating violence include sudden changes in friends, isolation from family, feeling pressured from partner (*boyfriend or girlfriend*), arguing with partner, defending or making excuses for the behaviors of partner, missing school, dropping out of extracurricular activities, declining grades, and any unexplainable injuries.

It is important to recognize that children and teens who grow up in violent families do not always experience violence in their dating relationships, although teens who have parents experiencing domestic violence may be at greater risk. It can be challenging to help teens understand the harmful impact of dating violence when they are witnessing domestic violence in their homes between their caregivers. Teens in homes where domestic violence has or is occurring may feel conflicted on how to deal with dating relationship challenges or seek support.

Guidance for conversations with teens about dating violence

Adolescents who have parents experiencing domestic violence may have different reactions to the violence and a variety of coping strategies. Some teens have intervened and been physically harmed by the violence, others have retreated into their own worlds as a means of escaping the abuse at home. Some teens are actively taking on adult responsibilities in the home and may have been labeled as “parentified.” They may be caretaking of the survivor, their siblings, and sometimes the adult caregiver who is the abusive intimate partner. Many teens witnessing domestic violence at home are at risk of school challenges, behavioral issues, depression, or becoming involved with the legal system.

Knowing how to connect and intervene with teens is important. Establishing open communication on a variety of topics can build trust and provide opportunities for engaging in deeper conversations.

It is important to have clear communication with teens and give teens transparent messages that hurting others is unacceptable and treating others with respect is how healthy relationships are created.

Parents who are dealing with their own abusive relationship may feel challenged to engage in open and honest dialogue about dating violence. Parents should be supported in addressing issues of dating violence within their families. Family counseling can also be helpful in supporting open dialogue between the teen and the parent when there has been domestic violence in the home. Teens know that the violence is wrong, but they may feel conflicted between siding with each parent, defending the abused parent, or intervening and putting themselves at risk.



Resources and links:



Related to dating violence:

Love is respect, a project of the National Domestic Violence Hotline, offers 24/7 information, support, and advocacy to young people between the ages of 13 and 26 who have questions or concerns about their romantic relationships. It also provides support to concerned friends and family members, teachers, counselors, and other service providers through the same free and confidential services via phone (1-866-331-9474), text (LOVEIS to 22522), and live chat: <https://www.loveisrespect.org/about/>

Futures Without Violence provides a guide for parents and caregivers on how to start a conversation about dating violence: <https://www.futureswithoutviolence.org/talk-teens-teen-dating-violence/>

“**The Halls**” is an eight-episode web series addressing gender-based violence in a high school. The Boston Public Health Commission program includes a discussion guide for high school youth: <http://thehallsboston.com/>

VAWnet, the National Online Resource Center on Violence Against Women, has a collection of prevention resources and responses to teen dating violence for middle school-age youth through college students:

<https://vawnet.org/sc/preventing-and-responding-teen-dating-violence>

CDC Dating Matters: Understanding Teen Dating Violence Prevention is a free online course for programs working in prevention with youth ages 11 through 14:

<https://www.cdc.gov/violenceprevention/datingmatters/index.html>

Apps for youth:

<https://itunes.apple.com/us/app/lina/id443740581?mt=8>

<https://www.circleof6app.com/>

Neurodiversity

Neurodiversity is a broad term that recognizes and respects the variety of neurological individual differences in regard to learning, attention, sociability, development, intellect, and cognition. These differences are sometimes labeled as Autism Spectrum Disorders, Attention Deficit Hyperactivity Disorder, and others.

Autism Spectrum Disorders may impact individuals in a variety of ways and are often characterized by behavioral, social, and communication differences. Some families seeking domestic violence services may have a child who has already been diagnosed with the disorder and are working within the

educational or behavioral health systems to support their child. These families have expertise on their child's disorder and can let the domestic violence program staff know what works best for them and their child. Other families may have concerns about their child's interactions with peers, noticeable speech delays, sensory issues, or inability to adapt to changes. These reactions and behaviors may concern caregivers and they may be uncertain of what to do. It is important to assess children who have experienced domestic violence first for trauma reactions and then secure referrals for further assessment that may be necessary for understanding additional underlying issues.

Children who display challenging behaviors, restricted social interactions, or decreased communication may benefit from more in-depth assessment. Although understanding and acceptance has increased for individuals dealing with neurodiversity, early intervention and accommodations can support children and families to reduce societal stigma and improve quality of life. Individuals diagnosed with Autism Spectrum Disorders may find the world confusing and may rely on caregivers and other support systems to help them safely navigate the world. It can benefit families and the program staff serving families to have some general information regarding neurodiversity.

Resources and links:



Internet resources for neuro-diverse individuals and families:

www.neurodiversity.com

Excellent resources for families and caregivers:

www.AutismSpeaks.org

<https://www.autismspeaks.org/tool-kit/parents-guide-autism>

Moms With Apps, apps for special needs.

Made by the developers at Moms With Apps to assist children and families with special needs. Other categories on same site are apps for reading, apps for learning, and apps for fun and creativity:

<https://blog.momswithapps.com/apps-for-special-needs/>



LGBTQ+, Sexuality, and Gender Identity

Children and teens who are questioning their sexuality, gender, or are beginning to identify as lesbian, gay, bi-sexual, transgender, or queer (LGBTQ+) benefit from support from their caregivers or other adults around them. Supportive adults and peers can help children and teens further develop a positive identity and maintain self-esteem. Children and teens may struggle with issues related to their gender identity or sexuality including relationships with family and peers, the “coming-out” process, dating and intimate relationships, isolation and loneliness, social pressures, spirituality and religious issues, societal stigma and discrimination, and community attitudes.

When working with youth, it is important to provide an environment that is nonjudgmental, honest, and honors the statements and feelings expressed by the child or teen.

It can be reassuring to youth to learn that approximately 10 percent of the population identifies as LGBTQ+. It also can be helpful to clarify terminology and increase everyone’s

understanding of current language use. For example, sexual behavior is not always the same thing as sexual orientation, and gender identity is not the same as sex assigned at birth. There are many online resources (see below links) for youth and adults to increase knowledge and help normalize experiences and identities.

It is important to never pressure a youth to “come out” as this is a very individual and personal process. Children and youth should choose when and how to tell family and friends. Creating safe opportunities for LGBTQ+ youth to control this process can mitigate harassment or dismissive experiences. LGBTQ+ youth are at greater risk of being bullied, abused, and rejected by people in their life, and are more than twice as likely to attempt suicide than heterosexual youth. Support groups for youth and caregivers are available in local communities, through schools, and offered via online formats. These groups can offer support to youth as they navigate their identity and sexuality. Caregivers also benefit from support groups to help manage concerns and offer strategies to maintain open dialogue and work to build trust and repair ruptured relationships and connections.

Gender identity is shaped by hormonal and societal influences, including family, school, community, and the media. Gender fluidity

or nonconformity to a male or female binary has been increasingly acknowledged and recognized in our society and throughout the world, but it's not a new phenomenon. Gender-expansive children become aware at an early age that they are “different,” and because of rigidly defined roles and “rules” sanctioned by the larger society about gender and gender roles, most gender-expansive children and youth experience isolation, rejection, and conflict in some social contexts, including within their family, school and after-school day care and activities, and religious and home communities.

As advocates, we have a role to play in supporting families to understand gender-expansive children and to support children and teens as they further define, explore, and assert their gender identity. We now know that individuals who are gender-expansive and transgender began to assert their experienced gender (as opposed to gender assigned by family and others) around age 2. There are many resources available to support families with gender-expansive and transgender children and teens, including books that may provide guidance to caregivers and providers who work with children and youth.

Resources and links:



Resources and links to support youth, their family members, and advocates:

Centers for Disease Control and Prevention LGBT Youth Resources:

<https://www.cdc.gov/lgbthealth/youth-resources.htm>

It Gets Better Project:

<https://itgetsbetter.org/>

<https://itgetsbetter.org/blog/lesson/glossary/>

Parents, Family, and Friends of Lesbian and Gays (PFLAG): www.pflag.org

The Trevor Project, trainings for youth serving professionals:

www.thetrevorproject.org

Social & Emotional Wellness Initiative:

<https://www.sewi.org/>

https://www.sewi.org/lgbtq?gclid=EAIaIQobChMI_9vf9sm67gIV4w59Ch2wgcC3EAAYAiAAEgI60fD_BwE

Colage, resources to support children, youth, and families with one or more caregivers identified as LGBTQ+:

<https://www.colage.org/>

Virtual Lab School, Understanding Development for Gender-Expansion and Transgender Children and Youth: <https://www.virtuallabschool.org/focused-topics/gender-safe/lesson-2>

Gender Spectrum, an organization that works to create gender-sensitive and inclusive environments for all children and teens: <https://genderspectrum.org/>

More information on how parents can support their gender-expansive children: <https://www.genderspectrum.org/audiences/parents-and-family>

Recommended print books for Gender Expansive Children and Transgender Youth:

Bianchi's *Becoming an Ally to the Gender-Expansive Child* (2018);

Ehrensaft's *The Gender Creative Child: Pathways for Nurturing and Supporting Children Who Live Outside Gender Boxes* (2016);

Brill and Kenney's *Transgender Teen: A Handbook for Parents and Professionals Supporting Transgender and Non-Binary Teens* (2016).

Considering Grief and Loss Experiences

It can be helpful to have an integrated understanding of the deep losses experienced within families impacted by domestic violence.

Grief is the reaction to loss, and we understand that families experiencing domestic violence may be dealing with grief over multiple losses.

The domestic violence survivor loses a relationship with someone they love and with whom they built a life, and often, this life includes children. Children may also lose a relationship with their other parent or relatives.

Children exposed to domestic violence experience the loss of their family system and may hold divided loyalties to their parents and caregivers. Children often experience great stress as they navigate between their caregivers who may be engaged in tremendous conflict and animosity. When children move out of their home with their protective parent, not only do they lose their home, bed, and belongings, but they also may lose their school, friendships, family finances (*lifestyle*), community, contact with relatives, cultural and spiritual practices, and their daily

routine. These losses can be overwhelming to a child. We can think of these losses as *ambiguous* (Boss, 2006), a term meaning that the possibility exists that the child may return home again and again when domestic violence survivors and their abusive partners reunite and try to maintain the relationship.

There is often uncertainty or a sense of incomplete loss when families have a history of experiencing domestic violence. Adult survivors often describe the absolute and devastating loneliness of being in an abusive relationship. This trauma includes conflicted feelings and sometimes immobility that arises from ambiguous loss. Children and teens exposed to domestic violence also experience ambiguous loss in the sense that one parent (or caregiver) is not physically present in their lives for periods of time but is psychologically present in the sense that their violence is the cause of the family's conflict, dissolution, or their relocation to a shelter or another setting that isn't home. Boss (2006) suggests that ambiguous loss is the most stressful kind of loss that people experience, if we consider that on average the research shows that domestic violence survivors leave their abusive partners seven to eight times before the relationship is over. Children may be caught up in this back-and-forth process while experiencing repeated loss, with no resolution available to them.





Critical Conversations

Helpful hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing compassionate policies within your program.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

- How are children and teens supported in your organization?
- Are there additional strategies that could be used to engage with children, teens, and their caregivers?
- How inclusive are the organization's services and programming?
- Does the organization explicitly reach out to youth in the community?

What can a direct staff person do?

- Ensure that children and teens are supported in the organization by bringing up relevant issues to coworkers and supervisors.
- Seek out guidance from a supervisor regarding questions about how best to serve and include the unique needs of children and teens and their caregivers.

Critical Conversations



What can a supervisor do?

- Support staff in learning about how best to engage and support children, teens, and their caregivers in creating inclusive services by developing internal trainings and seeking out external trainings.
- Initiate conversations during individual and team supervision to support more inclusive programming, and support the development of individual, group, and family-based services to meet the unique needs of children, teens, and their caregivers in your program settings.
- Anticipate what referrals for children and youth and their caregivers may be needed, and build relationships with those organizations and providers that can best address those needs.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Madison and her mother live in your transitional housing program. Madison is struggling with her emerging identity and is talking about running away. Madison shares that her mother has had a really difficult life, and she doesn't want to burden her or stress her out more by "telling her who I am." Madison has shared that her "church says it is a sin to be gay."



Things to consider:

- Madison's desire to run away is normal. Developmentally, Madison is dealing with many changes, and she may have a desire to differentiate from her mother without understanding how to do so while continuing to live with her.
- Madison's interest in protecting her mother is also understandable. Some children who grow up experiencing domestic violence and other trauma have a strong desire to protect their caregiver who has been abused.
- Madison may have lots of complicated feelings about her emerging sexuality.
- What are the family's beliefs about people who are identified as LGBTQ+? How might this belief be viewed within the context of her culture and community?

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin by empathizing with Madison's concerns; help normalize Madison's feelings by exploring the wish to run away and trying to contextualize this: new relationship, fantasies, etc.
- Explore and problem-solve with Madison ways she might be able to stay with her mom and not run away.
- Initiate the dialogue with Madison about protecting her mother and also her feelings (*maybe internalized shame or fear*) around her emerging sexual identity.



9. Supporting Parents and Caregivers Affected by Domestic Violence

Children’s physical and emotional safety and sense of felt security is connected to having consistently nurturing, responsive parenting and relationships with caregiving adults.

Living with intimate partner violence can lead to negative consequences for survivors, their children, and their relationships with each other.

In this section, we

provide practical guidance about forming partnerships with parents to address needs and issues related to their children and offer considerations for structuring family services within your program as well as coordinating referrals with community providers. We also offer resources for engaging and supporting caregivers to strengthen their parenting capacities and bonds with their children in the wake of domestic violence. In addition, we offer guidance on parenting after separation, supporting domestic violence survivors, and provide considerations and resources for engaging abusive partners who have regular and ongoing contact with their children. As domestic violence service providers, we frequently encounter domestic violence survivors with mental health and substance use-related needs who are parents. In sections 10 and 11, we talk about ways to navigate safety and build responsive caregiving with families facing these additional challenges.

Forming partnerships with parents and caregivers

Our work with children and teens is strengthened by forming a strong alliance with their protective caregivers.

Building a trusting relationship between yourself and the parent is a unique process that may take time to unfold. For adult survivors who have endured humiliation and criticism about their parenting capacities and control around their parenting role, we may find that protective parents carry shame and a sense of blame toward themselves or others. Parents often feel disempowered about their children—with teachers and schools, child specialists, and other helping professionals, including domestic violence advocates and mental health clinicians. We can keep this in mind by relating to parents as the experts on their children. This acknowledges their parental authority and may help parents think about what they want for their children and family in regard to services. This may change over time as they become more certain of themselves and trust that we will support them. We may also encounter parents who seem disengaged and may have very specific agendas about what's “wrong” with their

children and may want us to “fix” the problems as the experts.

The National Center on Domestic Violence, Trauma, and Mental Health's “*Guide for Engaging and Supporting Parents Affected by Domestic Violence*” offers principles and strategies for deepening engagement and entering into a collaborative partnership with parents: <http://www.nationalcenterdvtraumamh.org/publications-products/guide-for-engaging-and-supporting-parents-affected-by-domestic-violence/>

When we think about offering services to families, we want to be inclusive and mindful of the family's current living situation. Children experiencing domestic violence may be living in multi-generational homes with extended family; this can be protective for children and supportive to their parents but may also create tensions among the caregiving adults related to parenting roles, practices, and authority. Some children are living with grandparents and other relatives who are informally caregiving or who may have temporary or permanent custody after child welfare system involvement or because their biological parents are unable to care for them due to illness, incarceration, or death. The Centers for Disease Control and Prevention reports that 3 percent of all children in the

United States live apart from their parents, and two-thirds of those children live with grandparents (2019).

Depending on the circumstances, children and their caregivers may be facing unique and complex needs. When parents and children are separated due to child welfare involvement, we can support survivors by listening to and holding their concerns and pain around separation. We can also advocate for maintaining regular contact or visitation with their children (*when part of the plan*) and for adequate legal representation to support reunification whenever possible. Regardless of the current family living arrangement, we encourage domestic violence programs to include grandparents and other relatives who have primary responsibility for caregiving in the family, whether it be temporary or permanent in considering child and family services within your setting. We can also be a bridge between caregivers and their children as well as grandparents and other relatives and the family. This includes considerations for involving parents who have used violence and intimidation with their intimate partners and have ongoing involvement with their children.

Sequencing services: Whom to see when and in what order

We begin with “*where the parent and children are at*” (as described in the guiding principles discussed in the guide). Our program setting will impact what we offer. Shelter-based care is time-limited, and families generally enter services in crisis. We may simply begin with engaging the parent and children and offering support and services that fit with their current needs. Some families are able to transition from shelter-based services to transitional housing or community-based services offered by our program and also to services offered by community partners. Transitions to more formalized, weekly individual child, group, and parent-child services may be difficult for some families after leaving shelter. Often families seek community-based services either on their own or through referrals from schools and other providers. No matter how families enter services, there needs to be enough safety and stabilization in place before we offer more intensive services. We can take our cues from caregivers and their children to determine needs and timing.

Regardless of parents’ readiness to engage in services for or with their children, we can consider offering family activities that are fun, promote closeness, and can be planned out

together. These can be done with individual families or as part of a group with other families, depending on the program and opportunities. These activities can be initiated across domestic violence service settings in both shelter-based and community programs (see *Section 12*).

Readiness to engage in services and establishing an informal contract for services

When parents are interested in having their children engage in services, they may not be ready or willing to participate in joint parent-child services as part of the plan. Parents may be overwhelmed with their own concerns (e.g., *getting a permanent order of protection, going through a protracted court process, finding stable housing and employment*) and might benefit from supportive engagement with us before becoming involved with parent-child and family-centered services. When we encounter barriers to parent-child or family services, we may decide to explore this further with the parent to find out if they have fears about participating (e.g., *“he won’t open up if I’m there”*).

Conversely, parents may not want their children and teens involved in services because of fears about what might be said



to an advocate or mental health counselor in a domestic violence setting without their direct involvement. We can respect their wishes while also continuing to open space for dialogue about what might be beneficial to their children and why. We can be explicit about how services are offered and the limits of confidentiality.

Domestic violence programs are encouraged to establish protocols that are clear about parent involvement, regardless of whether or not individual and group services are offered to their children. Having an understanding at the outset of services that includes parents in the process is considered a best practice. This can be as simple as one-on-one check-ins with the caregiver about how things are going with their children. In turn, we can also provide caregivers with our reflections on how their children are benefiting from the services we are providing. At critical points in

the process, it can be enormously helpful to bring parents and children together to work through issues within their relationship in a safe space. In some instances, this may involve a lot of preparation and coaching to make this a healing experience and to avoid re-traumatization through more toxic interactions.

In our roles, we can offer hope about the possibility and power of making emotional repairs to relationships between protective caregivers and their children.

When seeing children alone:

The advocate or clinician needs to consider whether it makes sense to see children separately prior to engaging in parent-child and family meetings. If we decide to offer separate services, this should be clearly delineated and communicated to the protective parent with their consent. Advocates can then provide support to children. These services might include safety planning, psychoeducation about domestic violence (e.g., “*It’s not your fault*”), or establishing ways to self-regulate and self-soothe when trauma reminders arise or children are having trouble sleeping at night or concentrating in school.



As mentioned previously, when children are seen individually, then the advocate or clinician can still involve the parent in talking about how their child is doing at home and school and sharing some of what happens in individual contacts with the child. We discourage the practice of having the parent come in at the beginning of the meeting with the domestic violence advocate or mental health counselor; too often, the parent may air all of the things that went wrong during the week with their child in front of their child. This can be shaming for the child and may derail the process of establishing a trusting relationship between the advocate and the child. Having an agreement for parents to have their own private time to share their concerns and to gauge progress or “*sliding back*” is beneficial. Advocates and mental health clinicians in domestic violence settings

can provide support and perspective to parents about issues that are arising and help hold strong feelings related to their children's behavior and struggles. This can help build reflective capacity for caregivers.

There are two other important considerations to keep in mind: First, building a relationship with children without an alliance with their parents might impact parents' ongoing commitment and investment in bringing their children over time and possibly stir feelings of competition with the provider. Second, when services are completely separate, it can be challenging to hold the child and caregiver in mind at the same time. We may develop strong identifications with the child receiving services and miss an understanding of the different needs and perspectives held by children and their caregivers. These may be at odds (*e.g., push and pull to stay, leave, or reunite with the abusive partner and child's parent or stepparent; developmental push for more autonomy and freedom from teens versus pull of family responsibilities and caring for younger siblings, etc.*).

Parent-child and family services

Children often serve as trauma reminders for their parents (*and vice versa*), and that may present challenges for doing parent-

child or family-centered work. Depending on the specific concerns and goals of child and family-centered work, it can be helpful to introduce parent-child and family sessions to build stronger bonds between protective parents and their children. This is truly essential with younger children, since the attachment relationship scaffolds the child's future development and is critical to the healing process after exposure to trauma. As mentioned previously, advocates and therapists can introduce fun activities that build closeness and communication as part of the initial process of engaging with families. This process can begin in whatever domestic violence service setting the family enters.

Participation in parent-child and family therapy

We can also consider when it might be best to sequence treatment services. Generally, our decision-making in collaboration with the parent might look at these factors:

- Is there an immediate crisis situation?
- What is the nature of our relationship with this parent and family right now?
- How emotionally available and present is the parent at this time?
- Is there some level of safety and

stability within the family right now *(even though we might anticipate destabilizing situations related to visitation, court hearings, etc.)?*

Families are often in flux, and we may begin therapy services but keep returning to establishing or reestablishing a sense of safety while working on stress reduction and emotional regulation when trauma reminders come up or stressful situations emerge.

When there is a level of trust with the provider and stability within the family, then parent-child and family therapy services may be beneficial in addressing trauma-related responses and perceptions that each member holds about others in the family. This helps make meaning of children's and parents' feelings, reactions, and responses to each other, and helps to repair and strengthen relationships *(so that children can count on their protective parents to be responsive to their needs)*. These services are most likely to be successful when the practitioners are mental health clinicians working in domestic violence programs with specialized training in trauma-specific interventions using play, talk, and other expressive arts.

Programs may also refer out to trusted referral sources for trauma-specific treatment services with qualified mental health practitioners who understand domestic

violence. When services are provided in-house, then the mental health clinician should be receiving clinical supervision or outside consultation from a licensed practitioner. *(See Section 7 for more detail on preparing caregivers and children for referrals to mental health providers outside of your program.)*



When child and family-centered work is provisional or not recommended

When children have to keep “secrets” about coming to your program from their protective parent’s abusive partner *(who may or may not be living in the home currently)*, ongoing individual child work is contraindicated because it might compromise the safety of the child and adult survivor. In those situations,

age- and developmentally appropriate child safety planning with the parent and children would come first, along with strategies for managing scary and overwhelming feelings (such as deep breathing, etc.). As discussed previously, there may be other family-centered activities that families affected by domestic violence can engage in to strengthen bonds between protective parents and their children. Trauma-specific treatment interventions are not recommended when there is a present danger and the family situation is unsafe physically and emotionally.

Parenting after separation and considerations for working with abusive partners with ongoing involvement with their children

At its foundation, “good enough” parenting requires that parents prioritize their children’s needs and do not undermine each other in supporting their children’s healthy growth and development. In intimate partner relationships affected by domestic violence, the abusive partner may use children to control survivors or put their needs ahead of their children or their partner’s needs. After separation or

divorce, both parents have to carry out the custody or parenting arrangement set in court and often continue to share in the care and parenting of their children.

Survivors need to safely negotiate the challenges of shared parenting duties. Pickup and drop-off times can be flash points for increased risk, and we know that survivors sometimes make special arrangements at public places for the exchange of their children. In some instances, supervised visitation can be a safe way of having contact. Domestic violence survivors may be in the midst of protracted court cases with the threat of losing custody, or they may have joint custody that requires their children make frequent transitions between their parents’ homes and neighborhoods. This can be particularly difficult for young children who need the consistency of the attachment relationship with their protective parent. Survivors may also have concerns about their children’s safety and needs being met while they are with their former abusive partner.

Advocates can support survivors by listening to their concerns, holding strong feelings and reactions together, and helping parents sort through ways to prepare their children for these transitions.

We can support and encourage domestic violence survivors to have conversations upfront with their children about what to expect with the current parenting arrangement, answer their children's questions, and respond to their feelings, concerns, and any fears they might have that are related to time spent with each of their parents. It's not uncommon for children to "act out" after spending time with the parent who has been abusive to their other parent (*who may be the custodial parent*). We can help parents and their children understand and process their strong feelings related to this process and help support ways and rituals that are soothing and comforting during times of transition (*e.g., leaving one house for the other; returning home to the other parent*). Sometimes survivors may need our support in thinking about being supportive to their children by allowing them to share how they may have enjoyed their time with the other parent, without inducing guilt or feeling inadequate about what they are able to provide (*usually, materially with toys, sporting events, etc.*) in comparison to themselves.

Some domestic violence programs offer services for survivors only and some may also offer separate services for abusive partners or have referrals to programs that specialize in Partner Abuse Intervention Program (PAIP) services, sometimes referred to as

Batterer Intervention Programs. Traditional domestic violence programs are beginning to consider the question: What do we offer for the abusive partner who is parenting? Abusive partners may be motivated to seek PAIP services and to address harm done to their children as a result of domestic violence. For some abusive partners who are parenting, they may experience challenges with employment, housing, substance use, or lack of access to education and mental health services. Case management services focused on basic resources, coping skills, and referrals to community resources can support abusive partners as they have ongoing contact or custody of their children.

We believe that a first step begins when the abusive partner is motivated to attend and complete a local PAIP course of services. When former abusive partners can acknowledge the harms done to their partners and their children, they may then be ready to engage in services that support the parent-child relationship (*assuming there are no ongoing red flags regarding abuse or neglect of their children while in their care*). Domestic violence programs would want confirmations of real change as reported by the PAIP facilitators as well as the domestic violence survivors (*in a setting that is private and confidential*) before proceeding. There might be opportunities to collaborate with

local services to offer a parenting curriculum to formerly abusive partners who love their children and understand the consequences and impact of domestic violence for their children (see resources and links for more information).

Impact of child and family-centered work on staff relationships and program

There are pros and cons to having one advocate or mental health clinician working with multiple members of a family. The advantages of working with both the parent and child (*either separately or together*) are seen in these ways:

- We can maintain a relationship and alliance that holds both parties in mind at the same time.
- We can have a fuller perspective that weaves together the mutual and separate needs and capacities of each one.
- When we see the parent and child interacting with each other, we get new information from what we might hear and observe individually from each.

The disadvantages may be that we hear different information from each party during separate contacts that may be contradictory or conflict with the other's perspective. We, then, have to decide when and how to share what we've learned.

When we have more than one staff member in a program relating primarily to a specific family member (*e.g., one has contact with the child and the other does adult survivor-related advocacy and services*), there is a chance that conflicts and splits within the family we are serving will get played out among ourselves within the program.

It can also be difficult to manage and contain our own strong feelings when we feel identified with one family member more than the others or when we have concerns about a child's well-being that are not shared by the parent.

We each bring our own lived experiences growing up within our families and as adults to this work. It's important to be aware of what might get evoked in us and how we can best manage our own responses in order to stay connected and be effective in our work with children, parents, and families. Reflective supervision and outside consultation can be helpful for serving families well and for our own professional growth and development.



Section 9: Resources and Links

National Center on Domestic Violence, Trauma, and Mental Health’s “*Guide for Engaging and Supporting Parents Affected by Domestic Violence*” offers principles and strategies for deepening engagement and entering into a collaborative partnership with parents:

<http://www.nationalcenterdvtraumamh.org/publications-products/guide-for-engaging-and-supporting-parents-affected-by-domestic-violence/>

Working with parents with a history of intimate partner violence:

Preventing and Addressing Intimate Violence When Engaging Dads (PAIVED):

<https://www.acf.hhs.gov/opre/report/preventing-and-addressing-intimate-violence-when-engaging-dads-paived-challenges>

<https://www.acf.hhs.gov/opre/report/healing-and-supporting-fathers-principles-practices-and-resources-help-address-and>

<https://www.acf.hhs.gov/opre/report/healing-and-supporting-fathers-principles-practices-and-resources-help-address-and-0>

The **Caring Dads Curriculum** has been introduced in Canada, the United States, and internationally: <https://caringdads.org/about-caring-dads-1>



Critical Conversations

Helpful hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing inclusive and compassionate policies within your program.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

- What's our approach to providing individual, parent-child, and family-centered services?
- Do we have standardized guidance on how we serve children, parents, and families? Review this section and think about what's working well, what you might want to enhance or adapt, and what you want to stop doing.
- What kinds of support and advocacy can we routinely provide to parents who are separated from their children due to child welfare involvement or other circumstances?
- What's our stance around serving parents who have used violence with intimate partners? Engage in frank conversations about our biases, attitudes, etc. Can we partner with others either in-house or outside of our agency to offer services that support formerly abusive partners in their parenting role?

Critical Conversations



What can a direct staff person do?

- Become familiar with NCDVTMH's *"Guide for Engaging and Supporting Parents Affected by Domestic Violence"* and work through the guide yourself.
- If your role is primarily supporting adult survivors, then think about ways that you can introduce conversations with parents about their children and their children's needs.

What can a supervisor do?

- Introduce NCDVTMH's *"Guide for Engaging and Supporting Parents Affected by Domestic Violence"* to all staff and use as an orientation resource for new staff. Supervisors can work through the sections of the guide with their teams during team meetings, using questions posed in the text boxes, etc., and also encourage staff to do a self-guided read-through.
- Develop written guidance with input from staff and family to set clear expectations for program staff and families.
- Share different perspectives and insights on children, parents and families when multiple staff are involved with the same family via team staff meetings and conversations.
- Explore intra-agency or collaborative partnerships to offer services to formerly abusive partners who are parenting.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Katie is a domestic violence survivor with two children; they receive services at your agency. She has shared custody with her former abusive partner, Angela, who kept the family home and is financially well off. Katie used to stay at home and did most of the caregiving, but she has now returned to school to further her career and is struggling to pay rent for her small apartment.

Katie reports that the children seem to be adjusting well, but she feels like it's become a competition for the kids' love. She can't discipline the children for fear of *"losing them"* to Angela's gifts, fun trips, and living in their previous home with neighborhood friends and lifestyle.



Things to consider:

- Begin by understanding Katie's concerns. You may want to be curious about how discipline issues were handled prior to the separation and build on any parenting strengths identified by Katie.
- Help Katie understand how her parenting was undermined by her abusive partner and how this dynamic continues in this situation.
- It might be an opportunity to check Katie's interest in a parenting support group.

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin with empathizing with Katie's concerns and normalizing Katie's feelings; support her in managing her fears regarding disciplining her children and expectations of what she can and cannot control, etc.
- Initiate the dialogue with Katie, together with her children, about their expectations for their time together and some guidelines for behaviors and natural consequences.
- Explore and problem-solve with Katie inexpensive and creative ways she can have fun with her children.



10. Supporting Parents with Mental Health Needs and their Children in Domestic Violence Settings

When we engage with families affected by domestic violence, we encounter parents with mental health-related needs and conditions. The principles and approach we recommend center on the wisdom of domestic violence survivors as the experts on their own well-being.

We understand how mental health and well-being may be adversely affected by experiences of abuse and trauma in the current generation and across multiple generations.

This allows us to hold the needs of both parent and child in mind at the same time, in the context of children's development, family, culture, and community.

It's also important to

understand and integrate the beliefs and diverse perspectives held by survivors about mental health, mental illness, and well-being. By seeking to understand and connect in a nonjudgmental, respectful way, we build trustworthy relationships that can help counter the stigma and shame that caregivers and families may experience due to mental health-related conditions. Domestic violence advocates can enter into dialogues about accessing responsive care that is aligned with survivors' beliefs and needs. We can also offer resources that support safety, increase well-being, and strengthen parent-child relationships.

In this section, we look at the intersection of intimate partner violence and mental health, and the effects of societal stigma and coercive tactics used by abusive partners to undermine survivors' mental health, well-being, and capacity to parent. We explore ways that we can support the needs of parents with mental health conditions and their children and provide tips on making referrals to access responsive care, peer supports, and specialized treatment services. Next, we offer practical strategies for engaging in sensitive dialogues with parents who have mental health-related needs and challenges, explore how these may be affecting their parenting, and suggest ways to talk with children about their parents' mental health conditions and challenges. And, finally, as in the other sections of this toolkit, we offer critical conversations for staff to reflect on their own biases, beliefs, and assumptions about mental health conditions and parenting, and offer a training vignette that captures some of the issues presented in this section.

Intersection of parental mental health and domestic violence

Mental health-related issues and conditions are common in our society, and yet, stigma negatively affects how we view mental illness and help-seeking efforts. One in five

adults in the United States experiences mental health conditions (*such as depression, anxiety, or PTSD*), and one in 20 adults may be diagnosed with Major Depressive Disorder, Schizophrenia, or Bipolar Disorder (<https://www.nami.org/mhstats>, 2019). Fewer than 4 percent of adults in the United States experienced mental health conditions with a co-occurring substance use disorder in the same year. It's estimated that of the adults experiencing mental health conditions, more than 20 percent are parents of children from birth through age 18, living in the same household.

As advocates, we are aware of the insidious ways that intimate partner abuse in its many forms can negatively affect one's mental health and well-being⁹. Studies have shown that domestic violence increases mental health risks for survivors. Domestic violence survivors are three times more at risk for experiencing PTSD, major depression, and self-harming behaviors; four times more likely

⁹ NCDVTMH website on Mental Health Consequences of Intimate Partner Violence: <http://www.nationalcenter-dvtraumamh.org/wp-content/uploads/2015/10/Mitchell-Chapter-12.pdf>

to make a suicide attempt; and six times more likely to experience a substance use disorder than peers who have not experienced intimate partner violence¹⁰.

Survivors with mental health conditions are also at greater risk for being controlled by their abusive partners through a range of coercive tactics meant to undermine their mental health and parenting. The National Domestic Violence Hotline, in partnership with the National Center on Domestic Violence, Trauma, and Mental Health, conducted surveys with callers about their experiences with mental health and substance use coercion¹¹ in 2012. The Mental Health Coercion Survey, with more than 2,500 female-identified callers, found a high prevalence of coercive tactics—calling a person “crazy,” doing things to make one question one’s own perceptions and reality (*also called gaslighting*), discouraging a person from seeking help, controlling medications, preventing access to ongoing mental health

treatment, and acting in ways that were triggering or precipitated mental health crises. Abusive partners sought to undermine the credibility of survivors, saying, “*No one will believe you,*” in an effort to control access to sources of protection and safety. One of the most common coercive tactics used by abusive partners involved ongoing threats, harassment, and actions related to survivors’ children (*including threats to jeopardize custody, making false reports to child protective services, and threats of deportation, etc.*). In sum, abusive partners actively sought to undermine their intimate partner’s mental health and well-being, discouraged or blocked access to medication and mental health treatment services, and then used the societal stigma about mental health to further discredit their parenting to authorities (*threatening to make reports and saying their partner was “unfit to parent,” etc.*). This is an important backdrop to keep in mind as we approach conversations with domestic violence survivors about their mental health and well-being.

¹⁰ NCDVTMH infographics: <http://www.nationalcenterdvtraumamh.org/2019/09/information-memorandum-from-samhsa-and-acf-calls-for-collaboration-on-domestic-violence-substance-use-and-mental-health/#infographics6>).

¹¹ For more information about these surveys: <http://www.nationalcenterdvtraumamh.org/publications-products/mental-health-and-substance-use-coercion-surveys-report/>

Supporting the needs of parents with mental health challenges and their children

As we engage with caregivers and families with diverse experiences, beliefs, cultural practices, and traditions, we know that adult survivors differ in their views of what constitutes mental health, mental illness, and well-being. Domestic violence advocates can enter into dialogues to explore survivors' experiences, perspectives, and beliefs more deeply. We can counter stigma about mental illness by letting survivors know that experiences of domestic violence, trauma, and abuse can lead to mental health risks and challenges. Depending on the level of acculturation of the family and the legacy of collective, historical, and ongoing trauma for oppressed or marginalized communities, we may find differences between the perspectives of children and their caregivers across generations. We can approach these differences with sensitivity and support conversations to explore conflicting beliefs within families. Domestic violence advocates can also support survivors to



share meaningful aspects of their life story, including experiences of childhood trauma that may be affecting their well-being as adults. We can be curious about how these life experiences intersect with their current mental health needs and the strengths and vulnerabilities they may bring to their parenting role.

The following inquiries can be helpful in initiating conversations with domestic violence survivors with mental health conditions and challenges, always remembering to pace, pause, and follow their lead:

- Begin by exploring survivors' views about their own mental health and well-being.
- Explore whether their intimate partner or ex-partner has used mental health coercive tactics by asking, *"Has your partner or ex-partner tried to undermine your sense of sanity, called you 'crazy,' and tried to discredit you to others who might be sources of help and support?"*
- Inquire: *"Have you sought mental health services in the past, and if so, how did that go?"*
- Follow up by asking: *"Has your partner or ex-partner discouraged you from getting mental health services or used other coercive tactics such as controlling your medications or stopping you from accessing care?"*
- Ask, *"What's helped you cope? What's helped you regain balance and more well-being in your life?"*
- We can also inquire: *"Has your partner or ex-partner ever used your mental health issues to threaten, intimidate you, or use your mental health-related needs to influence child protective services or child custody decisions?"*

- Ask, *"Do you ever feel that your mental health-related needs may affect your ability to do things you need and want to do, including caring for your children?"*
- After giving birth, domestic violence survivors may be at higher risk for postpartum depression, so it's important to put this in context with new mothers and to help them access supportive resources in a timely manner¹².

¹² <https://www.domesticshelters.org/articles/identifying-abuse/postpartum-depression-linked-to-domestic-violence>

Once we have a fuller understanding of survivors' current and past mental health challenges, we can begin to gauge interest and present options for addressing mental health-related needs with survivors.

Making referrals for adult mental health services

In making referrals for adult mental health services, it is important that the domestic violence survivor is in the lead. We can talk through prior experiences, help prepare for what they might expect, and make warm referrals to providers within and outside of our agency programs (*e.g., make the first call together, find out about waiting lists and fees, etc.*). Some domestic violence survivors may want to access peer recovery services or culturally specific ways of healing from trauma and abuse. We recommend that domestic violence providers develop collaborative relationships with community mental health providers who are knowledgeable about domestic violence and understand the intersection with mental health, substance use, and abusive partners' coercive tactics related to mental health and substance use. Domestic violence survivors may also benefit from engaging with mental health providers who are qualified to offer evidence-informed,

gender responsive approaches that align with their needs and choices for mental health care. (**See Section 11** on *parental substance use for tips on making referrals and addressing barriers to coordinated care.*) In general, we have found that if adult survivors are in crisis due to ongoing abuse and other adverse circumstances, they might first benefit from receiving advocacy and mental health services that foster emotional and physical safety and stabilization. For more information on trauma-informed approaches to mental health care for domestic violence survivors, see this link from the NCDVTMH website: <http://www.nationalcenterdvtraumamh.org/publications-products/ncdvtmh-online-repository-of-trauma-focused-interventions-for-survivors-of-intimate-partner-violence/>

Supporting parent-child relationships and responsive caregiving for parents with mental health-related needs and challenges

Domestic violence advocates know that experiencing domestic violence and other lifetime trauma may affect parent-child relationships.

The concerns may be varied: from caregivers who are depressed and seem unable to connect with their children to engage in play, respond to their signals for help and support, and monitor their safety; to parents or caregivers who have issues with setting boundaries and discipline; to parents who are flooded with anger and harshly critical of their children and their behavior; to caregivers who seem to respond differently to their children depending on their gender or birth order or current age (*e.g., sometimes parents do well with babies in their arms and not as well once they are mobile*). Regardless of the issue and concerns, we can approach sensitive conversations with caregivers using the strategies outlined in NCDVTMH's

"Guide for Engaging and Supporting Parents Affected by Domestic Violence": <http://www.nationalcenterdvtraumamh.org/publications-products/guide-for-engaging-and-supporting-parents-affected-by-domestic-violence/>

We can begin with caregivers in the moment, gauging where they are and being sensitive to what stressors they are experiencing currently. When we're dysregulated, it's nearly impossible to focus and explore issues related to our well-being and that of our children. As domestic violence advocates, one of the ways in which we can be supportive is to "*be with*" the survivor and hold strong feelings together. In that way, we may become co-regulators for parents. When the timing is right, we can point out their strengths as individuals and as parents. Many parents will have some insights about how they are parenting and may share worries and concerns about their children. We can build on those reflections, offer our own observations, and enter into conversations about how their own state of mind and mental health challenges may be interfering with their capacity to be more consistently responsive to their children. If caregivers are unaware of how their own mental health challenges may be affecting their children's well-being and parenting, then we can gently and tentatively share our observations, while offering hope

for supporting and strengthening parent-child bonds and making repairs.

We can also help caregivers and children to talk about parental mental health conditions in language that fits for the family and is also developmentally sensitive.

These conversations can help children understand their parents' mental health conditions and challenges in a way that relieves anxiety, self-blame, and responsibility for taking care of their parents and younger siblings. Parents can explain that they are getting support for their own mental health, using destigmatizing language, and also reassure their children that the parent's mood or behavior is not the child's fault. When difficulties arise, we can support caregivers and children to co-create a narrative to explain what's happening and to make repairs in the relationship. For example, a caregiver might say: *"Sometimes I get really sad or upset and I'm learning how to cope with those feelings and get the support I need (from other grownups, going to a group, getting therapy, taking my medications) to manage and to feel better. When I'm not feeling well and may need some rest or time to myself, I know it can feel lonely and scary for you. Let's figure out a way for you to be OK until I'm feeling more like myself again"* (e.g., put

on one of your favorite DVDs, go play at your cousin's house, be with an adult family member, etc.). Of course, with babies and very young children, we may need to figure out what kinds of adult support and caregiving would provide respite for domestic violence survivors and responsive care for their children during those times. Quality day care and natural supports within the extended family and community may be important lifelines for families.

In concluding, we hope this section encourages domestic violence programs to take a thoughtful, well-informed approach to serving survivors and families with parental mental health conditions and to offer supports to help staff explore their own biases and assumptions and gain the necessary knowledge and skills to carry out their roles in a kind and compassionate way.



Critical Conversations

Helpful hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing inclusive and compassionate policies within your program.

Sometimes when we feel frustrated, stymied, or stuck in supporting domestic violence survivors who are parenting, we may use “othering” language in our conversations with each other, such as, “She’s borderline.” Hopefully we can regain perspective and view domestic violence survivors through a trauma-informed lens, which can help us be less judgmental and more compassionate.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

Engage in self-guided exercises and team-based conversations to explore staff perceptions and biases related to adults with mental health-related needs and conditions. Here are some potential questions for self-reflection and sharing:

- What are my views on mental health, mental illness, and mental health treatment and recovery?
- Are these the same as or different from the dominant views held in the United States or Western culture?
- How can I hold and support varying perspectives that may not align with my own views? How can we hold these differences as a program or organization?
- Do I harbor any bias about how mental health-related needs and conditions affect parenting capacity? If so, what are those perceptions?
- How are my perspectives and feelings informed by:
 - Experiences during my childhood and adolescence?
 - Growing up in my family?

Critical Conversations



- My own mental health and well-being and any experiences with mental health or recovery services?
- My culture and social identities (*i.e., gender identity, race, ethnicity, religion, sexual orientation, religion, etc.*)?
- My experiences as a survivor, as a parent (*if applicable*)?
- How have these perspectives and feelings changed over time?

What can a direct staff person do?

- Become familiar with the resources in your community that serve adult survivors and families affected by parental mental health conditions and challenges. This includes finding natural supports and services within the community to help promote children's healthy development and well-being (while their caregivers are accessing services and supports).
- Reflect on your own strengths and biases in working with parental mental health challenges and seek reflective supervision and consultation.



What can a supervisor do?

- In tandem with recommendations in Section 9, use NCDVTMH’s *“Guide for Engaging and Supporting Parents Affected by Domestic Violence”* to encourage staff to become familiar with the strategies that might work best with parents with mental health challenges—using an individually tailored approach.
- Explore policies and practices that destigmatize parental mental health issues and conditions, while creating programming and supports within your program and community to provide extra care as needed to meet children’s needs (*with the consent and understanding of their caregivers*).
- Explore intra-agency and collaborative partnerships with community providers that offer domestic violence-responsive mental health care and services for adult survivors who are parenting. These may include resources for evidence-informed family-centered approaches, such as Child-Parent Psychotherapy, as part of a coordinated care plan.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Cora is a domestic violence survivor who has entered shelter with her baby and two young children, ages 2 and 5. While holding her baby, Cora rocks herself back and forth on the couch in the common area and silently cries for long periods of time. Her 5-year-old daughter, Nina, offers the bottle for her mother to feed the baby, often changes the baby's diapers, and pats her mother on the back.



Things to consider:

- We are meeting this parent and her family during a time of crisis and transition with a new baby. What would be important for us to learn about what led to shelter?
- Cora seems depressed. Is this postpartum depression exacerbated by domestic violence? If so, is this a unique experience with this baby?
- How has Cora parented in the past? How has her parenting been affected by domestic violence? By mental health-related needs or conditions?
- Nina seems to be taking on a more adult caregiving role toward the baby and her mother. Is this specific to this particular period of crisis and transition, or is this a more established pattern in the family? We might also observe how Nina responds to her 2-year-old sibling.
- Nina's capacity for empathy and caregiving seems to indicate that she may have gotten some responsive caregiving at various times in her young life.

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin with finding out where Cora is at in the moment. Empathize with her feelings and state of mind and normalize her situation to decrease shame and self-blame.



- Explore if she might be feeling somewhat overwhelmed with her parental caregiving right now, and what might be helpful to her in caring for her children. Observe if she is able to differentiate and respond to any of her children's needs at this time.
- Be curious about how Cora has coped in the past (*e.g., What has been the history with the birth of her other child? Is this different or similar? What's helped alleviate stress, and helped her to regain her equilibrium?*).
- Depending on what is shared, initiate a conversation about postpartum depression and mental health and explore what resources and supports might be helpful to her and her children while she's staying in shelter and afterward.



11. Supporting Parents Who Use Substances and their Children in Domestic Violence Settings

Domestic violence programs and organizations are asking to be more informed about how to support domestic violence survivors and their children who are affected by parental drug and alcohol use. Taking an accessible, culturally responsive, and trauma-informed approach to supporting parents, who use substances, and their children begins with establishing trustworthy relationships. Through these connections, domestic violence advocates can help to counter the stigma and shame that so many parents and children experience due to substance use. When we understand how parental substance use may be connected with experiences of abuse and trauma, then we can focus our efforts on helping parents increase safety for themselves and their children.

We can offer resources that support safety, increase well-being, and strengthen parent-child relationships.

This approach recognizes that abusive partners often use substances to isolate survivors

from safe supports. Programs can screen survivors “in” to advocacy services based on need rather than screen “out” due to substance use. When programs exclude or exit survivors due to substance use, these actions are often experienced as retraumatizing, and

then survivors and their children may become more at risk when they are left without critical services and supports. As a companion to this section, programs might find it helpful to review NCDVTMH's "Committed to Safety for ALL Survivors," a guide for supporting adult survivors who use substances, in domestic violence settings: <http://www.nationalcenterdvtraumamh.org/publications-products/committed-to-safety/>

In this section, we begin by looking at the scope of parental substance use in the United States, the estimated numbers of children affected by their parents' drug or alcohol use, and the overlap between domestic violence, substance use, and involvement with the child welfare system. Then we'll discuss how substance use may affect parenting and how children may be affected by their parents' drug or alcohol use. We'll offer practical strategies for engaging in sensitive dialogues with parents, including how their substance use may be affecting their parenting. Next, we will examine common issues that might arise when working in our programs with parents using substances related to child safety and consistent nurturance, and how to make referrals for integrated and specialized services. And, finally, as in the other sections of this toolkit, we offer critical conversations for staff to reflect on their own biases



and assumptions about substance use and recovery, their responses to working with adults, children, and families affected by substance use, and what supports are helpful to sustain staff in doing responsive work with domestic violence survivors who use substances and their families.

Background on the scope of parental substance use in the United States and its effects

In 2017, almost 21 million people needed treatment for substance use, but only 4 million received any kind of treatment and even fewer received specialized services. Substance use trends amongst pregnant and parenting women have remained consistent

over the past 10 years, with the exception of prescription opioid and heroin use, which has risen steadily and been referred to as an epidemic in the United States. The percentage of pregnant women entering treatment who reported any prescription opioid misuse went from 2 percent to 28 percent from 1992 to 2010. The rate of deaths from overdoses has also increased dramatically from prescription opioids, heroin, and illegally manufactured fentanyl. Within a 10-year period between 2004-2014, the rate of infants experiencing Neonatal Abstinence Syndrome (NAS) because of exposure to opioids in utero increased by more than 400 percent from 1.5 to eight per 1,000 hospital births. State policies vary regarding treatment and recovery services for pregnant and parenting women with substance use-related needs and substance use disorders.

Substance use disorders are defined as the recurrent use of alcohol or other drugs, or both, resulting in significant impairment. Access to treatment services is limited in many areas and does not begin to meet the needs of people with substance use-related needs and disorders. Public health data shows that the vast majority of people who use substances (*many of whom have children in their care*) do not have a substance use disorder (SAMHSA NSDUH 2019). Additionally, many people who are living with a substance use disorder are

still able to responsibly parent and nurture their children, especially with access to nonjudgmental support and resources.

In a related trend to the rise of opioid use in the United States, more children are being placed in foster care, and of those in placement, more than one-third of these cases identified parental substance use as a factor, second only to neglect. We know anecdotally about the overlap of domestic violence, substance use, and child welfare system involvement, since more women are seeking safety in domestic violence shelters *without their children*. In addition, state statutes may take a punitive or criminal stance toward substance use-related disorders during pregnancy that has long-range consequences. Parents with an opioid use disorder whose children have been removed from the home are slower to achieve family reunification than parents who use alcohol or other drugs. Studies have shown that parents with custodial care of their children have higher rates of recovery compared with those who have lost care. Child protection statutes addressing parental substance use exist in 47 states. Check this link to find out more about statutes and policies in your state: <https://www.childwelfare.gov/topics/systemwide/laws-policies/state/>.

Impact of parental substance use on children

Based on the most recent data from the National Surveys on Drug Use and Health (covering 2009-2014)¹³, about 8.7 million, or 12.3 percent, of children in the United States aged 17 or younger were living with at least one parent within the past year who had a substance use disorder. About one in 10 children (7.5 million) lived in households with at least one parent with a past-year alcohol use disorder. About one in 35 children (2.1 million) lived in households with at least one parent who had a past-year illicit drug use disorder.

We know that maternal substance use, beginning in utero, may directly impact the infant at birth as well as their ongoing development. Pregnant women with alcohol, opioid, and other substance use disorders (when untreated) may lead to conditions such as Fetal Alcohol Syndrome and Neonatal Abstinence Syndrome. There may also be subtle effects, including irritability at



birth, difficulty soothing, and atypical neurodevelopmental impact. The infant's and developing child's neurodevelopmental differences may place additional stressors on the parent, immediately and over time, requiring support and services. Some children with parents with a substance use disorder may be relatively well adjusted, but many children are at increased risk for negative outcomes without intervention.

The impact of substance use on parenting is unique to each caregiver, family, and situation, and may vary over time. Studies show that the impact of parental substance use on children depends on a range of protective and risk factors.

13 Lipari, R.N. and Van Horn, S.L. Children living with parents who have a substance use disorder. The CBHSQ Report: August 24, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

Here are some factors to consider that increase or lessen the impact of parental substance use:

- The child's age when parental substance use is or was most problematic. Infants and younger children are more dependent on their caregivers for nurturance and consistent care.
- The strengths and coping abilities of the non-using primary caregiver or other caregiving adults in the child's extended family and community, and protective older siblings.
- The economic resources of the family and access to services and supports within the community.
- Whether child neglect or child abuse (*either physical or sexual*) is also occurring. This might include unsafe adults in and out of the home and lack of proper supervision.
- Opportunities to foster resiliency and well-being through attachment relationships.

In some instances, without protective factors that are buffering, parental substance use may lead to neglect, impaired judgment, lack of safety and consistent nurturance, and leave children at risk of victimization by others.

The cumulative effects of multiple experiences of trauma can also lead to emotional dysregulation in parents and children. Both parent and child may be fearful, and parents may lose confidence in their ability to soothe and nurture their children in the ways that they need. As advocates, we can help parents to self-soothe and self-regulate and to teach those skills to their children.

Responding to parental substance use and supporting the safety and well-being of domestic violence survivors and their children

Given the scope of the issue and recent trends discussed in the background sections, it's important to be knowledgeable about substance use in the context of your role as a domestic violence advocate or counselor. We can engage with and support survivors who use substances without ignoring or condemning them and be effective in our roles

without trying to determine whether they are living with an alcohol or substance use disorder. In turn, domestic violence advocates need to be trained, guided, and supported by organizational policies and protocols that support survivors and families with parental substance use.

Before engaging in a conversation, we can ask ourselves why domestic violence survivors might use substances. Any or all of these might be factors:

- Numbing pain, coping with an abusive partner
- History of using as part of a life pattern of childhood abuse *and* neglect
- History of trauma and mental health on well-being and impact of domestic violence
- Coping with other stressors, losses, and adversities, including racial/ethnic discrimination, oppressive systems, and lack of equity in resources
- Genetic and environmental factors related to generational, familial substance use
- Substance use coercion as part of the pattern of domestic violence.

Societal attitudes related to substance use and parenting tend to be stigmatizing and often harshly judgmental about mothers who use.

Societal stigma related to substance use may be internalized by the adult as a source of shame and may also be used by their abusive partner to threaten and intimidate the domestic violence survivor with authorities. These include threats and intimidation related to losing custody of their children by calling the authorities, such as child welfare, to report them as “unfit parents,” saying they won’t be believed, and court-related custody arrangements that seek to limit survivors’ contact with their children because of their substance use. **More information and resources about abusive partners’ tactics that are considered substance use coercion are available on NCDVTMH’s website:** <http://www.nationalcenterdvtraumamh.org/publications-products/su-coercion-reports/>

When we are able to establish a nonjudgmental, deeply respectful, and trustworthy connection with the adult survivor who is using substances and parenting, we might be able to engage in a conversation to better understand their life experiences, how they define their substance use (*benefits and effects*), and how it might

affect their overall functioning, including parenting. We might gain perspective on what may have led them to the initial and continuing use of substances, including alcohol, prescription drugs, and others. Many domestic violence survivors have also experienced substance use coercion as part of the pattern of intimate partner violence. In this way, we can be responsive and supportive to their needs and concerns, following their lead and the principle of self-determination in which domestic violence advocates are so well-versed. Understanding and trust builds over time, and we can always ask permission to revisit what we talked about in our initial conversations and check in on how they are doing and how their children are faring.



The following questions can be helpful in initiating a conversation with domestic violence survivors who use substances, always remembering to pace, pause, and follow their lead:

- When did the substance use start?
- What substance(s) are you currently using?
- How has this helped you cope with life circumstances and adversities?
- Have you experienced periods of using less, more, or not at all? What led to these variations?
- What attempts, if any, have you made to seek treatment services, and how did it go?
- What barriers to seeking care did you encounter? *(This might include having their partner sabotage their attempts at recovery by refusing transportation or not having adequate resources for childcare.)*
- Did your abusive partner ever use coercive tactics to force use beyond what you wanted?

Supporting caregiver-child relationships when substance use is a concern

Attachment relationships scaffold healthy development in children. The early attachment relationship between parent and infant or young child may be impacted when parental substance use affects bonding and emotional engagement with each other. This highlights the need for early intervention. Parent-child, family-centered, integrated treatment approaches and community supports for the adult who is using substances, and is also affected by domestic violence, can be critical to recovery. As advocates, we can also help support consistent routines and nurturing and responsive parenting. We can build on the parent's strengths, cultural beliefs and practices, and positive intentionality toward their children. When we can meet parents and families where they are and take a whole family approach to services, we can help increase both recovery and safety for all.

Parents may convey messages about what's acceptable to talk about within the home and outside of the family. Just like there may be nonverbal cues or injunctions for children to keep domestic violence “*secret*” from the outside world, parental substance use

may carry similar spoken or unspoken rules about this being a taboo subject. Both carry stigma and may also lead to consequences that the victimized parent fears regarding loss of primary custody of their children. Any perceived judgment from staff or risk of being exited from services decreases emotional safety for parents and their children, which in turn, increases the need to hide substance use, which interferes with the opportunity to access support.

Using strategies from NCDVTMH's “*Guide for Engaging and Supporting Parents Affected by Domestic Violence*” (<http://www.nationalcenterdvtraumamh.org/publications-products/guide-for-engaging-and-supporting-parents-affected-by-domestic-violence/>), we can approach sensitive conversations with caregivers about how substance use may be impacting their parenting and their children's safety and well-being. In a nonjudgmental, destigmatizing manner, we can begin to collaboratively explore potential concerns. Hopefully, we have had conversations about parents' own substance use prior to this discussion. Regardless, it's important to guard against making assumptions about how parents' substance use may be negatively impacting their children.

If the parent is not aware of any negative impact, we can tentatively share our

observations, based on contact with survivors and their children. We can say something like, “*We know that drinking or using drugs can make it more difficult to keep yourself and your children safe.*” We can then talk about safety planning, whether or not the parent is actively using drugs or alcohol, and what supports the caregiver thinks would be helpful. The goal is not to control or mandate actions that need to be followed by the survivor “*or else,*” related to our services, but to expand a lens that allows parents who use substances to take in ways to respond to these additional challenges without further inducing guilt and shame.

In addition to immediate safety concerns, we may observe that parents who use substances seem disengaged, preoccupied with drug seeking, and less connected emotionally to their children. They may also have times where they are not monitoring their children’s whereabouts (*e.g., with younger children getting into unsafe situations and with older children getting into situations that are high risk or staying away for periods of time*).

Children may carry big worries about their parents’ substance use, in a similar way to what we know about children’s reactions to domestic violence.

Children may also see the effects of their parents’ substance use and become frightened and confused by their parents’ behavior when intoxicated or “*drugged out.*” Children report being scared when they are unable to wake a parent up as they may be witnessing a parent who is overdosing. This is also true after separation, when abusive partners who use substances continue to have ongoing contact with their children through their shared parenting arrangements. If domestic violence survivors are not using substances, this often creates worry and concern about the safety and care of their children during contact with the other parent.

We can help parents and their children talk about substance use in destigmatizing ways that are simple, fact-based, and geared toward a child’s age and developmental capacities. There is a range of materials available to help facilitate these conversations, including coloring pages, picture books, and short videos. Sesame Street is featuring a new character named Karli (*see link at <https://sesamestreetincommunities.org/>*).

The National Association for Children of Addiction’s “*Start with the Heart*” pamphlet offers many resources to support age-sensitive discussions (<https://nacoa.org/resource/start-with-the-heart/>).

It is common for children to feel guilt and somehow responsible for their parents' substance use. We can provide support by helping parents address their children's feelings of guilt, shame, or responsibility.

"The Seven Cs of Addiction" is a tool from the National Association for Children of Addiction with messages for children to internalize with the support of their caregivers:

1. I didn't **cause** it.
2. I can't **control** it.
3. I can't **cure** it, but
4. I can help take **care** of myself by
5. **Communicating** my feelings,
6. Making healthy **choices**, and
7. **Celebrating** me.

The downloadable poster can be found here: <https://nacoa.org/resource/the-7cs/>

In the process, we can also help caregivers to break the secrecy that has surrounded their substance use by responding directly to their children's questions and fears. School-age children and teens may also benefit from attending group services with peers who are also coping with parental substance use.

We can also help survivors develop safety plans that encompass the parent's safety and state when using. We can begin by sharing with parents that we know survivors who use drugs or alcohol may have a harder time keeping safe, and so their children are often at increased risk. Ask: *"How can we help support you to make a plan that keeps your children safe, whether or not you're using?"* (See Section 5 on safety planning.)



Common questions about supporting families with parental substance use

Once in our services, there are some common questions that come up about how to best support parenting survivors who use substances, while also supporting the safety of their children. When we are offering residential services, we also need to consider the well-being and physical safety of other survivors and their children as well as staff. Many times, there are no clear-cut answers to these questions. Some things that can help navigate these nuanced situations include: a relational environment of trust, empathy, and collaboration; consultation with domestic violence-informed mental health and substance use specialists; collaboration with peer-based support specialists; thoughtful engagement (as opposed to reactivity); opportunities for reflective individual and team supervision and consultation; and simplified program rules that engage everyone in cultivating a safe environment.

What follows are some common questions and answers to consider for your program:

Q: How can we prevent syringes from being left in common areas where children or other survivors may find them?

A: People may need to use syringes to self-inject medication, such as insulin. Programs help prevent misplaced syringes by:

- Posting sharps containers in areas where people may commonly need to self-inject (*such as bathrooms*).
- Offering resources to support people using a new syringe each time they inject. Some people may be able to access these through insurance coverage, while others may not have insurance that covers syringes or may not be able to use their insurance due to safety concerns. Connecting people with local syringe service programs can help decrease the reuse of syringes. This supports safety for the person injecting as well as others because the person can safely dispose of the syringe immediately after use.
- Issuing personal lockboxes for safely storing items that need to be kept away from children (*such as medication and syringes*), as well as important documents and

other valuable items. Lockboxes have been found to not only increase physical safety within the environment, but also increase emotional safety and a sense of self-determination.

Q: How do we promote safety for the children of parents who use substances?

A: Cultivate a nonjudgmental, caring, and trustworthy relationship with each parent and their children. This can help minimize the felt need to hide substance use and maintain secrecy.

A: Help parents to safety plan around their substance use to minimize risk of interference with their ability to safely care for and nurture their children.

A: Help parents to identify safe social supports and encourage them in engaging their safe support network as part of safety planning for their children.

A: Help parents access children's resources, such as Head Start, summer camp, and other safe settings that support child development. These resources can provide a sense of stability for children, while also providing some respite for their parent.

A: Assist with childcare resources and respite care. These resources are often necessary for a parent to be able to begin considering what effect their substance use may have on their parenting and children (if any). If a parent finds that they need to make changes to their substance use, childcare will likely be an important recovery support resource.

A: If a crisis occurs where parents are unable to safely care for their children due to substances or any other reason, we can:

- Follow the program's trauma-informed crisis prevention and response protocol to directly address whatever safety concerns are present.
- After the crisis, it is important to provide follow-up by compassionately and collaboratively debriefing with the parent, getting their input on safety concerns and what contributed to these concerns, and collaboratively safety planning in hopes of preventing future crises.
- There may be times when we are mandated to make a report to child welfare. In these cases, it is important to take a trauma-informed approach to mandated reporting. This includes following

state guidelines and agency policies, consulting with a supervisor when reporting to Child Protective Services, whenever possible, involving the parent in the phone call or report, informing the parent of the next steps and what to expect, and offering your continuing support and advocacy for the survivor and their children as they navigate the child welfare system.

Q: How do we promote safety for other children in our program?

A: Support parents to monitor, care for, and protect their children. If a parent is concerned about their child being exposed to a survivor who appears to be intoxicated, help the parent to generate ideas and have options of how they can shield their child from the situation. At the same time, staff can also promote safety for children by being responsive to the survivor who appears intoxicated and engaging them in self-soothing activities and program areas that will support physical and emotional safety for everyone present.

A: Some domestic violence shelters where survivors share personal living space have found it helpful to consider whether a survivor is actively using substances before assigning rooms.

Making referrals and offering resources for survivors using substances

Domestic violence programs will need to prepare by becoming familiar with what resources are available in your community and cultivate relationships with community partners to find out more about what they offer, who's eligible to access the services, the process for entering services, and availability (vs. wait-list times). Some domestic violence programs have certified drug and alcohol counselors who are available to provide on-site counseling and resources within their organization. Cross-training and collaboration is invaluable in making referrals for those survivors who are interested and ready to seek supports and treatment recovery. It's helpful to know about the array of treatment and recovery support options. ***(For more information, see the table listed at the end of this section on Substance Use Disorder and Recovery Resources.)***

In building relationships with community providers in your area, it's important to find domestic violence- and trauma-informed substance use treatment and recovery support providers, and to ask about their approach and philosophy of care. Gender-

responsive care for women leads to better outcomes, higher rates of completion, and the opportunity to meet with a female-identified counselor ¹⁴. Peer support recovery services are helpful for survivors in destigmatizing shame around substance use. Research has found that women who experience emotional dysregulation had better outcomes in substance use programs that have a strong peer support component. **In sum**, a comprehensive approach helps to reduce barriers to care, is holistic, and integrates family-centered approaches to meet the needs of infants, children, and adolescents affected by parental substance use and their primary caregivers.

Once domestic violence advocates are familiar with the services landscape in our communities, then we can begin to explore options from the survivor’s perspective.

We can ask: *“What kinds of resources might be helpful for us to explore together?”* It’s also helpful to find out what their past experiences, if any, have been with accessing substance use services, such as treatment, recovery meetings, or other supports, and what those experiences were like for them.

When ready to share resources, you might say, *“I have some information on resources you may find helpful. Would it be all right if I shared those with you?”* or *“We have a resource folder with information on substance use services. Would it be helpful to review some options together?”* We can then elicit their response and find out what questions they might have and what they are thinking about in terms of next steps (*“What do you think you’ll do?”* *“How would you like to move forward?”*) without pressuring.

There are many valid reasons why parenting survivors who use substances would hesitate to talk about their substance use with staff. So, it is important that survivors can access resource information without having to tell staff that they are using substances. Some programs have found it helpful to make resource folders or pamphlets available in common areas where parents can access them. Another strategy is to post a discreet postcard on a resource bulletin board that has information for locating recovery resources. One thing to keep in mind is that information needs to be accessible, multilingual, offer an array of options, and understandable but still discreet enough so that parents don’t feel stigmatized in looking at the information.

¹⁴ For more information on gender-responsive care for women, see Stephanie Covington’s chapter titled “Helping Women Recover: Creating Gender-Responsive Treatment” in *The Handbook of Addiction Treatment for Women: Theory and Practice* (Eds. Straussner, SLA, and Brown, S; 2002).

Parents seeking treatment and recovery support services may encounter formidable barriers, including transportation, childcare, health care coverage, and financial resources.

Survivors then have the added burden of dealing with abuse and stalking that can often intensify when they attempt to access treatment and recovery services. Domestic violence advocates can proactively anticipate barriers with survivors and find out about accommodations and alternatives.

For example:

- Treatment services that offer sessions via tele-therapy when a survivor is unable to go in person due to safety concerns and/or transportation barriers.
- Services (*mutual aid, treatment, etc.*) that also offer childcare on-site.
- Treatment and recovery support services that also offer children's services that are coordinated with their parent's services.



- Treatment services that are able to offer sliding scale and/or grant-supported treatment for survivors who cannot afford copays or are unable to use their insurance due to safety concerns (*harm reduction, mutual aid groups, and recovery community organizations are free of charge*).

In conclusion, we hope this section encourages domestic violence programs to take a thoughtful and well-informed approach to serving survivors and families with parental substance use and to offer supports to help staff explore their own biases and assumptions and gain the necessary knowledge and skills to carry out their roles in a kind and compassionate way.

Section 11: Resources and Links



SAMHSA Behavioral Health Treatment Services Locator. This website features a treatment locator that can be used to find treatment resources for substance use and mental health concerns; information on locating peer-based support for mental health; and information on locating mutual aid groups for substance use disorders: <https://findtreatment.samhsa.gov/>

Faces & Voices of Recovery has a searchable directory of recovery community organizations that are affiliated with the Association of Recovery Community Organizations (ARCO): <https://facesandvoicesofrecovery.org/arco/arco-members-on-the-map/>

Information on different kinds of mutual aid recovery groups, including how to locate them in your community: <https://facesandvoicesofrecovery.org/resources/mutual-aid-resources/>

National Association for Children of Addiction has resources for families and providers that help support children who have one or more parents who experience substance use concerns: <https://nacoa.org/>

Academy of Perinatal Harm Reduction has health literacy resources for pregnant and parenting people with substance use histories as well as service providers, all through a reproductive and social justice lens: <https://www.perinatalharmreduction.org/>

Refer to NCDVTMH for recorded webinars on “*Committed to Safety for ALL Survivors*” and more on substance use and recovery.

See Tips for making referrals, offering support during the process, and expanding survivors’ access to substance use services ([link to handout](#)).

Table on Substance Use Disorder Treatment and Recovery Services with links:

Substance Use Support Resource	Description	Locating Resources*
Substance Use Disorder Treatment	<p>SUD treatment spans a continuum of care from residential treatment to outpatient-based care. Services can include counseling, withdrawal management, medication-assisted treatment, and continuity of care support. Treatment may also include comprehensive and holistic services, including recovery support services, integrated mental health care, and family-based services. Survivors and their children may particularly benefit from trauma-informed, gender responsive, multigenerational approaches.</p>	<p>SAMHSA Behavioral Health Treatment Services Locator</p>
Opioid Treatment Programs (OTPs)	<p>OTPs are dedicated to the treatment of opioid use disorders through interdisciplinary teams of counseling and medical professionals integrating medication-assisted treatment with behavioral health care. Methadone (<i>a highly evidence-based medication used in the treatment of opioid use disorders</i>) is only available through OTPs. OTPs may also offer mental health and care coordination services.</p>	<p>SAMHSA Opioid Treatment Program Directory</p>
Medication-Assisted Treatment (MAT)	<p>MAT uses medications under the supervision of a physician to treat Substance Use Disorders, often in combination with behavioral health support. There are currently FDA-approved medications to assist in the treatment of opioid use disorder, alcohol use disorder, nicotine use disorder, as well as medications used during withdrawal management services and to respond to overdose. MAT for opioid use during pregnancy improves healthy outcomes for the birthing person and their baby. While methadone is only available through OTPs, buprenorphine and other medications may be integrated into primary or obstetrics care, as well as more generally available through SUD treatment programs.</p>	<p>SAMHSA Buprenorphine Practitioner Locator</p>
Recovery Residences	<p>Recovery residences offer a structured substance-free living environment. They are typically designed for individuals, although there are some programs designed for mothers and their children.</p>	<p>National Alliance for Recovery Residences</p>

Substance Use Support Resource	Description	Locating Resources*
<p>Recovery Community Organizations (RCOs)</p>	<p>RCOs provide recovery support services, which may include vocational support, housing navigation, life skills support, resource advocacy, mutual aid groups, and harm reduction resources, often provided by a person in long-term recovery.</p>	<p><u>Faces & Voices of Recovery: Association of Recovery Community Organizations</u></p>
<p>Mutual Aid Community Recovery Support Groups</p>	<p>Mutual aid groups, such as Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, and Women for Sobriety, are free community-based groups that are typically facilitated by a member of that group's tradition who is also in recovery. The goal of these groups is to provide accessible peer-based support for people who share the goal of recovery. There is a range of traditions and styles, some of which are faith-based or gender-specific. Some groups offer free childcare for those attending.</p>	<p><u>Faces & Voices of Recovery: Mutual Aid Resources</u></p>
<p>Harm Reduction Organizations</p>	<p>Harm reduction organizations provide evidence-based information, support, and resources to promote the health of people who use substances and are accessible regardless of whether someone is seeking to change anything about their substance use. These stigma-free services often include overdose prevention services, peer-based support, access to health promotion materials including vaccinations and condoms, as well as new and sterile syringes, safe disposal of used syringes, and referrals for other recovery support resources (<i>including treatment, when desired</i>). Some provide additional health services, such as testing for HIV and hepatitis C, support with enrolling in health coverage, and medical care.</p>	<p><u>National Harm Reduction Coalition Directory</u></p>
<p>Overdose Prevention</p>	<p>Overdose prevention services include overdose prevention education, substance use safety planning, and knowing how to use and access naloxone (<i>Narcan</i>) in response to potential opioid overdoses.</p>	<p><u>National Harm Reduction Coalition Directory</u></p>

*Please note that these resource directories are national and may not list every resource found in your community. It may also be helpful to consult with your local public health agency as well as seek additional information through the internet and colleagues.



Critical Conversations

Helpful hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing inclusive and compassionate policies within your program.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

Engage in self-guided exercises and team-based conversations to explore staff perceptions and biases related to adults with substance use-related needs and the impact of parental substance use on their children's safety and well-being. Here are some potential questions for self-reflection and sharing:

- What are my views on alcohol use? Cannabis use? Other substances?
- Are there certain substances that I believe can be used more responsibly? How do I define responsible vs. problematic substance use?
- How do I feel when I see someone who appears intoxicated on alcohol or another substance?
- How are my perspectives and feelings informed by:
 - Experiences during my childhood and adolescence?
 - Growing up in my family?
 - My culture and social identities? (*i.e., gender identity, race, ethnicity, religion, sexual orientation, religion, etc.*)
 - My experiences as a survivor? (*if applicable*)
 - How have these perspectives and feelings changed over time?

Critical Conversations



What can a direct service staff person do?

- Become familiar with the resources in your community that serve adult survivors and families affected by substance use.
- Reflect on your own strengths and biases in working with parental substance use and seek reflective supervision and consultation.

What can a supervisor do?

- Review NCDVTMH's "*Committed to Safety for ALL Survivors*," a guide for supporting adult survivors who use substances in domestic violence settings (<http://www.nationalcenterdvtraumamh.org/publications-products/committed-to-safety/>), and reflect on what new policies and procedures you might want to put into place, what to keep, and what to stop doing. Get input at all levels within your organization.
- Introduce the guide in team-based meetings to further understanding and skills and to examine attitudes. You might begin by reviewing the section on "*Meeting People Where They Are*" pp. 26-29. This introduces the framework created by Prochaska and DiClemente on "*Stages of Change*," beginning with pre-contemplation, and has information on how domestic violence advocates can help support survivors who use substances at each stage.



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Sabrina is a 24-year-old woman who recently entered the shelter program with her 3-year-old daughter. She smokes methamphetamine one to two times per day on most days. She typically begins using in the morning and sometimes uses again during her daughter's nap. Sabrina tends to only eat at night as she starts to experience withdrawal from methamphetamine. Sabrina is an attentive parent, but she sometimes struggles to get up in the morning if she had trouble falling asleep the previous night. Sometimes Sabrina uses another substance to help her with falling asleep at night, which largely depends on what she can find. She has used alcohol, heroin, opioid pills, anti-anxiety pills, and cannabis in the past to try to fall asleep. Sabrina expresses that it's harder to fall asleep when she feels itchy or when she feels like she needs to stay awake to protect herself and her daughter.



Things to consider:

- Substance use is widely stigmatized in our society, and this stigma is often used against survivors by unsafe partners in a pattern of abuse known as substance use coercion. There is also increased stigma against women and caregivers who use substances.
- Sabrina's substance use may be related to her experiences of abuse and trauma. It is very likely that she has been emotionally abused based on her substance use and that any judgment, shame, or attempts to control her substance use from staff will replicate the abuse she's already experienced.
- Substance Use Disorder treatment can be difficult to access for many reasons, including treatment sabotage by an unsafe partner. Caregivers experience unique barriers to treatment and recovery services, including lack of childcare and family-based services, as well as fear of negative interactions with the child welfare system.
- Sabrina seems focused on protecting her daughter and is actively working to increase their safety (*she came to the shelter program, uses when her daughter is napping, and stays awake to protect herself and her daughter*).
- It seems like Sabrina is actively working to improve her ability to sleep so she can be more present for her daughter in the morning. She is actively considering what makes it harder to sleep and is trying to find ways to address the problem.
- What was her sleep like before coming to the shelter program? What else has she tried to improve her sleep and what's helped?
- What was her substance use like before coming to the shelter program? Does she notice any changes in what she uses, how she uses, or how the use impacts her?
- How is Sabrina's daughter doing? How is their relationship?



What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff? How can staff work together to counter stigma and build an empathy bridge?
- Focus and build on individual, parenting, and family strengths. Affirm Sabrina for caring for and protecting her daughter. Affirm and support their connection.
- Offer support and resources to help build their sense of emotional and physical safety.
- Focus on what Sabrina is defining as her needs and goals; support her informed decision-making and access to resources.
- Offer support with safety planning around her substance use, including strategies to maintain child safety as well as access to safer use resources (*if desired*).
- Affirm Sabrina for her insights and attempts to improve her sleep. Without judgment or shame, offer to talk about Sabrina's experience.
- Empathize. Getting up in the morning with toddlers is hard, even with a full night's sleep!
- Build on what's working: When is it easier to sleep? When does she feel more rested? What's different on the days she uses once (*vs. twice*)?



- What could help with the itchiness? Some ideas could include: a comforting lotion, a soothing bath, and other kinds of self-soothing like herbal tea or mind-body practices. It could also be helpful to keep nails short and hands washed to avoid skin infections.
- Support overall self-care and access to resources that support self-care. Eating, drinking water, and adequate sleep help prevent and reduce anxiety and other unwanted effects that can be associated with methamphetamine use. What are Sabrina's comfort foods? What feels easier to eat in the morning? Protein bars, yogurt, and bananas may be especially helpful in the context of methamphetamine use.



12. Activities for Families (Individual and Family Activities)

In this section, we talk about the value of parent-child focused and family-centered activities. We suggest an array of activities that domestic violence advocates and counselors can introduce to caregivers and their children, and that domestic violence advocates can use to engage with children and youth individually. We provide guidance on offering activities for caregivers and their children that match children's age and developmental capacities from birth through the teenage years. Activities are grouped broadly by age and developmental stage:

- Birth to 3 years old
- 4 to 8 years old
- 9 to 12 years old
- 13 years and older

In addition, we discuss best practices for engaging in family-centered activities and measures to support caregivers to be with their children in ways that strengthen the parent-child relationship, scaffold their children's ongoing development, and promote healing from the traumatic effects of domestic violence. This is followed by critical conversations for team-based discussion and what direct service staff and supervisors can do to promote more developmentally sensitive, family-centered services.

Value of developmentally sensitive, culturally responsive, family-centered activities

Parent-child focused and family-centered activities can support bonding and the healing process for domestic violence survivors and their children. Creative arts and movement activities can provide families with an opportunity to engage with each other in a variety of ways with support from advocates and counselors. Being together, playing, and sharing activities with one another can build connection, bring joy, and help repair relationship ruptures. Activities that are attuned to the ages and developmental capacities of children and teens not only build connections between caregivers and their children but can also lead to having novel and enriching experiences, mastering new skills, and gaining greater self-confidence—all of which help to scaffold children's ongoing development.

Offering culturally responsive activities that honor and are inclusive of families' favorite foods, rituals, practices, and cultural or religious traditions help to increase a sense of belonging and healing within a supportive community. Domestic violence agencies can

also partner with community members to teach and offer traditional practices that are culturally specific. For example, an Indigenous community in the United States may have elders who do beadwork and make pottery in a traditional way, which can be passed on to the next generations. Some families may want to connect with traditional healers and utilize traditional healing practices from their communities. Based on caregivers' preferences, beliefs about healing, and cultural traditions, we can support domestic violence survivors to contact community healers, *curanderas* or *curanderos*, elders, spiritual guides, or others.

The first step in working with children, teens, and their caregivers begins with building connection. They may benefit from individual, group, and family-centered experiences and sessions. (*See Section 9 on supporting parents and caregivers for guidance on sequencing services.*) Consider that children may also benefit from sessions focused on strengthening sibling relationships. Families are more likely to share and participate in services when we build connection and trust in our relationships with caregivers and their children. We can offer structured opportunities for interaction, while also exploring choices about what activities they are interested in doing together, as we get to know each other. Encourage and support

families to understand that discussing their experiences of domestic violence with each other can be a significant part of healing and moving forward in their growth. When families are not ready or reluctant to talk about what happened, they will still benefit from experiential healing and growth activities. Continuing to support children, teens, and caregivers in understanding their trauma reactions and in strengthening coping skills can be empowering and is often an ongoing process. Assisting families to be focused on their future can support and build upon their strengths and resilience.

Engaging in caregiver-child and family-centered activities

In getting ready to introduce parent-child focused and family-centered activities, our relationships with caregivers are key.

We view parents as partners who can engage in and support the meaningful use of family-centered activities with their children.

We may want to support survivors in remembering their own childhood experiences of feeling loved, cared for, and special as a way of bringing these feelings and experiences into

their relationships with their own children ([see link to handout for helping caregivers access positive caregiving memories](#)). Our role as domestic violence advocates and clinicians is to provide a safe environment to introduce, try out, and adapt various activities with the goals we just reviewed in this section.

It's helpful to hold four strands as we proceed:

First: Understand the role of attachment relationships between caregivers and their children and how these may be altered or disrupted by domestic violence and other traumatic experiences and adversities. Our goal is to strengthen the bond between caregivers and their children. Clinicians in domestic violence settings who are providing treatment services may also address vulnerabilities to responsive caregiving. Services can strengthen attachment and bonding and support a process of making repairs to ruptures that may have occurred within the parent-child relationship as a result of experiencing domestic violence. (*See Section 7 for trauma-informed, family-centered treatment interventions.*)

Second: Use a developmentally sensitive approach that considers not only the child's age but also how their overall development is unfolding. (*Are they developing typically or are there areas of delay or difference?*) We can use

our own observations and discussions with caregivers to determine what activities we select and what adaptations might be helpful.

Third: Introduce activities that are culturally inclusive, honoring caregivers' parenting beliefs and practices. For example, families may have different levels of acculturation between generations to the dominant culture in the United States. As domestic violence advocates, we can be supportive by understanding these beliefs, naming differences and tensions that may exist between generations, and encouraging communication about play and other family activities. When caregivers can engage in collaborative exploration with us, we can talk about what the value of these activities might be in reaching their goals for their children, themselves, and their families.

Fourth: Hold an awareness of how trauma responses may affect caregivers' and their children's capacities to engage in activities at any given point in time. When we experience trauma-related responses, our nervous system becomes dysregulated. Our autonomic nervous system takes over our brain and body as an instinctual response to keep ourselves safe and protected. When that happens, we automatically go into a "*fight or flight*" mode, or hyperarousal zone, OR we may "*freeze*," dissociate, or go into a state of hypoarousal or inactivity. In those states, we have a hard

time being present, concentrating on the task at hand, thinking and feeling at the same time, being reflective and empathic, staying connected with each other in the moment, and, in this context, engaging in activities together. When we are feeling safe, aware of the present moment, able to think and feel at the same time, experience empathy, and are open and curious, we are in an optimal arousal zone. Dr. Daniel Siegel, a professor of psychiatry at UCLA, coined the phrase "*window of tolerance*" to describe this state. This understanding applies to all of us and can be useful in becoming aware of the stress response system and trauma-related responses—our own and what may be happening with caregivers and their children. When we support families to engage in activities, we can recognize when they may become hyper- or hypoaroused and find ways to open the "*window of tolerance*" to come back into connection with each other and to regain a sense of felt safety. (Refer to the team-based activity on the Window of Tolerance toward the end of this section for how to apply this in your work; for more information and a helpful diagram on "*Living Within Your Window of Tolerance*" link to <https://laurakerr.com/wot-guide/>

In thinking about what happens to our nervous system when we experience distress or have trauma-related responses, it's easy to understand how caregivers may become dysregulated and how that might impact their parenting. In a hyperarousal state, they may yell, become hypervigilant, tense, irritable, and feel overwhelmed and generally reactive. In a hypoarousal state, caregivers may withdraw, feel numb, become disconnected from their children, or have trouble actively setting limits and saying "no." In either of those states, caregivers are unable to act as co-regulators for their children, who may be experiencing their own distress in the moment. Supporting caregivers to self-regulate and offering ways to calm and reset the nervous system helps expand their own capacities to reflect and offer co-regulation to their children. In this next section, many of the activities, especially with infants and younger children, involve the caregiver as a co-regulator to help soothe and calm upset and anxieties.





Activities for Supporting Caregivers, Children, and Families

This section includes a wide range of activities for use in working with families. Advocates may initiate planned activities for the family time together but be open to how they unfold. Allow yourself to really listen to their responses and be flexible about modifying and changing plans as needed. Activities are strengths-based and support building resilience and healing capacity in families.

Activities are grouped broadly by age and developmental stage and divided into three broad categories:

- Co-regulating and soothing activities
- Moving and playing together
- Creative and expressive arts

The activities are presented with clear directions, and some are linked within this section to handouts listing any supplies or materials that may be needed.

Intended audience and inclusion of more than one child in the family: The activities that follow describe ways to engage **primary caregivers and their children**. You may adapt some of these parent-child focused activities to include more than one child in the family, depending on ages and developmental capacities. It's also helpful to consider differences in relationships between parents and children within the family. For example, a parent may have a strong connection with their 8-year-old and have struggles in relating to their 4-year-old, who is identified as the “*problem child*” in the family. Advocates can encourage caregivers to attend to their relationship with a particular child or children by engaging in meaningful parent-child activities to address conflict and other vulnerabilities and to build connection.

On co-regulating activities:

As children develop, they are less reliant on their caregivers for co-regulation when feeling overwhelmed, distressed, or coping with trauma-related responses. By age 5 or 6, children begin to have their own capacity to self-soothe and self-regulate when upset. They will still need support from adult caregivers when feeling very distressed or overwhelmed. Sometimes children who have experienced ongoing trauma may need extra support in developing their own capacity for self-regulation. In the upper age ranges listed, the self-regulating activities, such as yoga and meditation, can be done together as a family.

In addition to the activities that follow, there are many therapeutic books and workbooks that provide guidance on various ways of promoting the attachment relationship, strengthening communication, and promoting healing and resilience within the family. One example is *Favorite Therapeutic Activities for Children, Adolescents, and Families: Practitioners Share Their Most Effective Interventions*, edited by Liana Lowenstein, which can be found here: <https://lianalowenstein.com/e-booklet.pdf>



Birth to 3 Years Old

When working with infants, toddlers, and their caregivers the focus is primarily on bonding and connecting.

At this developmental stage, babies and young children are dependent on their primary caregivers and rely on them to feel safe and consistently nurtured. Very young children

need a secure attachment relationship to feel loved, safe, and protected. Separations can be difficult at this age. Games such as “peek-a-boo” with babies and simple “hide and seek” with toddlers who are mobile are both enjoyable and reassuring as the caregiver is briefly separated visually and then reunited with the “found” child.

The attachment relationship between child and caregiver may have been disrupted by experiences of violence in the caregiving environment. Babies and young children may be easily overwhelmed and become dysregulated by loud noises, fighting, and an atmosphere of fear and tension in the home. These activities are designed to strengthen the attachment relationship and to bring pleasure that supports bonding between parent and child. The activities create shared experiences that are enriching, and support caregivers to be co-regulators for their children when they are upset or distressed.

Co-regulating and Soothing Activities:



1. Infant massage

Caregiver can use gentle lotion or oil in warm space to gently rub infant's arms and hands, legs and feet, belly and back, and face and head. Advocates can support caregiver in validating their response to baby's cues. ([Link to handout for basic directions](#)). This activity creates an opportunity for caregiver and baby to bond and connect.

2. Baby burrito

Caregiver can swaddle baby or toddler in blanket, keeping face out but arms and legs tucked in. If infant/toddler finds this calming for a short time, caregiver can gently rock and talk softly with infant/toddler and then unwrap the baby burrito ([Link to handout for simple instructions](#)).

3. Pet the teddy bear

Caregiver can use soft stuffed toys and model gently "petting" the soft toy and using language to convey gentle touch. Caregiver can encourage baby or toddler to use their hand and gently "pet" the stuffed toy. Caregiver can say "soft" or "gentle" and use words to describe what they are doing. This activity offers an opportunity for caregivers to model gentle and soothing behaviors for baby or toddler.

Moving and Playing Together:



1. Roll the ball

Caregiver and baby or toddler can sit on the ground, or lay on stomach facing each other, and roll a ball back and forth between them. This activity can be modified by closing the distance between caregiver and baby or toddler to make it easier, as extending the distance can make this activity more difficult. This activity offers a simple way to engage in play and connection.

2. Blowing Bubbles

Using watered down dish soap or purchased “*bubbles*” caregiver and baby or toddler can take turns blowing bubbles, chasing bubbles, and popping bubbles. This activity offers a simple way to engage in play and move together.

3. Pots and Pans “Music”

Caregiver can place a kitchen pot or metal bowl and wooden spoon on the floor between them and the toddler. Caregiver can model using spoon and pot as a drum and encourage the toddler to try it out and use spoon and pot to make music. Caregiver and child can sing together. Encourage caregiver to introduce simple songs (*A, B, C, or Twinkle-Twinkle*) or follow the child’s lead with made up songs. This activity offers an opportunity to connect, play, and make some noise together through drumming and singing.

Creative and Expressive Arts:



1. Paint with water

Caregiver and baby or toddler can use paint brushes and a cup of water outside to “*paint*”. If a paint brush is not available, fingers dipped in the water will also work. Caregiver and baby or toddler can use water “*paint*” on whatever objects will dry easily – rocks, walls, cement, tree trunks, etc. This easy activity offers an opportunity for caregiver and toddler or baby to “*paint*” together and express themselves through art.

2. Coloring and drawing together

Caregiver and baby or toddler can use paper on the ground with large crayons or markers to create pictures together. Option to have colored chalk to color outside on cement or sidewalk. Caregiver can be encouraged to draw and color with the baby or toddler, creating art together. This activity offers an opportunity for caregiver and baby or toddler to engage and be creative together.

3. Treasure search

Caregiver and toddler can take a walk together and search outside on the ground for “*special*” rocks and leaves. Caregiver can be encouraged to follow the toddler’s lead in finding “*treasures*”. These “*treasures*” can be placed on the ground to create a temporary design or glued to paper for a permanent design. ([Link to handout for simple instructions](#)). This activity offers an opportunity for caregiver and baby or toddler to engage in an “*adventure*” together.



4 to 8 years old

When working with children and their caregivers, the focus is often on expanding children's repertoire of ways to manage strong feelings, including trauma responses and controlling their own impulses.

Caregiver-child focused activities at this age can strengthen children's ability to tolerate rules and limits within the safety of the attachment relationship, as they move into the broader world of other children, school, and adults outside of the immediate and extended family. During this developmental stage, children begin to master new skills, such as riding a bicycle, and become more confident and competent in many ways. Children need acknowledgment, encouragement, and support by their primary caregivers to feel seen, loved and understood. The Circle of Security[®] can be applied here as caregivers delight in their children's going out to explore and achieve "*on the top of the circle*" and then coming back "*on the bottom of the circle*" for reassurance and help with organizing strong feelings and impulses. Children may also need to hear that they are not to blame for the violence they experienced in their caregiving environment. Caregivers who have experienced domestic violence and other trauma may have difficulty with beginning to "*let go,*" and children may have trouble concentrating in school and being separated from their caregivers. Domestic violence advocates and clinicians can help families to name, work through, and support these sensitivities.

Co-regulating and Soothing Activities:



1. Relaxation activities

Caregiver and child can practice relaxation skills together, like deep breathing. Visual cues can help children remember skills. The body relaxation activity ([link to handout on Body Relaxation Script](#)) is a type of progressive muscle relaxation activity that invites children to tense and relax various parts of their body. For example, this includes “squeeze the lemon,” where children are invited to make fists with their hands, squeezing out the juice of the lemon, and then releasing the tension in their hands. This activity offers opportunities for caregivers and children to practice skills together to manage big feelings and times of dysregulation.

2. Guided imagery

This can be a way to support caregivers and children in relaxing and focusing on themselves. Caregiver and child can be supported by imagining a safe space they can visualize in their minds. Advocates can ask caregiver and child to “*imagine a safe and happy place*” and ask questions to help them visualize the place in order to return to it mentally. ([Link to handout for simple instructions, including a script.](#)) This activity offers a creative activity for caregivers and children to practice finding calm and soothing spaces.

3. Storytelling

Caregiver and child can read a book together or share stories together of what happened during their day or create “*make-believe*” stories with calming themes. Advocates can co-create stories with the caregiver and child, and make the family or the child the “*star*” of the story. Caregivers can expand on this story with their child. Caregivers may also want to create opportunities to share quiet times with their child during the day and evenings, especially prior to bedtime. Storytelling offers a way to help caregivers to be close with children.

Moving and Playing Together:



1. “Shake It Out”

Caregiver and child can dance around each other, shake arms and legs, and be silly to get out excess energy before settling into a quieter activity together. Caregivers and children may need to move and release pent-up feelings prior to sharing in other activities. Advocates can invite caregiver and child to move together. Advocates can “*shake it out*” with the family and demonstrate different physical movements like swinging arms, moving hands, shaking legs and feet, and dancing to increase the family’s participation. This is a practical way to support movement and play and “*get the wiggles out*” in an intentional way.

2. Follow-the-leader:

The caregiver and child take turns leading and following each other. This works well as both an inside and outside activity. Advocates can demonstrate small motions, facial expressions, slight gestures with hands and arms or larger movements involving the whole body, skipping, walking toe to heel, “*crab-walking*,” crawling, twirling, and walking backward. Advocates can invite caregiver and child to follow them first and then encourage caregiver and child to take on the leadership role. This activity gives families an opportunity to play and children to gain confidence in leading activities.

3. Wishes and fears:

Caregiver and child can create a visual picture of their wishes and fears for their family ([link to handout for simple instructions](#)). Advocates can direct the caregiver and child to draw a house and write down their hopes and wishes on the paper on the inside of the house. This can also be used to help clarify the family’s goals. The caregiver and child can then write down their fears on the paper on the outside of the house. This drawing can be decorated and hung up as a visual reminder. This activity can support caregivers and children in focusing on their hopes and wishes for their future together, including some of their goals.

Creative and Expressive Arts:



1. Nature walks

Caregiver, child, and advocate can take a walk outside in a park, through an arroyo, or any open safe space available to them. Advocate and caregiver can stay curious with child's exploration and follow child's lead. Search for leaves, sticks, rocks, feathers, flowers, and birds to notice and leave where they are found or for inanimate objects, consider possible use for creative arts projects. *(See magic wand activity below.)*

2. Handmade stress balls

Advocates can help caregivers and children make their own stress ball using uninflated balloons and cornstarch or flour. See following link for video: https://www.youtube.com/watch?v=gHOp22_Sjqg

Or use this link for written directions: <https://www.thesprucecrafts.com/how-to-make-a-stress-ball-1244219>

3. Magic wand

Create a magic wand out of found objects or supplies like a stick or cardboard from a used paper towel roll, add string, paint, stickers, feathers, etc. The child and caregiver can imagine if they had a magic wand what and how they might use it for their family *(link to handout for simple instructions)*. This activity offers a way for caregivers to support the child's creativity and invite an honest discussion between caregivers and children about their hopes and wishes for their family.



9 to 12 years old

When working with children, preteens, and their caregivers in this age group, the focus is on continuing to master skills related to self-soothing and self-regulation and consolidating a sense of belonging within their family, culture, and broader community.

At this developmental stage, children are developing a greater sense of competency through their achievements at school and with outside activities and interests, while building stronger friendships and negotiating conflicts with peers. Children may be more vulnerable to bullying and may feel isolated from peers and family.

Experiencing domestic violence may also be derailing of some aspects of children's ongoing healthy development. Domestic violence advocates and clinicians can support caregivers and children to communicate about "*what's happening*," to understand the impact of domestic violence and what happened "*in the past*," and to recognize positive changes within the caregiver-child and family relationships as the situation stabilizes and family members are safer. Engage the family in activities that encourage reflection, coping strategies, and self-expression—either directly or using creative and expressive arts.

Co-regulating and Soothing Activities:



1. Mindfulness and relaxation cards

The caregiver and child can draw out and create their own “*mindful cards*” that they can use together for relaxation. The advocate can provide drawing materials (*paper and pens*) for card creation. These can be basic pictures or elaborately designed cards that remind the caregiver and child to breathe deeply or visualize calm. The advocate can print out cards for caregiver and child to use together: <https://fit.sanfordhealth.org/resources/mindful-moments-printable>. This activity provides a creative way for families to practice mindfulness together.

2. Fingerholds

The caregiver and child can practice using this technique of fingerholds to calm and relieve distress when strong feelings arise. This technique can also be used with older children and teens. <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/01/Fingerhold-Practice-for-Managing-Emotions-Stress-Final.pdf>

3. Emotional umbrella

The caregiver and child can be directed to imagine they are under an umbrella and that the raindrops falling on the umbrella are other people’s emotions. The caregiver and child can discuss which emotions they want the umbrella to protect them from and which emotions feel OK to get them “wet” ([link to handout for simple instructions](#)). This activity can be a way to increase capacity to understand and manage difficult emotions and visualize “*protection*.”

Moving and Playing Together:



1. Cooperative games

The advocate can have games like Jenga or Kerplunk available for the caregiver and child to play. The focus is on “winning” as a team and not individual competition. Jenga can be used with multigenerational families or multiple children. Jenga blocks can also have questions or prompts taped or written on the sides of each block to encourage dialogue between caregivers and children.

2. Scavenger hunt

The advocate can invite caregiver and child to search for specific items that might be found in a room, outside location, or other space. Items might include the following: something “soft,” something “squishy,” something “solid,” something made of cotton, something made of metal, something they can write with, something green or other colors ([link to handout for simple instructions](#)). Advocates can be creative and encourage the caregiver to also suggest items for the child to search for.

3. Simon Says

The advocate, caregiver, and child take turns leading and following during this activity. This works well as both an inside and outside activity. Advocates can demonstrate the game. The advocate, caregiver, and child face each other. Advocate gives directions, and the caregiver and child follow the directions. Play continues only as long as the advocate says, “Simon says.” If the advocate gives a direction without saying “Simon says” and the caregiver or the child follow that direction, then they are either “out” or they become “Simon.” Advocate can be Simon first and then encourage caregiver and child to take on the Simon role. This activity gives families an opportunity to play while listening carefully. Children can gain confidence in leading activities with their caregiver.

Creative and Expressive Arts:



1. Family hands poster

The caregiver and child can work collaboratively with each family member, tracing their hands on a large piece of paper or poster board and writing or drawing pictures on each hand of what that family member “brings” to their family and what their strengths are. The empty space on the paper surrounding each of the family members’ handprints can also be decorated with words or pictures of who the family is as a unit and what their family strength is. This activity needs paper, pens, markers, or crayons. This creative activity helps caregivers and children identify and share individual and collective strengths.

2. Family strengths collage

Caregiver and child can work collaboratively to create a family collage that represents the family or shows the family’s strengths. Each family member can make contributions to the collage through drawings, pictures, words, poems, written sections, or pictures cut out from magazines. The materials needed for this activity are paper, pens, markers, crayons, scissors, glue, and magazines. This activity supports family connection and expression of how the family sees themselves as a unit.

3. Family wheel of wellness

(modified and based on Myers and Sweeney’s Wheel of Wellness, 2008) can help families identify their new family unit as whole following a disruption due to violence and separation. The caregiver and children draw a circle together and identify different important aspects of their family life (*physical, emotional, work, school, play, community, relatives, etc.*). The family can visualize parts of their life that have been impacted by the violence, and also visualize the wholeness of life moving forward. This activity creates opportunities for the family to discuss the violence and its impact on their life.



13 years and older

When working with teens and their caregivers the focus is on communication, consolidating identity, perspective-taking and empathy, and separation from family without premature emancipation or being “stuck” in the child role developmentally.

There may be a history of anger, enmeshment, role reversals, or more toxic forms of communication between caregivers and their teenage children. In many instances, domestic violence advocates and clinicians may help support communication by first working separately with the caregiver and the teen, and then facilitating opportunities for structured dialogue where each can listen to the other to build more empathy and understanding.

Caregivers may also be going through their own process of healing and recovery and can use facilitated support in hearing how this has been for their children while they may not have been as nurturing and attentive as they would have hoped to be. This can be a way of acknowledging feelings, pain and growth, and hopes for the future.

Co-regulating and Soothing Activities:



1. Body scan relaxation activity:

The caregiver and teen can be invited to practice relaxation skills together by using breathing to manage stress or anxiety. Advocates can invite the caregiver and teen to scan their bodies and identify the parts of their body that might be holding tension or stress. Advocates can invite caregiver and teen to inhale deeply through their nose and imagine the breath going through their body to the place they identified as holding tension, stress, or anxiety. Caregiver and teen can then visualize the tension leaving their body as they exhale. Repeat this three times, breathing slowly. This activity offers opportunities for caregivers and teens to practice skills together and have a useful tool during times of overwhelming stress.

2. Progressive muscle relaxation:

Caregiver and teen can be invited to practice relaxation skills together by using progressive muscle relaxation breathing to enhance a sense of calm. Advocates can invite the caregiver and teen to sit in a comfortable position and tighten and relax muscles in all parts of their bodies. Advocates can start at the top of the head, directing caregiver and teen to tighten their foreheads and then relax their foreheads, then squeeze their eyes and relax their eyes, tighten their jaw and mouth, and then relax their jaw and mouth, tighten and squeeze their shoulders and then relax their shoulders, and so on through their arms, hands, fingers, stomach, thighs, calves, feet, and toes. Caregiver and teen can discuss afterward the difference between the muscles being tightened and released. This activity offers opportunities for caregivers and teens to practice relaxation skills together.



3. Finger labyrinth breathing:

Advocates can invite the caregiver and teen to draw a labyrinth together. They can each draw their own or draw one together. This labyrinth can be used as a visual prop for breathing together. Caregiver and teen can use their finger to slowly trace the labyrinth while breathing deeply. Free printable labyrinths are available here:

<https://www.teacherspayteachers.com/Product/Printable-Finger-Labyrinth-Set-1-FREE-PRINTABLE-2125305>

Moving and Playing Together:



1. Role reversal

Caregivers and teens can take on the roles of “*playing*” each other to enhance communication skills and conflict-resolution skills. Advocates can ask the caregiver and teen to engage in a conversation with the caregiver being the teen and the teen being the caregiver. Maybe there is an issue that has been difficult to address and both the caregiver and teen are expressing a need for resolution. A role reversal activity can take some practice for all those involved. The caregiver and teen should be encouraged to really see the situation from the perspective of the other person and try to have an honest and genuine dialogue of the challenging situation. This activity is intended to enhance empathy for each other and deeper understanding of the other’s perspective and view of situation.

2. Feelings charades

Caregivers and teens “*act out*” feelings and emotions while taking turns guessing what the other is acting out. Advocates can participate and start the charades with an easy or subtle example and then rotate acting out emotions between the caregiver and teen. This activity can help bring greater awareness to both the caregiver and teen about how different emotions are expressed and potential for misinterpreting feelings.

3. Personal ads

The caregiver and teen can create personal ads about themselves ([link to *handout for simple instructions*](#)). This activity can help the caregiver and teen focus on positive aspects of themselves and share those with each other.

Creative and Expressive Arts:



1. Masks

Advocates can invite the caregiver and teen to create and decorate masks of themselves. Advocates can encourage caregiver and teen to decorate the masks to represent or show what is hidden on the inside of the mask and what is seen by others on the outside of the mask. Masks can be as elaborate as time allows. Paper plates with holes for eyes cut out can be a quick option, or papier-mâché can be used for a project over a few days. Directions for papier-mâché masks: <https://www.thesprucecrafts.com/how-to-paper-mache-mask-1106527>.

Advocates can encourage the caregiver and teen to share with each other parts of themselves that they “show” to others and part of themselves that they keep more private and hidden.

2. Family values tree

This activity engages caregivers and teens in identifying their unique values ([link to handout for simple instructions](#)). Advocates can discuss with the caregiver and teen how recognition of values within a family is integral to the development of healthy families. This activity is an opportunity for the caregiver and teen to reflect on their family values and discuss any changes in their values they have identified as they integrate and move on from their traumatic experiences related to domestic violence.

3. Poetry and music

Advocates can invite the caregiver and teen to share their favorite music or poems. These can be poems or songs they have written or those authored by others. The caregiver and teen can be encouraged to play a favorite song or read a favorite poem and discuss the reason it is significant. This activity can be an opportunity for caregiver and teen to connect through meaningful sharing.



Activities for Advocates Supporting Children and Teens

This section includes activities for advocates to use with children and teens when caregivers are not present. Similar to working with families, the first step in working with children and teens begins with building a connection and relationship of trust. Children and teens may be hesitant to disclose previously guarded family secrets. Once a safe space is created and “felt” by children and teens, it can be vital to their healing for them to talk about traumatic experiences and discuss the impact on themselves and their current relationships. Even if children and teens choose not to engage in dialogue about their traumatic experiences, they will still benefit from experiential healing activities.

Supporting children and teens in understanding their trauma reactions and enhancing coping skills can be empowering and is an ongoing process.

Assisting children and teens to be focused on their future can support their resilience. Children and teens also benefit from group experiences where they can be invited to share with others and listen to others' experiences of abuse. Children, teens, and caregivers may also benefit from individual sessions, and children also benefit from sessions focused on sibling relationships.



This next section includes a wide range of activities for use with children and teens. It is important for children and teens to have choices and exercise some control over selecting preferred activities. Instead of having a planned activity that “*must*” occur, advocates can try following the child’s or teen’s interests. Advocates might bring up planned activities for a group or individual time together but remain open to children’s and teen’s reactions and really listen to their responses. Some of the following activities are strengths-based and supportive to building resilience and healing capacity in children and teens; others involve some skill building; and some are fun and distracting. Activities include suggested age levels, and most don’t require supplies or preparation. The activity descriptions below will specify if materials are needed.



Birth to 3 Years Old

When working with infants and toddlers, it is important to first assess and meet their immediate needs and then work to connect with them, as they may be upset and dysregulated due to separation from their caregiver. Babies and toddlers can often be distracted by simple activities.

Co-regulating and Soothing Activities:



1. Rocking Chair

If the organization has a rocking chair or glider, the advocate can hold the baby or toddler on their lap or over their shoulder, rocking gently. If a rocking chair is not available, the advocate can gently “rock” their body back and forth while sitting on the floor with baby or gently sway while standing and holding baby. The advocate can pay attention to cues from infant or toddler to check in and see if the child finds this activity calming. If so, continue for a short time, and the advocate might talk softly or hum or sing to the infant or toddler. This activity may help calm some babies and young toddlers.

2. Reading Books

Advocates can use board books or any type of picture book to read to babies and toddlers. Young children enjoy being part of the reading experience, and advocates can invite children to point to objects and colors on the pages. Reading can be a quiet activity indoors or outside. This activity can be helpful in soothing and distracting babies and toddlers.

3. Music and singing

Advocates can play music or sing songs with the baby or toddler. Mellow music from the radio can be soothing, or easy-to-remember children’s songs can be enjoyed by young children. They might even sing along with the advocate. The ABCs or “*Twinkle, Twinkle Little Star*” are easy for young children to sing along with. This activity may be distracting and enjoyable for babies and toddlers.

Moving and Playing Together:



1. Peekaboo

Advocates can play peekaboo with babies by placing their hands over their face or a small blanket over their head to “hide” and then removing hands or blanket to “reappear.” Older babies or toddlers may mimic the advocate. This activity can be enjoyable and reassuring as the advocate briefly “disappears” from baby’s sight and then reappears.

2. Hide-and-peek

Advocates can play hide-and-peek with toddlers who are mobile. This activity can take place in a small area where the advocate can maintain visual contact and “pretend” hide from the toddler and then be found. Toddler may be able to “hide” with the advocate and be “found” by another child or adult.

3. “So big”

Advocates can play with babies and young toddlers by helping them move their arms from resting to over their heads or help the baby and toddler move from sitting to standing. Advocates can say “so big!” as they assist the child’s arms or body moving upward.

Creative and Expressive Arts:



1. Drawing, coloring, painting, and Play-Doh

Young children enjoy creating art with whatever materials advocates have available. An inexpensive version of Play-Doh can be easily made with flour, salt, and water. Video link: <https://www.youtube.com/watch?v=oAIAm6BF0fs>.

2. Crinkle paper or sock toss

Advocates can use a piece of paper or newspaper and crinkle it up into a ball shape or twist and roll clean socks into a ball shape. Advocates can toss it back and forth with the toddler. This activity is a fun way to use easy-to-find objects as toys.

3. Chalk art:

Advocates can support creativity in toddlers and children of all ages through chalk drawings on cement. Chalk can be used to make pictures, play X's and O's, or create a hopscotch board for older children.



4 TO 8 YEARS OLD



4 to 8 years old

When working with children it is important to have on hand a number of basic art supplies such as paper, crayons, and washable markers. Advocates can have a deck of cards, bubbles, and Play-Doh available for easy entertainment when spending time with children. Children benefit from activities where they can build competencies, skills, and have fun. Children learn through play, and any opportunities advocates can provide for meaningful play will engage them.

Co-regulating and Soothing Activities:



1. Deep breathing:

Advocates can invite children to breathe deeply. In this activity called “*Pick a flower, blow a pinwheel,*” the child is asked to pick a pretend flower with their right hand. Then smell the fragrance of the flower by taking a deep breath in through their nose. Now, pretend they are blowing a pinwheel that they are holding in their other hand. Blow out as hard as they can through their mouth to make the pinwheel go around. No materials needed, but some programs have opted to make flowers out of pipe cleaners and have also purchased small pinwheels to do this activity. This is a fun way to do deep breathing.

2. Countdown to calm:

Advocates can invite the child to sit comfortably and quietly (*or in their head*) count backward from 100. Depending on the age of the child, advocates can count with the child or the child can count independently.

3. Calm stones:

Advocates can invite the child to think about what “*calm*” feels like to them and what words describe that sense of calm. The advocate and child can use small “*found*” stones and write the word(s) the child generates on the stone with permanent marker. Children can keep this small stone in their pocket as a reminder of that calm sensation. This activity can be part of another activity such as a nature walk or treasure search.

Moving and Playing Together:



1. “I spy”

The advocate and child can do this activity while taking a walk or sitting quietly inside or outside. The advocate and child can take turns saying “*I spy with my little eye something ____*” (fill in the blank with a hint about something visible: “. . . that is red” or “. . . that begins with the letter M” or “. . . shiny”). Then the advocate or child can look for what the other “spied.” This is a simple game that can be expanded on; for example, there are screen variations on YouTube: <https://www.youtube.com/watch?v=mwyv-4sOsrc>.

2. Follow-the-leader

The advocate and child can play follow-the-leader indoors or outside. Advocates can follow the child’s lead. The advocate may need to model how to play follow-the-leader first by setting examples with skipping, walking backward, hopping, or making silly faces and silly movements. Advocates can then encourage the child to take the lead and make up things that the advocate will copy.

3. Card games

Advocates can play card games with children using any deck of cards.

Example “Go Fish” video: <https://www.youtube.com/watch?v=tzEVIbiOZXc>

Example “Garbage” video: <https://www.youtube.com/watch?v=AaDUJele9LM>

Example “Speed” video: <https://www.youtube.com/watch?v=vqtuntlmn6U>

Creative and Expressive Arts:



1. Calming jars

These jars are easy to make with children. Advocates might want to make one to keep on hand and use with children or they can make one with the child. Link to simple instructions: <https://www.youtube.com/watch?v=4U02fQwWDfI>.

2. Tell a story of me

Advocates can encourage sharing about oneself by inviting the child to tell a story. Advocates can demonstrate this activity and tell a story of themselves getting to work that day, something they did before going to work, or even a story about growing up that they are comfortable sharing. Advocates can use “*Once upon a time, there was a . . .*” as an opening for the storytelling.

3. I am the treasure

Advocates can encourage children to draw themselves in the middle of a piece of paper and then draw out a “*map*” to reach them. Children can identify and include safe places and people on their treasure map.



9 to 12 years old

When working with children and preteens it is important to offer activities that encourage a sense of belonging and community. Children this age also benefit from group activities with similarly aged children. Activities below may help encourage self-expression and enhance self-esteem as they learn about themselves and build resilience.

Co-regulating and Soothing Activities:



1. Mindfulness activities

Advocates can view and download free meditation and breathing resources to use with children and teens: <https://bitsofpositivity.com/the-ultimate-list-of-free-meditation-printables-for-kids-mindfulness-resources/>.

2. Easy yoga poses

The advocate and child can do yoga poses together indoors or outside. Advocates can direct the child using easy prompts like, “*Stand like a tree and sway like the wind is gently blowing*” or “*Be a mountain, stand tall and solid, and be still*” or “*Be a cat and stretch.*”

3. Journaling

Advocates can offer children a small journal or make a journal book from pieces of paper stapled together. Advocates can encourage children to write and draw in their journals when they are feeling overwhelmed with emotions. Video link to five easy bookbinding methods: <https://www.youtube.com/watch?v=WuAbZW-RiRs>.

Moving and Playing Together:



1. “I feel” game

Draw pictures of faces or cut out faces from magazines and label the feelings that face is expressing. Once this is done, scenarios can be discussed and the child can use the pictures to discuss how “*someone*” may feel in that situation.

2. Emotions ball

Using an easy-to-catch ball, write (*with permanent marker*) different emotions on the ball. Playing catch with a group of children, teens or one-on-one, read the emotion that is under the thumb when the ball is caught, and then have the “*catcher*” describe the last time they experienced those feelings.

3. “Flying to the moon”

Advocates can invite the child to play a fun memory game using the alphabet and their imagination. Advocates can begin with an item that starts with the letter A by saying, “*I am flying to the moon, and I am going to bring an Astronaut.*” Then invite the child to go next, including what the advocate said and adding something that starts with the letter B. The child might say, “*I am flying to the moon, and I am going to bring an Astronaut and a Banana.*” Continue through the alphabet until one person forgets one of the items going to the moon.

Creative and Expressive Arts:



1. Exploring who I am

Advocates can help children create treasure boxes. Advocates can recycle tissue boxes, and have children decorate the inside and outside of the tissue box. Children might want to decorate the outside of the box with pictures and words that represent who they “show” to the world and then the inside of the box with pictures or words to represent their whole true self.

2. Worry dolls

Advocates can share information with children about worry dolls (*sometimes called Guatemalan worry dolls*). Worry dolls can be told a child’s worries before bedtime and placed under their pillow so the child can sleep peacefully and not “dream” about their worries or concerns. Advocates can encourage the child to share a worry or concern they have while creating a worry doll. Worry dolls can be easily made from pipe cleaners or two craft sticks glued together to form the doll. Yarn, fabric, and string can be wrapped around the pipe cleaners or craft sticks to create clothing for the worry doll. Video link: <https://www.youtube.com/watch?v=7lcoBtyUVVM>

3. Kindness rocks

Advocates can invite children to paint rocks with kind words and messages and place rocks throughout the shelter yard or safely in local park areas. Advocates can look here for additional ideas on kindness rocks: <https://www.triedandtrueblog.com/kindness-rocks-project-with-kids/>



13 years and older

When working with teens, it is important to consider their unique interests and skills. Teens benefit from activities that nurture connection and provide them with some strategies for managing stress.

Co-regulating and Soothing Activities:



1. Staying present:

Advocates can invite teens to focus on being present in the moment to reduce feelings of anxiety and worry about their future. Advocates can invite teens to focus on something in the room that is pleasant or interesting to them. Advocates can encourage them to focus their attention on that object and notice when their mind begins to wander away from that object. Advocates can gently direct teens to bring their focus back to the object. This is an opportunity for discussion on concentration and mindfulness.

2. Worry stones:

Advocates can offer teens small, smooth stones to hold in their hand and rub when they feel worried or concerned about something. Advocates can help teens strategize ways to stay grounded when overwhelmed with strong feelings. Teens can also write words or short phrases on their stones with permanent marker.

3. Communication skills:

Advocates can support teens in expressing their needs. Practicing communication skills and using “*I-statements*” can assist teens in building competence and feeling empowered to more fully express themselves. Advocates can generate scenarios or ask teens for situations in which they find themselves challenged to “*speak up.*”

Moving and Playing Together:



1. Take a walk

Advocates can offer to meet with teens outside in a confidential location or to take a walk, if this is a safe option. Teens benefit from physically moving while sharing about themselves, rather than sitting in an office answering questions.

2. Leading activities with younger children

Advocates might want to invite teens to assist them with activities for younger children. In no way is this to be a burden on the teen. Instead, it's a voluntary opportunity for the teen to engage in play and potentially lead activities and games **WITH** the advocate. Teens may feel resistance to “*playing*,” but when placed in the position of leader (*with supervision from the advocate*) they may more easily find themselves playing.

3. Card games

Advocates may invite teens to play card games. Teens may know games they can teach to advocates, or advocates may want to show them how to play.

Crazy Eights: <https://www.youtube.com/watch?v=dW6wJrJhM-0>

Spades: <https://www.youtube.com/watch?v=YXvexhgl0WM>

Gin Rummy: <https://www.youtube.com/watch?v=F20GGPDmjaM>

Creative and Expressive Arts:



1. Exploring identity

Advocates can offer teens paper, magazines, glue, scissors, and markers to create a collage of themselves. Teens can be encouraged to be creative through pictures and words they draw or find that express who they are. Advocates can use this time to quietly sit with teens and allow space for reflection and creativity. Advocates can also work alongside the teen and create their own collage and engage in discussion regarding selected pictures or words

2. Letter writing

Advocates can support teens in writing letters that **WON'T** be sent. Teens can write a letter to their noncustodial parent as a way to express and honor the complex and often conflicted feelings they may have toward their parent or relative who was violent toward their non-abusive parent or caregiver. Advocates can offer ways for the teen to destroy the letter after it is completed. Tearing up, burying, and dunking in water are all options to ritualize the destruction.

3. Journaling

Advocates can encourage teens to journal about their feelings. This can be through writing, drawing, poetry, or however the teen feels they can express themselves. Advocates may have empty journals or school notebooks available to give to teens. Advocates and teens might find creative ways to make tiny books to use for art or journaling. Video link to tiny paper books: <https://www.youtube.com/watch?v=21qi9ZcQVto>

Virtual activities (adapting to remote ways of connecting through internet devices)

The following list was developed by the New Mexico Children’s Capacity Building Project’s Peer Support Group:

For individual sessions with children and teens:

- 1. Use therapy workbooks:** Use your favorite workbooks or worksheets and prompts and modify the directives for video or telephonic use (e.g., *Helping Traumatized Families: A Workbook for Therapists* by Charles Figley and Laurel J. Kiser).
- 2. Box up basic art supplies for sessions with children and teens:** Boxes can be dropped off or picked up. Include: paper, crayons, markers, Play-Doh, clay, empty Kleenex boxes, empty paper towel or toilet paper rolls, brown paper bags or socks for making puppets, a small plastic bag of beads or Legos, and any other easy crafting materials.
- 3. Collaborate on the space or area with children, teens, and their caregivers:** If possible, have the child or teen suggest a space to use for sessions. It may be a small area where they can create a “*happiness nest*” of their special things, including a box of supplies or toys just for session (**see #2**), a favorite little stuffed animal, a mindful rock, lip balm, and more.
- 4. Make up your own Mad Libs:** Have children or teens fill in statements you develop to encourage discussion of feelings.
- 5. Play “show-and-tell” over video:** Ask children to bring their own toy (or favorite app, video game, or device for teens) to share or play.
- 6. Scavenger hunt:** Invite children to find items by searching through their room or house for basic items: something soft, something squishy, something made of cotton, something made of metal, etc.
- 7. Breathing together** can provide an opportunity to co-regulate. Below are a few ways to visualize breathing that may be helpful with children and teens. Be aware of offering breathing activities and visualizations with closed eyes. Children and teens can be encouraged to keep their eyes open as closing their eyes might bring up trauma reminders.
 - a. “Favorite food breathing”:** Invite children and teens to imagine their favorite food (e.g., a favorite meal or a favorite cookie), then have them inhale deeply through

- b. Screen share short videos, mindfulness exercises, and other games like “Guessing the Feelings” (from the movie *Inside Out*) (<https://www.youtube.com/watch?v=dOkyKyVFnsS>) or the Feelings Candy Land game (<https://www.pathwaystopeacecounseling.com/product-page/feelings-candy-land-game-instructions>).
 - c. **Simple emoji emotions:** Use emojis to discuss feelings and emotions.
14. Consider participating in apps and games that teens use already. Focus on the nonviolent games or apps that help teens explore social skills and group process.

For family sessions:

- 1. **Use family therapy books:** Use your favorite activities from guides or therapy workbooks and worksheets and/or prompts and modify directives when working with children and families remotely (e.g., *Helping Traumatized Families* by Charles Figley and Laurel J. Kiser; *Parents as Partners in Child Therapy: A Clinician’s Guide* by Paris Goodyear-Brown).
- 2. Box up basic supplies for sessions though drop-off and pickup. Include: paper, crayons, markers, Play-Doh, clay, empty Kleenex boxes, empty paper towel or toilet paper rolls, brown paper bags or socks for making puppets, a small plastic bag of beads or Legos, and any other easy crafting materials.
- 3. Draw together—with the entire family visible on screen:
 - a. Draw any picture together with or without words.
 - b. Draw your family together.
 - c. Draw a big circle on paper and cut it up like a puzzle. Each family member decorates their piece of the puzzle and then bring the pieces together again and talk about how each part adds to the whole.
 - d. **Child-led drawing:** Invite the child to start by drawing a simple shape on a piece of paper and then pass the paper on to the caregiver or sibling. Then the caregiver or sibling adds to it, and they continue to pass it back and forth until the child feels like it is finished.
 - e. **Handprints:** Trace family members’ hands on paper, and then each person writes on the handprints what they appreciate about each family member.
- 4. Play together—with the entire family visible on screen:
 - a. Invite the family to play “tissue ball” (using a tissue, blow on it, wave arms

and hands to keep it up in the air) or “hot potato” or “pass the ball” (a ball can be made with a crumpled-up piece of paper and the advocate can start and stop the time) with or without words.

- b.** Encourage the family to be outside together and go on a “mindfulness walk.” They can pay attention to their five senses, noticing what they see, smell, hear, taste, and feel.

- c.** Family fun box: Invite the family to decorate an empty tissue box and fill it with free, fun family activities.

Try this link for “**10 Creative Ways to Engage Children and Youth Through Virtual Activities**”:

<https://dvchildwelfare.org/resources/tip-sheet-1/>





Critical Conversations

Helpful hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing compassionate policies within your program.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

- Consider whether you and others in your organization have an interest in engaging in family-centered activities or activities with children and teens.

What can a direct staff person do?

- Consider your own interests, talents, and skills and what you might share with families while initiating family-centered activities.
- Think about activities you currently use and how these might become activities for children, teens, and families.
- Consider establishing a weekly “*family craft*” night or child friendly movie night.

Critical Conversations



What can a supervisor do?

- Consider hiring future staff members who have training and experience working with children, teens, and families.
- Consider engaging staff members who may be interested in participating in organizing family-centered activities. What strengths, abilities, skills, and interests might they bring to your organization to create valuable family-centered activities?
- Consider bringing in community elders and volunteers to engage children and families in special, culturally specific activities.

Team-based activity on the Window of Tolerance

Refer to the background description about the window of tolerance earlier in this section. Engage in a discussion about how this concept might be helpful in supporting caregivers and families to engage in individual, caregiver-child, and family activities.

- What barriers might you encounter in successfully engaging in activities when any family member is outside of the “window of tolerance”?
- What strategies might you use to help family members return to an optimal zone, where they are connected to each other, in the present moment, and ready to engage?
- How can you support caregivers’ capacity to offer co-regulation to their children?





Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Julie is a shelter advocate who works on the weekends. She has noticed over the past few weeks that many of the survivors and children spend most weekend days watching TV. Julie and the shelter manager discussed Julie taking interested families on an outing to promote a little fun and help reduce boredom. They could go to a park in a nearby community where survivors might feel safe. Julie is excited and has a few ideas but no budget to buy anything. Julie isn't really sure where to start and wants this first outing to be fun and engaging for the families.



Things to consider:

- Sometimes the best fun happens organically. It is great to plan activities, and it is also important to let families choose what they want to do.
- Consider initiating conversations with survivors and their children to see what they enjoy and would like to do—maybe pack a lunch, play on playground equipment, or bake cookies. Encourage families to be involved in the planning to increase engagement.
- Make sure to consider the various ages, developmental stages, and abilities as you create optional activities for families.
- Check in with survivors regarding safety on outings. What is most critical to maintaining safety?

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Be aware of your own responses to families as you plan outings. Make sure you're really listening to families and not imposing your ideas or preferences onto them.
- Begin by checking in with families to gauge how family members are doing in the moment and ask about any concerns related to the planned outing (*including safety concerns*).
- Make sure you have everything you might need before you go on the outing.



Section 12: Resources and Links

Binkley, E. (2013). Creative strategies for treating victims of domestic violence. *Journal of Creativity in Mental Health*, 8:305-313. doi: 10.1080/15401383.2013.821932

Kerr, L.K., Ph.D. (2015, Updated March 2020). Live Within Your Window of Tolerance, <https://laurakkerr.com/wot-guide/>

Therapeutic games: https://childswork.com/collections/games?gclid=EAIAIQobChMI0vm63Ya08gIVideWCh3-eQAsEAAYAiAAEgLFZvD_BwE

Link to NCDVTMH's website for more exercises for grounding, emotional regulation, and relaxation: <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/01/Exercises-for-Grounding-Emotional-Regulation-Relaxation-Final.pdf>

“Empowering Children in Shelter” resource (click on **Dropbox link at the bottom of the page**). This culturally specific resource for American Indian and Native Alaskan children, teens, and their caregivers is a compendium of activities that can be shared and adapted. It's designed to honor Indigenous cultural traditions and to teach activities and crafts to the next generation: <https://www.nativewomenssociety.org/resources>



13. Evaluating Program Services and Outcomes

This section is a short primer on understanding, planning, and conducting evaluations. It can be applied to how your organization is developing, enhancing, and sustaining family-centered programming and services. It begins with an overview on evaluation, a description of various kinds of evaluations, and the benefits of evaluating services. Next, it covers the planning process, “right-sizing” evaluations, defining outcomes, and considerations for value-driven, inclusive, ethical, trauma-informed, developmentally sensitive, family-centered, and accessible processes for all participants. Sample questions to prompt your thinking about family-centered outcome evaluations are also included. As in previous sections, we conclude with critical conversations for team-based discussion, action steps for direct service staff and supervisors, a vignette to apply understanding, and helpful resources and links to further your knowledge and practice in this area.

Introductory overview on evaluating program services and outcomes

Programs of all sizes and types can benefit from evaluating their services. The term evaluation describes a range of approaches that can include everything from storytelling and photography-based projects to surveys that use numbers. Evaluations help us to understand outcomes—or what has changed as a result of your

program—for individuals, families, specific services (e.g., *prevention, residential services*), or communities. Evaluations can also help us understand what is working well, what can be improved, and why.

Types of evaluations

You can think about evaluations as falling under two broad categories: formative and summative evaluations. Within these two broad categories, there are different evaluation approaches you can use.

- **Formative evaluations** are done while a program or service is forming and developing. You can use it as you begin a new program or service. It allows you to quickly catch any problems so that you can address them or identify things that are going well so that you can build on your strengths.
 - **Process evaluations** are a kind of formative evaluation, and they allow you to track how things are done, how programs change, or how new services are implemented. This type of evaluation allows you to track important information about your program or services related to “*who, what, where, when*” kinds of questions. For example,

a process evaluation may help you track how many families are accessing arts-based groups in your program and how many families are not accessing these services. This information can help your program better understand any barriers to accessing services, for example, and can help your program make changes midstream to improve services.

- **Summative evaluations** happen after a program has become established and help you to understand the impact of services on survivors, families, youth, or communities. They often center feedback from people who have received services, from staff members, or from community members.
 - **Impact evaluations** are a kind of summative evaluation, and they look at how your services or policies drive change within your organization or community. Impact evaluations deal with big picture questions, like whether your service has improved community well-being, or whether your service has led to better health for youth in your community.

- **Outcome evaluations** are another kind of summative evaluation. They help your program understand how well it is meeting its goals (*what came out of your work*). The kinds of questions that outcome evaluations can answer are more focused than impact evaluations, like whether a service has increased knowledge about healthy relationships among teens. Outcomes can be short-term or long-term.

Any evaluation method your program chooses to use **can** and **should** reflect your program and community's values, needs, culture, and viewpoints! There are many ways to make sure that evaluations are trauma-informed, culturally responsive, and center families and youth in different developmental stages. There are also many ways to make sure that evaluations are accessible and inclusive, so that anyone who wants to participate can participate.



Why should we evaluate our services?

It can be daunting to think about evaluating your program's services: There is so much to consider on top of what your program already does every day. Also, people sometimes see evaluations as being too technical, mathematical, time-consuming, and generally difficult to do. But evaluations can be responsive to your community, involve little to no math, help to build and strengthen relationships, and be a worthwhile investment of time and effort. While some programs have a staff member who works on research or evaluations, you can also do this without a specialist. If your program does not collect feedback from survivors, even starting with a simple survey or focus group is an important step!

Evaluations can help you to:

- Understand how well your services are working and whether they are doing what you hope they would be doing
- Figure out if your program is truly meeting its stated goals
- Learn if there are parts of your community that your program is not serving, or not serving as well as it could, and why this may be the case
- Enhance your program's work with children, teens, and their caregivers
- Deepen relationships with families, community members, and between staff members in your program
- Lead to improvements in how your organization works with staff members and understands their needs
- Identify new needs within your community and services
- Document and celebrate successes
- Identify any service gaps or barriers to services
- Advocate for your program and your community
- Secure funding for your program or community
- Change community policies, local laws, or advocate for broader social change

Evaluations are an important part of making sure that your program is constantly learning, improving, and responding to the needs of families and youth.

Depending on your program's funders, you may already be collecting information that they use to evaluate your program. Doing your own evaluation can build on or use the information you already collect and might lead to asking new questions that may not currently be the focus of funder reports, but that nonetheless provide valuable and important information for future funding.

Setting an evaluation plan

An evaluation plan is a roadmap that helps you keep your evaluation organized and on track, and it is an important first step toward documenting the impact of your work. There are several guides that provide clear, comprehensive information on setting an evaluation plan.

We recommend the following resources:

Community Tool Box from the University of Kansas provides excellent information on

how to set an evaluation plan, particularly if your program is interested in using surveys or interviews: <https://ctb.ku.edu/en/table-of-contents/evaluate/evaluation/evaluation-plan/main>

Esperanza United created a clear, organized chart to help you build your evaluation plan. This resource is particularly helpful for ensuring that your evaluation is centered in the cultural values of the people that your program serves: <https://esperanzaunited.org/en/knowledge-base/building-evidence/evaluation-plan/>

This resource guide from **Public Policy Associates, Inc.** provides comprehensive information on creating racially equitable evaluations. It was written for evaluators, though it does have information that may be helpful for programs too: <http://publicpolicy.com/wp-content/uploads/2017/04/PPA-Culturally-Responsive-Lens.pdf>

Act For Youth created a helpful guide on doing Youth Participatory Evaluation, which is a kind of evaluation that engages young people in evaluating the programs that serve them: <http://actforyouth.net/youth-development/evaluation/ype.cfm>

Making sure your evaluation is “right-sized”

In setting your evaluation plan, we encourage you to take some time to ensure that your evaluation is “right-sized.” If you collect too much information, or information that is very hard to interpret and understand, that can be a barrier to understanding your results. Many evaluations falter because of information overload. It may be tempting to ask every question you can imagine. But this can be overwhelming to both the person completing the evaluation and the people responsible for interpreting the results!

If you collect too little information or miss important indicators, it can make it hard to interpret your results. For example, let’s say that you distribute a survey to survivors to collect feedback on the usefulness of your services, but you don’t include questions on demographics or length of service. Without collecting information on demographics, it can make it much more difficult to understand whether your program is equitable to and responsive to the needs of participants of all races, ethnicities, gender identities, sexual orientations, ages, parenting statuses, or other identities. Similarly, if your survey does not include information on length of service, it can be difficult to interpret the

results. For example, if the survey was given to participants who have been with your program for a long period of time, then it is more likely that they are satisfied and happy with your program. In setting your evaluation plan, it is critical to strike a balance between comprehensiveness and brevity.

If you are using storytelling, interviews, or listening sessions, there are other factors to consider in making sure that your evaluation is “right-sized.” It will be important to decide whether you will be taking notes or recording sessions where stories are shared. If you are recording your listening sessions or focus groups, it can be extremely time-consuming or expensive to transcribe the stories. Think about your program’s capacity to help figure out how many people you can talk with and how long the interviews or storytelling sessions might be.



Outcomes and values

Many kinds of evaluations help you to measure outcomes, or what occurred as a result of your program or services (*what came out of your program*). Outcomes can reflect short-term or long-term goals. Outcomes need to be small enough to be measurable. This does not mean that you need to use surveys or collect data that involves numbers, though. Outcomes can also be measured through storytelling, photography, or listening circles, for example. These are all recognized ways to measure outcomes and document the impact of your work. Many professional evaluators recommend collecting both numeric data (*quantitative data*) and feedback or stories in participants' own words (*qualitative data*).

Some examples of measurable outcomes can include:

- Increased overall attendance at family events held by your program
- Increased parental knowledge of how trauma can affect children and teens
- Increased social support among participants in your program
- Increased feelings of safety and connection to caregivers among youth

- Increased feelings of closeness between caregivers and their children
- Increased self-esteem and self-efficacy among children and teens
- Increased coping strategies for when trauma reminders arise
- Increased feelings of well-being among children and teens served by your program
- Increased feelings of empowerment among participants in your program

When thinking about defining outcomes for your program, start with identifying and noting your program and community's values, cultural values, and the value you believe your services bring to your community. Think about the families your program works with: What do you know is most important to them? What makes a difference for them? It is critical to work with people who are centered in your work when defining your outcomes. In thinking about outcomes, it is helpful to keep in mind an adage that comes from the Disabilities Rights Movement: "*Nothing about us without us.*" For example, if you are interested in how your program improves parenting capacity, it is important for caregivers—as well as staff members involved in your program—to have an important role in defining, setting, and interpreting outcomes.



Ensuring accessibility

Along with ensuring that your evaluation reflects the values important to your program and community, it is essential to make sure that your evaluation is accessible. Depending on your program and community, accessibility may mean different things. It could mean making sure that evaluation materials and activities are:

- Provided in all of the languages spoken by those who are interested in participating
- Written to be accessible to people with lower literacy levels, or provided in such a way that anyone of any literacy level could easily participate
- Equally accessible to people with disabilities while centering their needs and experiences

- Accessible to participants of all cultural backgrounds
- Free of any objectifying or oppressive language or activities
- Held at times when people who work various shifts can participate
- Conducted to make sure that parents with children of all ages are able to participate (*e.g., childcare is made available, children and teens are able to participate with their caregivers*)
- Developmentally appropriate for children and teens who participate
- Welcoming and attentive to the feelings and needs of participants
- Trauma-informed, which includes attention to the power differentials that may be present

If your evaluation plan includes collecting information from staff members, you should incorporate the same attention to accessibility that you would with program participants or community members. This may mean ensuring that staff members who work in each program, during each shift, and at each level can participate. It also can mean ensuring that evaluation activities are done as anonymously as possible so that staff members can feel free to provide honest, constructive feedback.



Evaluation ethics and principles

Ensuring that your evaluation is accessible is one aspect of having an ethical evaluation. There are additional ethical principles to follow:

Make sure that your evaluation is beneficial. This may mean that your evaluation will benefit your community, families, people who access your program's services, or your staff members. Benefit should be defined by the people your program serves. Programs may sometimes decide to evaluate their services to "prove" that they are effective. Or they carry out an evaluation with an assumption that the results will be favorable to them and show all the amazing things their program is doing. While understandable, this can have unintended

consequences with real impacts on survivors and their families. It can obscure or minimize issues that your program needs to address in order to better meet the needs of families. When this happens, your evaluation is no longer beneficial. For an evaluation to be beneficial, the information needs to be used! A good way of thinking about the benefits is the following phrase from Chicago Beyond: *"What value is generated, for whom, and at what cost?"*

Ensure that your evaluation does not unintentionally cause harm. Be thoughtful about language, attitudes, or actions that relate to race, class, gender identity, ability, sexual orientation, age, or other aspects of identity and life experience. Harm can be overt, or it can be subtle: Either way, great care needs to be taken to minimize or eliminate any chance of harm in every step of the evaluation process. This includes ways that evaluators' identity, biases, points of privilege, or own experiences can create harm, both in collecting information and in interpreting results.

In conducting evaluations within domestic violence programs or services, it is essential to ensure that great care is taken to reduce any chance of harm from abusive partners. For example, if an evaluation participant is living with an abusive partner, you would never send them home with written materials about

the evaluation or the topic being covered in the evaluation. Also be aware of the power differentials that exist between staff who are implementing evaluations and youth who are participating. Figure out ways to include youth in the process of developing outcome evaluations.

Make sure that your evaluation is trauma-informed. This means taking into consideration the pervasiveness of trauma, avoiding activities that could be re-traumatizing, and taking special care to understand the power and control dynamics between participants and evaluators. This includes trauma related to survivors' identity and collective and historical trauma. Completing surveys, participating in focus groups, or doing other evaluation-related activities may be emotionally exhausting or evoke trauma reminders, depending on the topic and the types of questions asked. When children and teens are engaged in the process, additional care should be taken to ensure that evaluation methods and materials are developmentally appropriate.

Confirm that your evaluation is fair and inclusive. This means that it is open and available to anyone who wishes to participate and that there are no barriers to participation related to identity. This also means that your evaluation considers the time of participants.

In appreciation of the time and effort involved in participating in evaluation activities, many programs offer money or gift cards as a thank you. However, it is important to make sure that the amount given is not so large that it is coercive, and not so small that it is insufficient. If your evaluation activities require a participant to use transportation, it is important to offer money to cover the cost, as not being able to afford transportation could exclude someone from participating. Also, many programs provide snacks and light refreshments when they do focus groups or listening sessions.

Be sure your evaluation is rooted in respect. Before participating in any evaluation activities, participants should be fully informed about what to expect. This includes the **concept of informed consent:** that people's choice to participate, or not, is fully respected and honored. This includes information on anything in the evaluation that could potentially be a trauma reminder or upsetting. They should also be told whether the evaluation will be confidential so they can factor that into their decision. Consent is an ongoing process, and a participant can withdraw their consent without negative consequences at any point during an evaluation. This can look like a participant deciding to walk out of a focus group or choosing not to answer questions on a survey.

We can take care to ensure that no one should have information collected about them without their willing consent and knowledge. It's also necessary to have the protective parents or caregivers provide consent for their children's participation in any evaluation activities. Children also have the right to refuse participation whether their parents have given consent or not.

Ensure that your evaluation is impartial.

This means that you don't only select participants who you know have had great experiences with your program to make your program look better.

When setting your evaluation plan, review all activities to ensure that they meet these ethical principles. You may consider holding conversations with your colleagues, staff members, program participants, and community members to expand your ethics protections. Professional evaluators and researchers need to complete training on ethics in research in order to practice. This is often done through the CITI Program, and people who are not affiliated with universities can freely get this training. You can find more information about that here: <https://about.citiprogram.org/en/homepage/>.



Managing data and interpreting results

There is a lot to consider in managing the information that you collect and interpreting your results. This tip sheet from the National Resource Center on Domestic Violence does an excellent job of walking you through everything that you will need to consider:

<https://www.dvevidenceproject.org/wp-content/themes/DVEProject/files/issue/EvalSeries5-GatheringData.pdf>.

As with setting outcomes, it is critical that community members, families, youth, participants, and staff members play a role in interpreting results. In most cases, this will improve your evaluation by ensuring that the results are consistent with the experiences of participants. Often, participants will have unique insights into findings that those without lived experience may not have.

Sample questions for developing family-centered evaluations

In thinking about the kinds of questions you could ask in an evaluation, we are sharing some sample prompts. As part of preparing this toolkit, we conducted listening sessions with staff, supervisors, and parents and primary caregivers in a number of programs. These are some of the questions that were used:

Questions for both staff and supervisors:

- What concerns do children and youth identify regarding their parents or caregivers?
 - What other issues or concerns come up in your day-to-day work related to the well-being of children, including their behaviors, health, mental health, and substance use-related needs?
 - Tell us from your perspective how child and family services work within your program.
 - What do trauma-informed, family-centered services mean to you?
 - How well integrated are children's services within your program?
- What is missing within your program around services for children and parents?
 - **AS APPLICABLE:** As a staff member who works with children and parents
 - How well do you think other staff members understand your work?
 - How supported do you feel in your work?
 - What do you wish program leadership understood about your work?
 - What do you feel good about in your work with children and parents?
 - What kinds of training, information, or support would be helpful for you in working with parents or caregivers and their children?

Questions for supervisors:

- What comes up most frequently for the staff you support—both successes and challenges—around doing family-centered work?
- In what ways does your organization's culture support children and parents? What could be improved?
- In what ways do you see any “*siloing*” within your organization around work with children or family-centered work?
- What challenges come up for you in supporting staff members who work with children and parents?

Questions for parents:

- What do you see as one of your greatest strengths as a parent or caregiver? What are you most proud of?
- What's the hardest thing for you right now in being a parent?
- If you can think back to when you first came to this program, what worries did you have about your children then?
- What worries do you have about your children these days?
- For you as a parent, what about this program has been the most helpful to you and your family?
- If you could design a program to fit your family's needs, what else might you want to see offered here? In the community?

Critical Conversations



Helpful hints:

Decide beforehand who might best facilitate these conversations within your program and organization. Use these discussions as a springboard for guiding best practices and establishing inclusive and compassionate policies within your program.

The following part offers some critical conversations and specific topics for consideration by both direct staff and supervisors. Domestic violence organizations can use these critical conversation prompts to initiate conversations during meetings or supervision to invite staff to discuss family-centered approaches within the organization or possible changes and ways to integrate a more family-centered perspective.

- How does the organization evaluate services?
- Are there ways the organization assesses specific funder-required outcomes?

What can a direct staff person do?

- Ensure that clients have opportunities to provide feedback on services they are currently receiving or have received previously.

What can a supervisor do?

- Ensure the organization is evaluating services and creating opportunities for clients to provide feedback.
- Regularly incorporate client feedback into conversations with staff as a way to generate initiatives to improve services and develop additional programming.
- Anticipate the need for ongoing program development and consider innovative suggestions from staff and stakeholders



Vignette

The following vignette can be utilized in multiple ways: as a prompt to introduce new ideas, as an invitation for deeper staff discussions on specific topics, or as a mini-training opportunity. The vignette is followed by things to consider and suggestions of what you can do.

Jackie is a new community-based domestic violence program supervisor. She joined the organization six months ago and has noticed that the program only evaluates their services through an exit survey. Jackie is interested in getting more feedback from survivors and their children and looking at other ways to measure all the great work that the organization provides in the community. Jackie brought her ideas to the director, who gave her the go-ahead. Jackie wants to increase interest and build some “*buy in*” from other staff, but where to begin?



Things to consider:

- Sometimes staff and coworkers can be resistant to change. Consider initiating conversations regarding changes in gaining additional survivor and youth feedback as one way to help prepare everyone for possible changes to the current feedback process.
- Feedback from clients can be so valuable as we make our services more family-centered.

What you can do:

- Be aware of what feelings and reactions get evoked in you as the advocate or counselor. What are the potential assumptions, judgments, or concerns that are coming up for you and other staff?
- Begin with empathizing with staffs' concerns and explore attitudes toward change and potential resistance to change.
- Initiate the dialogues during staff meetings (*see "critical conversations" above*).



Section 13: Resources and Links

Because there is so much to consider when undertaking an evaluation, we have prepared a list of curated resources for you.

Information about types of evaluations: <https://www.cdc.gov/std/Program/pupestd/Types%20of%20Evaluation.pdf>

Evaluation basics, plus why programs should consider evaluating their work: <http://meera.snre.umich.edu/evaluation-what-it-and-why-do-it>

This guide from the National Resource Center on Domestic Violence provides clear and useful information on understanding outcomes in evaluation: <https://www.dvevidenceproject.org/wp-content/themes/DVEProject/files/issue/EvalSeries4-WhatEffects.pdf>

This academic journal article provides nuanced information on **grounding evaluations in Indigenous practices and worldviews:** <https://evaluationcanada.ca/secure/23-2-013.pdf>

The **Core Principles Reflection Exercise** from Esperanza United can help your program identify the values of your community, including cultural values. While it was created for programs working within Latinx communities, the questions can be adapted for programs in many cultural contexts: <https://esperanzaunited.org/en/knowledge-base/building-evidence/evaluation-plan/>

This resource from **Wilder Research** provides excellent information about **principles of ethics in evaluations:**

<http://www.evaluatod.org/assets/resources/evaluation-guides/evaluationethics-2-09.pdf>

Section 13: Resources and Links



This resource, also from Wilder Research, provides guidance **on ensuring that your evaluation is trauma-informed**: https://www.wilder.org/sites/default/files/imports/TraumaTipSheet_10-16.pdf

This guidebook, prepared by **Chicago Beyond**, provides outstanding **information about power dynamics**, including those related to identity, between researchers and those being researched: <https://chicagobeyond.org/researchequity/>

NCDVTMH has created an **Evaluation Toolkit for Accessible, Culturally Responsive, Trauma-Informed (ACRTI) Domestic Violence programs**. This includes four surveys:

- One survey for program staff on ACRTI policies and procedures (*The Trauma-Informed Capacity Assessment, or TICA*)
- One survey on elements of ACRTI practice for advocates, counselors, and supervisors within domestic violence programs (*The ACRTI Practice Measure*)
- One survey on what has changed for survivors and their children as a result of accessing trauma-informed domestic violence services (*The Trauma-Informed Outcome Measures, or TIOS*)
- One survey to measure survivors' ratings of how trauma-informed their domestic violence program and its staff is (*The Trauma-Informed Practice Scale, or TIPS*)

The ACRTI Evaluation Toolkit (*in process*) will be available on this site:

<http://www.nationalcenterdvtraumamh.org>



Appendix: References and Handouts

References and links by section:

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Section 3 | Handout 1



Reflective Supervision in Domestic Violence Programs

Reflective Supervision (RS) is:	... because in work with children and families experiencing domestic violence, you:
<p>Focused on professional growth. RS supports staff - and supervisors! - in building skills important to their individual work.</p>	<p>Support children and families to strengthen parent-child bonds, and enhance coping skills.</p>
<p>Strengths-based. RS helps staff identify their unique strengths and supports staff in applying their skills to the challenges of the work.</p>	<p>Identify and build on the strengths of children and parents in healing from the traumatic effects of experiencing DV.</p>
<p>Safe. RS provides a secure environment where staff can discuss the strong feelings that are evoked in them, the real challenges of their work and their own vulnerabilities in a way that supports growth.</p>	<p>Build a trauma-informed atmosphere of safety, mutual trust and respect.</p>
<p>Individualized. RS is based in learning about each unique staff member and what is most helpful to them in their work.</p>	<p>Individualize your services to each child and family in the context of their culture and community.</p>
<p>Characterized by active listening. Reflective supervisors listen intently to staff, paying attention to spoken language and unspoken cues.</p>	<p>Bear witness to their experiences and feelings, actively "listening" to what they tell you with their words, their voices, and their body language.</p>

Adapted by Expanded Training & Consultation Cadre (Chicago) NCDVTMH (2013) from the Early Head Start National Resource Center.

Section 3 | Handout 2



My North Star Instructions

Ask yourself:

- What was the motivating factor for you to work in the domestic violence field? What brought you here? **This is at the center of your North Star.**
- What are the moments when the work adds value or meaning to your life? What are the elements of a really good day? **These are the “arms” of your North Star.**
- What are your strengths, how are you resilient, what are your activities for well-being, and who are the people, pets, and communities who support you? **This is the universe of your North Star.**

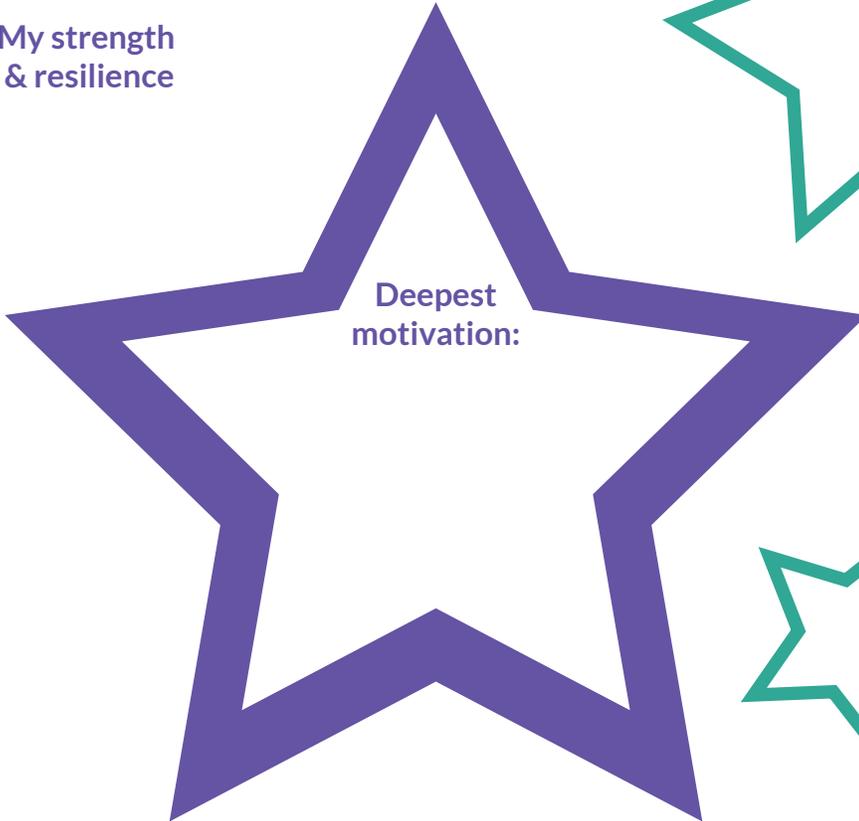
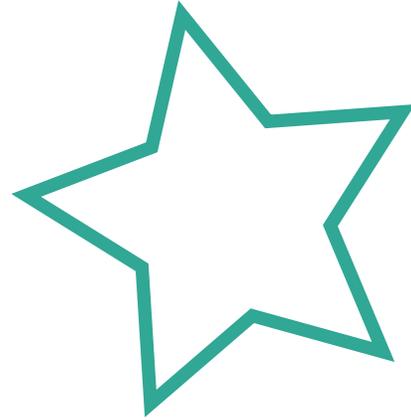
Section 3 | Handout 2



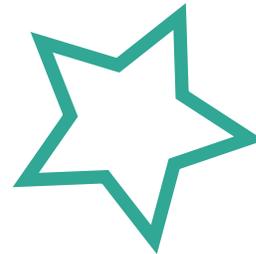
My North Star Worksheet



My strength
& resilience



Deepest
motivation:



A good day
looks like

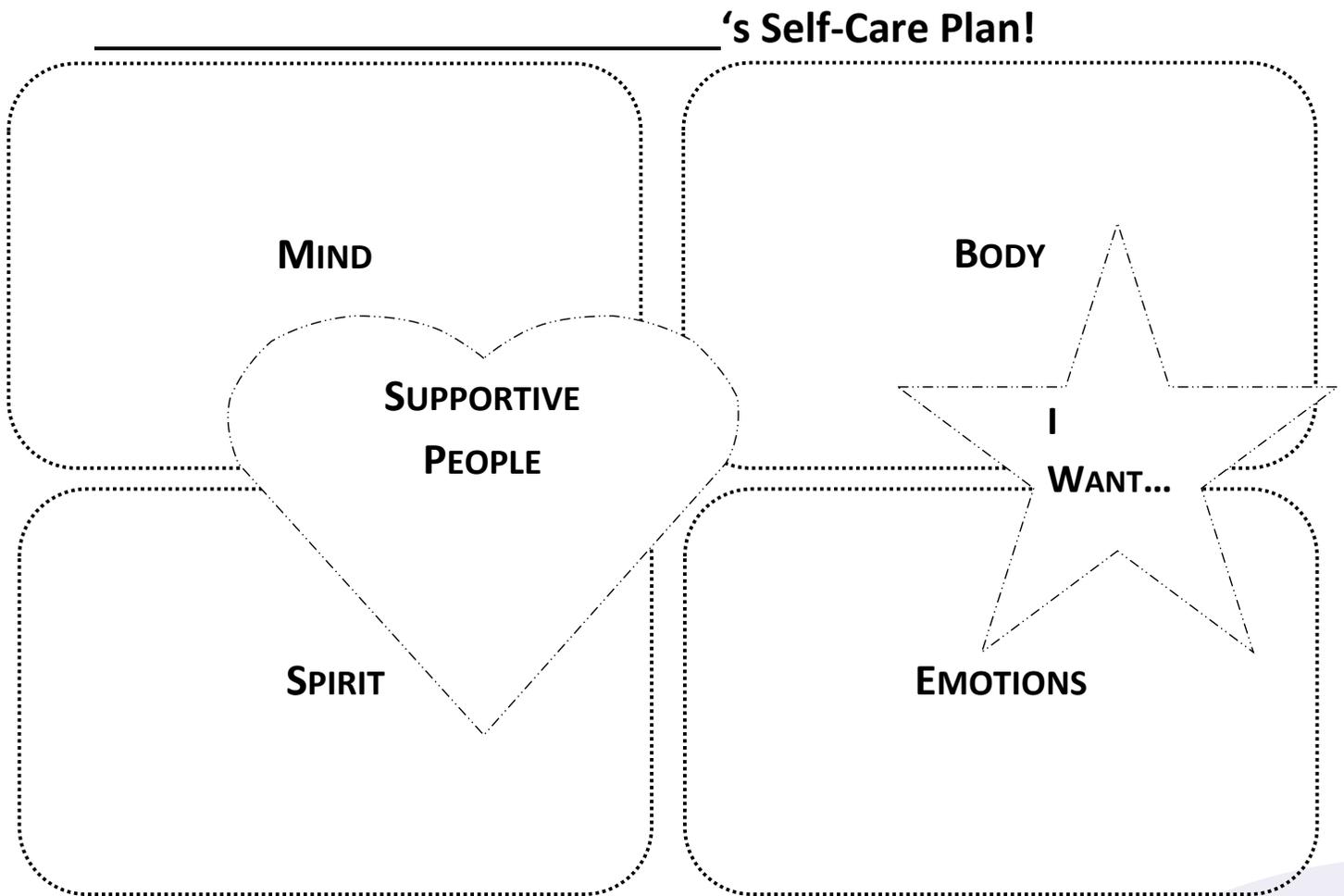


Section 3 | Handout 3



Creating a Self-Care Plan with guidance

Creating A Self Care Plan has instructions. Remember that self-care is *not* a programmatic expectation and it includes organizational wellness and supports.



Section 3 | Handout 3



Creating a Self-Care Plan with guidance

Your self-care plan may change over time. You may notice a heavier focus on one area over others. Some activities may land in more than one box. All of that is okay... this is YOUR plan!

Mind:

What helps your mind? What helps you get through your day and move you closer to your goals? What keeps you sharp and helps rejuvenate you? What works for you?

Body:

What helps your body? Goals for this category might be getting 8 hours of sleep, going to the gym 3 days a week, or eating 5 fruits and veggies a day. Maybe your plan looks different. What helps your body function at its best? What works for you?

Spirit:

What helps you feel connected to something larger than yourself? Will your plan include prayer, meditation, or a religious service? Or maybe hikes in nature help your spirit and you want to aim for a few per month. Perhaps volunteering at an animal shelter is something that really helps your spirit. What works for you?

Emotions:

What improves your mood? Perhaps it is singing, dancing, journaling, meditation, or even yoga. It could be socializing with friends and family. What helps YOU calm your mind and lighten your emotions? Perhaps you look for things that make you laugh! Perhaps you look for a positive outlet for frustration and anger. What works for you?

Supportive People:

Who are the people who really have your back? Who can you ask to help you enact aspects of this self-care plan?

I Want to Accomplish:

BIG PICTURE, what do you want for yourself? What words describe how you want to feel and what you want to have as a result of intentional focus on your self-care?

Modified from Ignacio Pecheco's Self Care Plan by
Social Work Tech: available @ socialworktech.com

Section 3 | Handout 4



16 Warning Signs of Trauma Exposure Response (van Dernoot Lipsky)¹

It is perfectly normal to have a response to trauma exposure! Whether you identify with one, a few, many, or none of the warning signs, you are okay. Know that your awareness and curiosity about these signs can lead to more insight and compassion for yourself, your clients, your co-workers and your work. As you move through the list, pay attention to how you feel, while honoring the courage it takes to look honestly at yourself and your own responses.

1. Feeling helpless and hopeless

Difficult to see that any progress is being made. Successes are hard to keep in focus. May feel overwhelmed, or have a sense of despair about change.

2. A sense that one can never do enough

Holding the belief that *“I am not doing enough and I should be doing more.”*

3. Hypervigilance

Feeling *“on”* and wholly focused on our work to the extent that being present for anything else can seem impossible.

4. Diminished creativity

Feel less innovative, bored, decreased sense of joy, and may want more structure.

5. Inability to embrace complexity

Crave clear signs of right and wrong; good and bad – while feeling the urgent need to choose sides. More likely to say *“no”* and may be more dogmatic and opinionated.

6. Minimizing

May consider less extreme experiences of trauma as *“less”* important or deserving of time and support. May downplay anything that does not fall into the *“most extreme”* category.

7. Chronic exhaustion/physical ailments

A bone-tired, soul-tired, heart-tired kind of exhaustion in every cell of your body. May lead to a number of physical ailments, such as headaches, back issues, as we carry the weight of the work within our bodies.

¹ Laura van Dernoot Lipsky (2009). *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*. San Francisco: Berrett-Koehler Publishers

Section 3 | Handout 4 Continued

8. Inability to listen/Deliberate avoidance

Highlight of your day, when you're not working; hoping the family isn't home or a no show; leaving your voice mail message box full. In personal life, going out less with people, or engaging superficially, or only socializing with people who "get it."

9. Dissociative moments

Experience of being engaged and then having something unhinge within you; might be losing last 5 seconds of the conversation. Happens when we cut ourselves off from our internal experience to guard against sensations and emotions that may be overwhelming to us.

10. Sense of persecution

May become convinced that others are responsible for our well-being; when we experience a profound lack of personal efficacy to transform our circumstances.

11. Guilt

Unable to find joy in life; feeling guilt associated with how we live in a world with such disparities in resources and privilege.

12. Fear

Fear of intense feelings, of personal vulnerability, or of potential victimization.

13. Anger and Cynicism

Trying to do right, when feeling one's

self, clients, or colleagues are being treated unjustly. Or anger over systemic oppression, discrimination and unjust treatment of groups of people. Use of humor or sarcasm to cope with anger.

14. Inability to empathize/Numbing

Often happens when we're overwhelmed with incoming stimuli related to our work. May numb out intense feelings, where any hint of experiencing them again may be scary or distasteful. Or may leave us feeling out of control.

15. Addictions

Find ourselves using drugs, alcohol, food, sex, social media, and other distractions to "check out." OR work as an "intoxicant" or adrenaline rush.

16. Grandiosity: an inflated sense of importance related to one's work

When work becomes the center of our identity and it feeds our sense of grandiosity. My work is so important and therefore, so am I.

Section 5 | Handout 1



Our Family Safety Plan

This is a draft family safety plan (adapted from End Abuse Wisconsin: the Wisconsin Coalition Against Domestic Violence). It includes some basic elements of joint safety planning to initiate conversations with families. Advocates may want to complete safety plans verbally depending on a families' particular situation and knowledge about the abusive partner. This version may be too long for some children or include items that are not safe for all families, e.g., calling 911. It omits some specific elements that domestic violence survivors may want to include, e.g., planning for safety at school, childcare, or visitation exchanges, and safety procedures in case of fire or in the presence of weapons. Safety planning is an ongoing process; expect to make frequent revisions as the family's situation changes. Domestic violence programs can customize this template to meet the unique needs of survivors and their children.

Our Names

These are **safe people** who kids in our family can talk to or call when there is trouble:

<i>Name</i>	<i>Phone</i>

Our family uses a signal when there is trouble. **Our family signal is:**

When we see or hear the signal, the kids will:

Section 5 | Handout 1 Continued

Where can kids go when we don't feel safe at home? (Think of a safe place that has more than one exit and a safe place that does not have things that can be used as weapons.)

Safe places in our home

Safe places near our home

How will the kids get out of the house if there is danger?

Who will help younger brothers and sisters if there is danger?

What will this person do?

Things kids should NOT do when there is trouble:

1.

2.

3.

Kids in our family understand that we should NOT try to stop a fight between adults.

Kids in our family understand that when adults fight in our house, IT IS NOT OUR FAULT.

Kids in our family can call 911 if someone is hurt or afraid. It can help to describe what is happening in our house. Stay on the phone and answer questions.

Our address is:

Our phone number is:

Section 5 | Handout 1 Continued



Here are some other things our family can do to stay safe:

1. _____
2. _____
3. _____

If we need to leave home quickly, here are a few things we would like to take with us:

In order to stay safe, our family needs to be careful about who we can tell about our safety plan.

People who can know about our safety plan are:

1. _____
2. _____

Section 5 | Handout 2



My Safety Plan for Children and Youth

When people are fighting, remember to be SAFE:

- S** – Stay out of the fight
- A** – Ask for help
- F** – Find an adult who will help you
- E** – Each time, every day, I know it's not my fault

What can I do to be safe?

Where can I go to be safe?

These are the safe exits from my house:

Who are safe people I can talk to about my problem?

Practice calling 911

My name is _____. I am _____ years old. I need help.

Somebody is hurting my _____ (parent or caregiver).

I live at _____

The phone number here is _____

Remember: It's not your fault!

Section 5 | Handout 3



Bedtime Beads

(Adapted from Natalie Caufield)¹

PURPOSE:

This activity uses relaxation skills for self-regulation. The beads incorporate both deep breathing skills that have previously been learned and practiced by the child/family and positive self-affirmations, images, and memories. In creating the beads, the parent (or activity leader) and child can talk about what images the child is selecting and why they are meaningful. If done with the parent, this activity can promote increased communication and closeness. Some children may need help in thinking about what images, words, or memories to include on the beads.

Once the beads are completed, they can be carried with the child to school, to visitation with the non-custodial parent, etc. and/or used as a bedtime ritual at home. For many children, the transition to bedtime is particularly difficult, and if this becomes part of the family routine, it can help ease this transition to sleep.

RECOMMENDED AGE RANGE:

3 years – 16 years old.

INSTRUCTIONS:

The participant will be constructing a necklace from large and small beads and using a sturdy string that can be knotted. The small beads can be all the same color (or plain wooden beads) that represent the “breath beads.” These are alternated with the larger beads that are decorated with positive images (e.g. people, places, objects, animals, such as family pet, beach) or inspirational words (e.g. love, hope, gratitude) or an image that represents a positive memory (e.g. family trip, kicking a winning goal in soccer, etc.).

For younger children, stickers may be used, and they may also need some assistance from a parent or the activity leaders in making the image(s) that they select.

MATERIALS:

String, small beads, larger beads, paints, markers, stickers

¹ Lowenstein (ed) (2008). *Assessment and Treatment Activities for Children, Adolescents, and Families*. Champion Press: Toronto, Canada.

Section 6 | Handout 1

Developmental Tasks – Ages and Stages

The primary developmental tasks at various ages and stages of development provide an important framework or "developmental lens" that is critical to understanding typical development and the potential impact of trauma on children and adolescents.

Ages and Stages:	Primary Developmental Tasks
Early Childhood (Birth to 5)	<ul style="list-style-type: none"> ● Becoming attached ● Learning self-regulation and modulation of feelings ● Cognitive Development ● Coping with shame and guilt
School-Aged Child (6-11 years)	<ul style="list-style-type: none"> ● Developing competency at many tasks ● Developing relationships with peers ● Developing a sense of right and wrong ● Accepting responsibility for own behavior ● Becoming more competent at controlling feelings and impulses ● Increasing store of knowledge and ability to think abstractly
Adolescence (12+ years)	<ul style="list-style-type: none"> ● Developing their own stable sense of identity ● Coping with emerging sexual urges ● Continued growth in ability to reason abstractly ● Struggles with family about separation and autonomy ● Develop intimate relationships outside the family

Blumenfeld and Groves, Children and Trauma: A Curriculum for Mental Health Clinicians

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Section 6 | Handout 2

Tips for Supporting Children and Youth Exposed to Domestic Violence: What You Might See and What You Can Do

As advocates, our initial primary focus may be on supporting the adult survivors who come into our programs for services, and we may feel less equipped to work with their children or may feel unsure of how to be helpful. This tipsheet is a starting place for understanding how we can better support children who have been exposed to violence in their homes and how we can support parents to help their children cope more adaptively with trauma-related responses.

Many factors influence our developmental journey through infancy, childhood, and adolescence! Our biology, our relationships with caregiving adults, our experiences, our environment, and the interaction between all of these. Painful, scary, and overwhelming experiences, such as community violence and domestic violence, can profoundly impact that developmental journey. Although there are common trauma responses across childhood, understanding the specific needs and experiences of children at each developmental stage will help you best support them in their ongoing development while increasing healthy coping skills in the wake of violence. The following pages give a brief overview of what you may observe and what you can do at each developmental stage.

Infants, Toddlers, & Preschoolers	
What you may observe:	How you can help (and support parents to help):
<ul style="list-style-type: none"> • Sleep disturbances • Disturbances in feeding • Feelings of helplessness and passivity • Generalized fearfulness • Specific new fears • Loss of recently acquired developmental skills (e.g., walking or talking) • Clinginess and separation anxiety • Inhibited play and exploration • Thinking and talking about the traumatic event 	<ul style="list-style-type: none"> • Support parents in keeping their children close to them. • Help the child anticipate what will happen. • Give choices. • Provide reassurance when the child needs it. • Name the child's feelings. • Expect to need to do these over and over again. It is normal for children to need repeated reassurance.

Adapted from the Domestic Violence and Mental Health Policy Initiative's 2008 *Children Exposed to Domestic Violence: A Curriculum for DV Advocates* (written by Patricia Van Horn, JD, PhD). Chicago, IL: DVMHPI.

Section 6 | Handout 2 Continued

- Being upset at reminders and doing their best to avoid reminders
- Irritability
- Aggressiveness
- Scanning for danger/expecting danger
- Easily startled

School-Age Children

What you may observe:

- Posttraumatic play¹
- Thinking and talking about the trauma outside play
- Being upset at reminders of the trauma and doing their best to avoid reminders
- Specific fears, often triggered by traumatic reminders
- Feeling guilty about the trauma and responsible for what happened
- Fantasies of revenge
- Fear of being overwhelmed by their feelings
- Impaired concentration and difficulty learning
- Sleep disturbances
- Headaches, stomach aches, or other physical symptoms
- Concerns about their own safety and the safety of others
- Aggressive behavior
- Anxiety
- Withdrawn behavior

How you can help (and support parents to help):

- Listen to the child's concerns.
- Answer questions truthfully and simply.
- Support the parent in letting the child stay close to her.
- Offer reassurance that you and the parent are working together to keep the family safe.
- Name the child's feelings and encourage the child to find ways to express them through language, play, or drawing.
- Help the child anticipate what will happen next.
- Give choices.
- Expect to have to do these things again and again.

¹ Posttraumatic play is a kind of play that some children engage in who have been exposed to trauma. Posttraumatic play is a repetitive reenactment of a traumatic experience or event without mastery.

Section 6 | Handout 2 Continued

Adolescents	
What you may observe:	How you can help (and support parents to help):
<ul style="list-style-type: none"> • Detachment, shame, and guilt • Self-consciousness about their fears and intense feelings • “Acting out” and sensation-seeking behaviors that may include life-threatening reenactments • Abrupt shifts in relationships • Desire for and plans to take revenge • Radical changes in attitude and changes in self-identity • Premature entrance into adulthood or reluctance to leave home • Being upset at reminders of the trauma and doing their best to avoid reminders • Coping behaviors that may include self-endangering behaviors such as substance abuse and/or cutting 	<ul style="list-style-type: none"> • Provide an environment in which the teen can talk about concerns. • Give choices. • Support parents in letting their teens stay close to them—even relatively independent teens may need extra support after a traumatic event. • Help teens anticipate what will happen next. • Answer questions honestly. • Help teens find ways to express their strong feelings: journaling, writing stories or poems, art. • Expect to have to do these things again and again.

Section 7 | Handout 1



Repairing Relationships with a Time-In

(This is a guideline. It is, of course, harder than this page makes it sound.)

I'm Upset and My Child Is Upset

When necessary, I start with a "Time-Out"* (for me, for my child, or for both of us) until:

- I know that I am bigger, stronger, wiser, and kind, and
- I remind myself that no matter how I feel, my child needs me.

* A "Time-Out" can be helpful as a first step, but not as a punishment.

I'm Calm (enough) and My Child is Upset

We can build a safe "repair routine" together (remember: the first 1,000 times are the hardest!).

- I take charge so my child is not too out of control.
- We can change location. Go to a neutral place that is our "Time-in" spot, where we sit together and let feelings begin to change.
- I maintain a calm tone of voice (firm, reassuring, and kind).
- We can do something different (for several minutes): read, or look out the window, or attend to a chore together.
- I help my child bring words to her/his feelings. ("It looks like this is hard for you." "Are you mad/sad/afraid?")
- I talk about my feelings about what just happened. ("When you did that, I felt...")
- I stay with my child until s/he is calm *enough*. (It may take a while for a child to calm down from overwhelming and unorganized feelings. Rule of thumb: Stay in charge and stay sympathetic.)

I'm Calm (enough) and My Child is Calm (enough)

I use the following to support our repair and to make repair easier in the future.

- I help my child use words for the needs and feelings that s/he is struggling with by listening and talking together. (Remember KISS—Keep It Short And Sweet)
- I help my child take responsibility for her/his part and I can take responsibility for my part. (Rule of thumb: No blaming allowed.)
- We talk about new ways of dealing with the problem in the future. (Even for very young children, talking out loud about new options will establish a pattern and a feeling that can be repeated through the years.)

Bottom line: It's the relationship (and only the relationship) that will build my child's capacity to organize her/his feelings. My child's problem may look like something that is being done on purpose. But at its root, it's an issue of needing to reconnect and learning to handle difficult feelings in a safe and secure way. By taking an "I can/we can" perspective ("Together, we're going to figure out what you need") my child will realize that I'm in charge as someone who is bigger, stronger, wiser, and kind. This will reassure her/him that feelings will settle and organize, and the relationship will be repaired.

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Section 11 | Handout 1



Tips for making referrals, offering support during the process, and expanding survivors' access to substance use services

Referral

If an individual is interested in trying out a resource (reinforcing that it is led/chosen by the survivor):

- Help prepare for their first appointment/meeting
 - What can they expect?
 - What do they need to bring (if anything)?
 - What are some things they may be asked or asked to do? How do they feel about participating?
 - We can help them brainstorm how they can respond (as well as how we can help advocate) if they are asked to do or talk about something that they don't feel comfortable doing/talking about.
 - Finding trauma-informed and domestic violence-informed resources can be particularly helpful in this area.
 - What would they find supportive after the first appointment/meeting?
- We can offer in-person support for first meeting(s) including: transportation, watching children (if no childcare available at resource), encouraging the person and helping to increase their sense of safety and connection as they try out this new resource, advocating for domestic violence-informed services and safety needs with substance use provider, providing support, and talking with the person about their experience after their meeting/appointment with the substance use provider.

Section 11 | Handout 1 Continued



Post-appointment support

We can offer support after someone has attended an initial meeting/appointment by:

- Asking about their experience. Below are some examples of open-ended questions we can use:
 - “How did it go?”
 - “What did it feel like for you while you were there? How about afterward?”
 - “Whom did you get to meet and talk with?” (providers and other clients)
 - “What were some of your takeaways?”
- Listen for and affirm the individual’s personal strengths, growth, and values as they share their experience, while also empathizing with any difficulties they express.
 - We can support the survivor in making sense of any potentially contradictory messages, concepts, or skills that they are receiving in substance use services.
- For example, if a survivor shares with us that their addiction counselor is advising them to place their children in their abusive partner’s custody in order to focus on their recovery, we want to offer resources and support to help them make their own decision about the best way to proceed. In this case, we can offer the perspective that children typically do better when they remain connected to their non-abusive parent and offer information on family-based recovery resources that would support the survivor and their children together.

Section 11 | Handout 1 Continued



Tips for expanding parents' access to substance use services

- Offer information on an array of resources (different kinds of services, approaches, etc.)
- Have accessible and multilingual informational materials available
- Have a computer available for survivors to confidentially access online mutual aid support and/or teletherapy services.
- Host substance use support groups on-site
 - We can offer skill-building support groups based on meeting people where they are, for example:
 - **Continuing recovery relapse prevention group** for people already in recovery
 - **Recovery support group for people actively working on recovery skills**
 - **Harm reduction group** for people who are not ready or able to work on recovery at this time
 - **Offer mutual aid groups** (that are open to any survivor who has the desire to make self-defined positive changes in relation to their substance use). There are many different kinds of mutual aid groups. Most need to be facilitated by someone who is a member of that tradition. One exception is SMART Recovery, which offers online facilitator training. When safe to do so, some programs have hosted mutual aid groups that are facilitated by a trusted volunteer or board member who is a member of that mutual aid tradition.

Section 12 | Handout 1



Accessing Positive Caregiving Memories from Childhood to Support Parenting and Caregiver-Child Bonding

This activity is designed to elicit an adult's positive memories from childhood as a means of bringing these experiences into their current relationship with their own child or children. Parents or caregivers who are living in domestic violence shelters or participating in center-based domestic violence program services have found this activity to be helpful in taking steps to feel closer and more connected to their children. The beauty of this activity is that adult caregivers can draw on their own childhood experiences and memories to then experience joy and closeness with their children. It's not something that we have to teach or model, but an inner resource that already exists.

How to introduce this activity

Before you introduce this activity, it's important to have established rapport with the parent or caregiver. It's helpful to have heard directly from parents about their hopes and dreams for their children and talk about any concerns or worries they might have about their children as well as their struggles with parenting under the current circumstances.

Advocates often observe struggles that parents are having in attending to their children's needs after experiencing past and ongoing intimate partner violence and other life stressors. They may notice that parents seem numb, exhausted, and distracted in a way that can interfere with their day-to-day capacity to be present and connected with their children.

When the timing is right, you can ask if they would be interested in doing an activity with you that is designed to bring up good memories from their own childhood and that may help them feel closer to their children right now.

Engaging in a structured dialogue

This activity has been adapted from an interview protocol developed by the Child Trauma Project at the University of California, San Francisco:

Section 12 | Handout 1 Continued



Present the initial inquiry questions and listen to the way in which the person speaks about their memory and the details stimulated by the inquiry. You can use or adapt the **initial inquiry** text below and use a gentle, paced tone to initiate the reflective portion of this exchange. Then, after hearing the person's description of their memory, use the **follow-up questions** to expand on the first memory, explore their wishes for the relationship with their own child or children, and think about how they might use these memories in the future.

Initial Inquiry:

- I am going to ask you about a memory of a time when you were little. You may listen with your eyes open, cast down, or closed (whatever feels most comfortable for you).
- Do you have a memory of a time when you were little when you felt especially loved, understood, or safe? *[If the person is initially having a hard time accessing such a memory, clarify that this does not have to be a memory involving a primary caregiver, parent, or family member. It can also include a memory with a family pet or other animals.]*
 - What is the content of the memory? What is happening? Who is with you? How old are you in this memory?
 - Do you remember any smells, sights, sounds, or other sensations that are connected with this memory?
 - What are you feeling as you remember this time, this person, this experience?

Follow-up questions:

- Do you have another memory involving your _____ *[name or person involved in the first memory]* where you felt especially loved, understood, or safe?
- Are there memories of feeling especially loved, understood, or safe with anyone else? (If yes) Can you tell me about that? *[Use the same probes as above to elicit more detail.]*
- Is there anything from your memories that you might want use in raising your child and to help you bring that kind of feeling to you and your child?

Section 12 | Handout 1 Continued



Before you use this activity, consider the following:

Not everyone will be able to access specific memories from their childhood. If that happens during this exchange, let the person know that sometimes people do have difficulty remembering and may not have memories of this kind that they can easily recall or may not have had experiences like these in their childhood. Reassure them that there are other ways to approach this and to get continued support.

An example of how this was used with a parent in shelter:

A mother of two young children had been living in shelter for about two months and was in the midst of obtaining a permanent order of protection against her abusive partner. She was having trauma-related responses as she recalled and began documenting the history of violence and abusive actions that her partner had used against her and the children. As the legal proceeding was unfolding, the advocate observed that this parent was having difficulty relating and providing emotional support to her 3-1/2-year-old daughter. The advocate suggested doing this structured conversation, and the parent was interested. As a result, she was able to access some positive memories about her own mother. She recalled a few special times when she was able to have time alone with her mother. She was allowed to stay up late after her younger siblings were in bed. She and her mother would cuddle on the couch, eating popcorn and watching movies together on television. Drawing on these specific memories, she decided to recreate these feelings with her own daughter by initiating a special time each week before bedtime to cuddle with her daughter on the couch with a bowl of popcorn while watching a DVD. They both began to look forward to this special time, selecting a “movie of the week,” laughing, eating popcorn, cuddling, and enjoying each other.

Section 12 | Handout 2



Infant Massage (birth to 18 months)

This activity uses touch and relaxation for co-regulation and soothing. Caregivers can incorporate deep breathing skills and gentle calming words into the massage. Infant massage can be soothing for babies and can help with transitions to sleep. Rubbing a baby's back before naps or bedtime can become part of a routine and can help some babies fall asleep.

Recommended age range:

0 years – 18 months old.

Toddler may also enjoy this but may only tolerate it for brief periods of time

Instructions:

The caregiver will be massaging the infant's body for a short period of time. The caregiver can place baby on soft blanket on the floor (*or with careful supervision on a bed*) in a warm room. Caregiver can put some lotion in their hands, warm it, and then gently begin rubbing the lotion on the baby's arms and hands, legs and feet, belly and back, face and head (*avoiding eyes and mouth*). The caregiver can use a calm, soft tone in their voice to communicate with the baby what they are doing and inviting some opportunity for co-regulation and even some language development. Caregivers can be supported in noticing their baby's cues of what might feel good to their baby, what might be too much stimulation, and noticing when baby is done. Caregivers can describe what they are doing "*auntie is rubbing your hands now*" and ask questions: "*does this feel good?*". We can support caregivers in responding to simple cues (*example - if baby is smiling and babbling, caregiver can continue, if baby is breaking eye contact and seems uninterested, caregiver can stop*).

Materials:

A blanket, gentle "*baby*" lotion, warm space

Section 12 | Handout 3



Baby Burrito (birth to 3 years)

This activity uses swaddling, touch, and relaxation for co-regulation. Caregivers can incorporate deep breathing skills and gentle soothing words into the swaddling. Some babies and toddlers enjoy swaddling and others do not like to be confined.

Recommended age range:

0 years – 3 years old. Older toddlers may also enjoy this for a brief period of time.

Instructions:

The caregiver will be using a blanket to swaddle the baby's body for a short amount of time. The caregiver can place baby on soft blanket on the floor or safely on a bed in a warm room and then wrap the corners of the blanket around the baby or toddlers body, keeping face out but arms and legs tucked in. Link for video instructions on swaddling:

<https://www.youtube.com/watch?v=ioISOof-EDpc>

If baby or toddler finds this calming for a short time, caregiver can gently rock and talk softly with baby or toddler and then unwrap the “baby burrito”. The caregiver can use a gentle, soft tone in their voice to communicate with the baby what they are doing and inviting some opportunity for co-regulation and even a little language development. Caregivers can be supported in noticing baby's cues of what might feel good to their baby, what might be too much stimulation, and noticing when baby is done. Caregivers can describe what they are doing “mommy is making you cozy in a blanket, wrapping up your arms and hands now” and ask questions: “does this feel good?”. We can support caregivers in responding to simple cues (example – if baby is smiling and babbling, caregiver can continue, if baby is breaking eye contact and seems uninterested, caregiver can stop).

Materials:

A blanket

Section 12 | Handout 4



Treasure Search and Scavenger Hunt (all ages)

This activity uses creativity, movement, and play to connect caregivers and their children. Caregivers and children can be outside or inside and “search” together for “treasures”. Found objects can be searched for spontaneously or specific items can be identified to search for (for variation on treasure search, see scavenger hunt below). Objects can be used to create a temporary design or create a story about the “treasure”. Caregivers and children can make a permanent collage on paper with glue.

Recommended age range:

All ages

Instructions:

The caregiver and child can explore and search for treasures together. Caregivers can stay genuinely curious and follow the child’s lead and pay close attention to what the child notices. The caregiver can communicate with the child what they are doing and create some opportunities for talking as they explore and search for “treasures”. Treasures might be anything from leaves, sticks, and rocks, bottle caps, feathers, etc.

A scavenger hunt is a variation on a treasure search. Scavenger hunts can be as simple or complicated as advocates and caregivers want. Items to be found can also be basic household items that are easy to collect. Children can be invited to find items by searching through the room or the house for something “soft”, something “squishy”, something made of cotton, something made of metal, something they can write with, something green, etc.

Caregivers can be supported to notice and respond to their child’s cues. We can support caregivers in following their child’s lead and not taking over the exploration process.

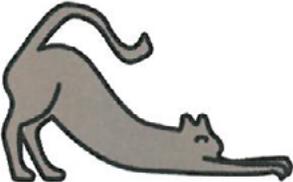
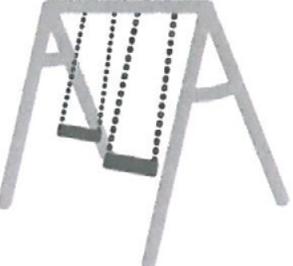
Materials:

For permanent collage – paper and glue, otherwise no other materials needed.

Section 12 | Handout 5

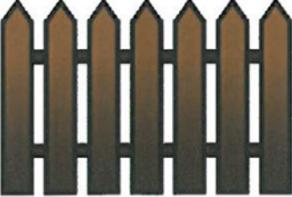
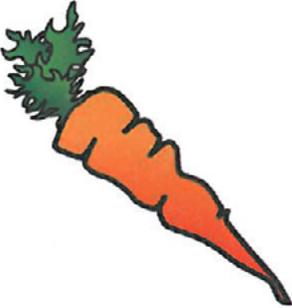
A Relaxing Training Script for Parents to Use with Their Children

When you feel tense, upset, or nervous, muscles in your body tighten. By practicing tightening certain muscles in your body, you will learn to relax them. Now get comfortable!

	<p>Hands and Arms: <i>Squeeze a Lemon</i> Pretend you have a whole lemon in each hand. Now squeeze it hard. Try to squeeze all the juice out! Feel the tightness in your hand and arm as you squeeze. Squeeze hard! Don't leave a single drop. (Hold for 10 seconds). Now relax and let the lemon drop from your hand. See how much better your hand and arm feel when they are relaxed.</p>
	<p>Arms and Shoulders: <i>Stretch Like a Cat</i> Pretend you are a furry, lazy cat and you just woke up from a nap. Stretch your arms out in front of you. Now raise them way up high over your head. Feel the pull in your shoulders. Stretch higher and try to touch the ceiling. (Hold for 10 seconds). Great! Let them drop very quickly and feel how good it is to be relaxed. It feels good and warm and lazy.</p>
	<p>Shoulders and Neck: <i>Hide in Your Shell</i> Now pretend you are a turtle. Try to pull your head into your shell. Try to pull your shoulders up to your ears and push your head down into your shoulders. Hold it tight! (Hold for 10 seconds). Okay, you can come out now. Feel your shoulders relax.</p>
	<p>Back: <i>Swing Up High</i> Pretend you are on a swing at the park. Swing your upper body back and forth, back and forth. To get really high, use your arms to help you swing! Keep swinging! (Hold for 10 seconds). Great. You're all done on the swing. Sit back and relax.</p>

<http://kc.vanderbilt.edu/asdbloodwork/parent/muscletensing.php>

Section 12 | Handout 5 Continued

	<p>Stomach: <i>Squeeze Through a Fence</i> Now pretend that you want to squeeze through a narrow fence. You'll have to make yourself very skinny if you're going to make it through. Suck your stomach in, try to squeeze it against your back bone. Get it real small and tight. Hold it as tight as you can! (Hold for 10 seconds). Okay, you've made it! You got through the fence. Settle back and let your stomach come back out where it belongs.</p>
	<p>Jaw: <i>Chew That Carrot</i> Now, pretend that you are trying to eat a giant, hard carrot. It is very hard to chew. Bite down on it. As hard as you can. We want to turn that carrot into mush! Keep biting. (Hold for 10 seconds). Good. Now relax. You've eaten the carrot. Let yourself go as loose as you can.</p>
	<p>Face and Nose: <i>Get That Fly Off Your Nose</i> Here comes a pesky old fly and he has landed on your nose! Try to get him off without using your hands. Wrinkle up your nose. Make as many wrinkles in your nose as you can. Scrunch up your nose real hard and hold it just as tight as you can. Notice that when you scrunch up your nose, your cheeks and your mouth and your forehead and your eyes all help you and they get tight, too. (Hold for 10 seconds). Good. You've chased him away. Now you can just relax and let your whole face go smooth.</p>
	<p>Legs and Feet: <i>Squish Your Toes in the Mud</i> Now pretend that you are standing barefoot in a big, fat mud puddle. Squish your toes down deep into the mud. Try to get your feet down to the bottom of the mud puddle. You'll probably need your legs to help you push. Squish your toes down. Push your feet, hard! (Hold for 10 seconds). Okay, come back out now. Relax your feet, relax your legs, and relax your toes. It feels so good to be relaxed. No tenseness anywhere. You feel warm and tingly.</p>

Section 12 | Handout 6



Guided Imagery (ages 4 and older)

This activity uses guided imagery as a way to support domestic violence survivors and their children in relaxing, using their imagination, and focusing on themselves. Caregivers and child can be supported by imagining safe spaces “where they can escape during times of abuse” (Binkley, 2013, p. 310). This activity offers a creative collaborative activity for caregivers and children to practice finding calm, safe, happy spaces.

Recommended age range:

4 years – up.

Instructions:

Caregivers and child can be invited to sit in a comfortable position, with eyes closed or lowered if closing eyes is too triggering. Advocates can help family get centered through a deep breath and then simply ask caregiver and child to “imagine a safe and happy place”. The following brief script includes a few questions to help guide caregiver and child in visualizing the place. Remember to pause and give time for caregiver and child to process the question.

- Find a comfortable position and take a deep breath
- Begin by putting aside any worries and begin to relax
- Rest eyes looking down on the ground or close them, if that is comfortable for you
- Take a deep breath and imagine a safe and happy place, this can be anywhere you may have been before or a place you think you might enjoy
- Take a look around, what do you see? Who is with you?
- Focus on what is happening around you? What do you hear? Do you smell or taste anything?

Section 12 | Handout 6 Continued



- Focus in on this place and remember that you can return here in your mind whenever you want.
- Take a last deep breath and bring your awareness back to the here and now.
- What was that experience like for you?
- Open invitation to share about safe and happy place. Caregiver and child can be asked to describe this place in detail to help them be able to quickly and easily return to it mentally again and again.

Pay attention to cues from child and caregiver, watch for engagement during the process, and notice when they become restless, as this may be the time to end the guided imagery.

The caregiver can also be prompted to use this activity with their child. Keeping a gentle, soft tone in their voice, they can invite their child to picture a safe and happy place.

Caregivers can be supported in noticing their child's cues and ending the visualization when child is done.

Materials:

None

Section 12 | Handout 7



Wishes and Fears (ages 4-8)

This activity uses creativity and art to encourage caregivers and their children to share and co-create a visual representation of their wishes.

Recommended age range:

4 – 8 years old.

Instructions:

Caregiver and child will be creating a visual picture of their wishes for their family. Advocates can direct caregiver and child to first draw a house and then write down their hopes and wishes on the paper on the inside the house. Advocates can encourage caregiver and child to also share with each other their goals for their family. Advocates can check in with caregiver and child to see if they want to also write down their fears on the paper on the outside of the house. Advocates can follow the family's lead. This drawing can be decorated and hung up as a visual reminder. This activity can support caregivers and children in focusing on their hopes and wishes for their future together, including some of their goals.

Older children and teens may also enjoy this activity.

Materials:

Paper, pencils or pens, markers or crayons.

Section 12 | Handout 8



Magic Wand (ages 4-8)

This activity uses found objects or household supplies to create a “magic” wand. Caregiver and child will create wands and imagine how they might use magic wands for their family.

Recommended age range:

4 - 8 years. Some older children may also enjoy this activity.

Instructions:

The caregiver and child will use found objects or supplies like a stick, or cardboard from a used paper towel roll as the main wand. Caregiver and child can paint or use marker on the wand and then add string, stickers, beads, glitter or feathers to create their own wand. Child and caregiver can imagine if they had a “magic” wand - what and how they might use it for their family. This activity offers a way for caregivers to support child’s creativity and invite an honest discussion between caregivers and children about their hopes and wishes for their family.

Materials:

Sticks, or cardboard roll from a used paper towel roll. An unsharpened pencil can also work. String, paint, markers, stickers, glue, beads, glitter, feathers, etc.

Section 12 | Handout 9



Emotional Umbrella (ages 9-12)

This activity uses caregiver and child's imagination as an avenue to discuss a range of emotions and their comfort and discomfort with those emotions.

Recommended age range:

9 - 12 years.

Instructions:

The caregiver and child can be directed to imagine they are under an umbrella. They can have their own umbrellas or share one umbrella. Advocate can ask them to describe details of umbrella (*size, color, pattern or design*) or advocate can offer drawing materials and encourage caregiver and child to draw out and color the umbrella. Advocate can direct caregiver and child to imagine that it begins raining and the rain drops falling on the umbrella are other people's emotions. Caregiver and child can discuss which "*rain emotions*" they want the umbrella to protect them from and which "*rain emotions*" feel ok for them to get "*wet*" by. This activity can be a way to increase capacity to understand and manage experiencing difficult emotions from others and visualize a sense of "protection". This activity can create opportunities for caregivers and children to engage in discussions of a wide range of emotions and ways of minimizing the impact of other's emotional "*rain*".

Materials:

None, or paper and drawing materials for option to draw out umbrella and emotional rain

Section 12 | Handout 10

Personal Ads (ages 13 and older)

This activity encourages caregiver and teens to create personal ads about themselves focusing on positive aspects of who they are while sharing about themselves with their family member.

Recommended age range:

13 years and up.

Instructions:

The caregiver and child can be directed to imagine they are placing an advertisement in the paper for each other. Advocates can discuss with the caregiver and teen how their lives have changed due to the domestic violence in their home. Discussion might include how the caregiver and teen themselves have been changes. Advocates can explain that a personal ad in a newspaper is usually someone seeking something, ex: someone to provide care for a pet or someone to help an elder with yard work. The purpose of this activity is for the teen to write a personal ad about themselves seeking a caregiver and the caregiver to write a personal ad about themselves seeking a teenager. Advocates can encourage caregiver and teen to describe themselves and their identity and emphasize their strengths. The ad should also include what they are looking for in a caregiver or teen. This activity can create opportunities for caregivers and teens to engage in discussions of their strengths and their needs.

Materials:

Paper and pens, or pencils. Example of appropriate personal ad if needed.

Section 12 | Handout 11



Family Values Tree (ages 13 and older)

This activity is adapted from Molly Deloris' "Value Tree" activity. Molly Deloris does this activity with adult survivors of domestic violence at Roberta's Place in Grants, New Mexico.

Every family is unique and therefore the values they hold as important are also unique. The development and recognition of values within a family are integral factors in caregiving. When meeting with a family, an introduction to values is given to start "planting the seeds" for the growth of the family value tree. Caregivers can be encouraged to discuss the "seeds" of important values or qualities that were "planted" within themselves as they grew and matured. They can also share the traits and values they want to see reflected in their children. This activity gives caregivers and teens an opportunity to share and discuss family values while engaging in some creativity.

Recommended age range:

13 years and up.

Instructions:

The caregiver and teen will draw a tree together on a piece of paper. Leaves can be drawn directly on the tree or cut out of colored paper. Caregiver and teen will write the individual family value on each leaf and add it to the tree. This can be done during one meeting or over a series of meetings with the family, depending on available time. Caregiver and teen can decorate the family value tree and display it in their room as a reminder of their values. This family value tree can be co-created with caregiver and teen adding the values.

Materials:

Paper (construction paper or colored paper), pencils, markers, and other supplies for decorating.



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