IS IGNORANCE REALLY BLISS?

CHILD WELFARE WORKERS SPEAK OUT ABOUT THEIR UNDERSTANDING OF BEST PRACTICE WHEN WORKING WITH CHILDREN EXPOSED TO DOMESTIC VIOLENCE

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by

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A Thesis submitted to the

School of Graduate Studies

in partial fulfillment of the requirements for the degree of

Master of Social Work

School of Social Work

Memorial University of Newfoundland

May 2013

St. John's Newfoundland

ABSTRACT

The most recent Canadian Social Survey, completed in 2009, reports 6% of Canadians who responded have experienced spousal violence within the preceding 5 years (Statistics Canada, 2011). This research study focuses on child welfare workers' understanding of best practice when working with children and their families after a child has been exposed to domestic violence. A sample of ten social workers within the Nova Scotia child welfare system was selected and interviewed about their experiences working with children exposed to domestic violence. A grounded theory approach using a multi-stage coding process was used to analyze data. The theoretical findings indicate that in child welfare it is perceived that "Ignorance is Bliss". A personal and systematic dilemma faced by child welfare workers is revealed in determining what best practices are, the implications of services on outcomes, and ideas for change in addressing children's exposure to domestic violence.

ACKNOWLEDGEMENTS AND DEDICATION

A special thanks to Dr. Catherine de Boer for providing constant support and guidance during this stage of my journey, as well as the professors and colleagues I met while attending Memorial University. I would like to express my appreciation to the child welfare offices, District Managers, and child welfare staff for allowing me into your world to bring together this research study. Thank you to my husband for being up for the challenge of working together again while one of us goes back to school and all that comes along with it! I also want to acknowledge Ian Robertson who planted a seed as my Undergraduate Placement Supervisor. Thank you for exposing me to the world of post-modernism, I hope to never lose my passion for social change.

My work is dedicated to my younger sisters Brooke and Jillian. My drive and motivation comes from wanting to be a role model for both of you and to show you that regardless of barriers, with the right support, you can accomplish your goals.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

RCMP – Royal Canadian Mounted Police

CASW – Canadian Association of Social Workers

NSASW – Nova Scotia Association of Social Workers

EBP – Evidence-based Practice(s)

DCS – Department of Community Services

WRAM – Washington Risk Assessment Matrix

LIST OF APPENDICIES

CHAPTER 1

INTRODUCTION

A child welfare office in Nova Scotia receives a call from a constable at the local RCMP station reporting an incident she and her partner responded to the previous evening. She reports to the intake worker that a neighbour called the RCMP Wednesday night at 11:47p.m. proclaiming to have heard adults screaming at each other and children crying. She also heard a young voice yell, "Stop hitting mommy". The RCMP officers attended the home and the father had already left the house. The mother was sitting in the living room crying and had a swollen lip and red marks on her arms and legs, which she states were from her husband grabbing her, pushing her up against the wall, and kicking her. There was a vase of slightly wilted flowers broken on the floor in the kitchen. When asked if there were any children in the home the mother indicated the children were in their bedrooms and said, "They didn't see what happened, it started after they fell asleep".

Upon investigation, one of the RCMP officers found a five-year-old boy and eight-year-old girl in the eldest child's bedroom. The little girl was crouched on the floor by her door with a blanket wrapped around her and was awake while her little brother was tucked in her bed and sleeping. No physical injuries were seen on the children, who were wearing full-length pajamas. The little girl's eyes were red and swollen from crying and the little boy had the blankets covering his ears. The RCMP officer asked the little girl if she was okay and she shook her head "yes" and forced a smile.

The intake worker documents the information reported by the constable and asks her to fax the incident report. He then reviews the computer system to determine if there has been prior child welfare involvement with the family and determines that there has

been. Agency involvement began five years ago when the little girl was three-years-old. Over the past five years multiple referrals were made, which were ultimately deemed inconclusive. The concerns reported were parent substance abuse, parent mental/emotional health, domestic violence, and substantial risk of physical harm to the children. In addition, a year and a half ago there were two separate referrals regarding domestic violence and both were substantiated. From the file notes it could be seen that the parents engaged in couples counselling and a relationships program that ended seven months ago. The file had been closed three months ago.

The intake worker writes up the referral and reviews it with the supervisor. In keeping with the child welfare standards with respect to incidents of domestic violence, the referral is assigned a response time of two business days. The file is then assigned to a child welfare worker to investigate.

Although fabricated, the sequence of events depicted above offers a realistic representation of the nature and type of information a child welfare intake worker might receive in situations where there has been a reported incident of domestic violence. My involvement as a child welfare worker subsequently led to my interest in this research regarding the interactions child welfare workers have with children after they are assigned files similar to the one depicted above. The overarching question I sought to answer was, what are child welfare workers' understandings of best practices when working with children exposed to domestic violence? Particular questions I was interested in seeking answers to were:

1. What would the worker's experiences be?
2. What knowledge would the worker have about how exposure to domestic violence affects children?

3. What would a child welfare worker's role be with children exposed to domestic violence?
4. What are workers understandings of both best practice and common practice when working with children who have been exposed to domestic violence?

Background of the Study

My curiosity about this topic came from my five years experience as a child welfare social worker, when I wondered if my work with families where domestic violence was a presenting problem was to the benefit or detriment of children's well being. In situations of domestic violence, and specifically with respect to client self-determination, I often felt my role as a social worker was in conflict with my role as a child welfare worker.

According to Section 1.3.1 of the *Canadian Association of Social Workers (CASW) Guidelines for Ethical Practice* (2005), "Social workers promote the self-determination and autonomy of clients, actively encouraging them to make informed decisions on their own behalf" (p. 4). In the child welfare system much of clients' autonomy is compromised when they are considered "involuntary" or when their behaviours pose a threat to themselves or their children. Social work services and interventions in child welfare are specifically directed by Section 1.4 of the *CASW Guidelines for Ethical Practice* as it speaks to social workers' responsibilities in situations such as those found in child welfare where a mandate guides practice and clients are often involuntary. That said, when decisions are made pertaining to the direction of a file, client self-determination is not promoted in the sense that there are a range of decision-making options for the client which involve either following the directions given by a child welfare worker, or not, and if not, the client will experience

consequences. These consequences can be quite severe and can include the separation of children from parents. Although in child welfare it is necessary at times to enforce decisions regarding the protection of a child, there are also appropriate times and places where self-determination and autonomy can be allowed. Section 1.4.4 of the *CASW Guidelines for Ethical Practice* states:

> In all cases where clients' right to self-determination is limited by duty of care (e.g., client intent to self-harm), the law (e.g., child abuse), or court order, social workers assist clients to negotiate and attain as much self-determination as possible. In particular, involuntary clients are made aware of any limitations that apply to their right to refuse services and are advised how information will be shared with other parties (p. 6).

Additionally sections 1.4.5 and 1.4.6 state that whenever possible social workers notify clients regarding decisions made about them (except where harm may be caused as a result); in instances where clients lack capacity, social workers are responsible for advocating that their interests be represented by a third party. It was my experience that outside of matters that involved the court process it was not common child welfare practice for case conferences to be held with clients, their support people, and service providers to make collaborative decisions regarding the direction of the file. These collaborative case conferences were mandatory and regularly scheduled during the court process, yet not a requirement with cases not requiring court intervention. In situations where domestic violence was being addressed and the court was not involved, the common practice was to hold team meetings with the primary worker, supervisor, and other child welfare staff where decisions were made for the client and direction of the file. That decision was later conveyed to the clients as an already established plan. At this point client choice was limited to whether or not they would cooperate with the presented

plan, with clients being informed that non-compliance could lead to more intrusive actions, including an application to the court to enforce the plan.

In my experience, it has been especially difficult to find the delicate balance between protecting children and maximizing the parents' rights to self-determination and autonomy within a child welfare system that is policy and standard driven. This difficulty was exacerbated by other challenges such as high caseloads, financial restrictions, limited resources, and working within a system that was reactive by nature. I wondered if those same policies and procedures provided the most effective way for child welfare workers to work with children and families and if it resulted in the best outcomes or if something was missing. As a social worker I understood that exposure to domestic violence negatively affected children and I also was aware of the responses and treatment required, however, as a child welfare worker I did not have the time to do the best quality of work I knew I could do with the number of cases I had, and with the resources available to meet the specific needs of children.

I often felt I had limited power to assert the need for change within the system to do the work I wanted to do with families, and I did not always have the child welfare agency supporting what I felt I needed to do as a social worker. On a few occasions a supervisor indicated that I spent too much time with clients, even in situations where I was required to inform a parent that an application was being made to the courts for permanent care of their children and to explain the reasons for the application. My idea of good quality service did not always match that of supervisors' whose primary concern was the total number of files I was expected to carry. I often had to sit with the knowledge that children were still at risk, knowing I could not do anything about it.

Working in an environment where I felt I was unable to do my best work as a social worker led to a lot of sleepless nights.

My knowledge of services available to children and families was passed on to me by workers in child welfare, learned though my collaborative work with other community professionals, and shared by the families I worked with as they spoke about their experiences in the community. My most basic knowledge was that a) exposure to domestic violence affects children negatively, b) violence becomes part of a cyclical relationship pattern between the couple, with periods of relative calm, and c) violence is generational, meaning children who are exposed to violence are more likely to either engage in violence themselves or be victims of violence in their adult relationships. This research was an exploration of what is being done in child welfare with respect to helping children exposed to domestic violence. It was my hope that the findings could help us learn more about what can be done to break the cycle for children so violence need not be an ongoing part of their lives nor a prescription for their future.

Purpose of the Study

In Nova Scotia, the *Children and Family Services Act* (1990) governs the mandate for protection of children. Each province has a similar Act to be followed by professionals to ensure consistency in practice regarding services provided to children and their families, the protection of children, and adoption. There are areas in these Acts that outline potential physical and emotional risks when a child is exposed to domestic violence. In the *Children and Family Services Act* (1990), the need to protect children

based on those risks is outlined under Sections 22(2) (b) & (g). Section 22(2) (i) specifically identifies potential risks associated with repeated domestic violence:

> the child has suffered physical or emotional harm caused by being exposed to repeated domestic violence by or towards a parent or guardian of the child, and the child's parent or guardian fails or refuses to obtain services or treatment to remedy or alleviate the violence (*Children and Family Services Act*, 1990, C.5).

The *Children and Family Services Act* (1990) directs community members, professionals, police/RCMP, and child welfare workers to respond to situations where children have been exposed to domestic violence. Once a situation of domestic violence is designated as requiring involvement from the child welfare system, there are policies and procedures that direct the interventions put in place to support the welfare of the child and family.

This study explored child welfare workers' understanding of best practice when working with children exposed to domestic violence. Child welfare workers in selected child welfare offices in Nova Scotia participated. They were asked to share their knowledge and experiences of best practices when working with children exposed to domestic violence. The primary objectives of this research were:

1. to discover child welfare workers' experiences working with children who have been exposed to domestic violence;
2. to discover the knowledge child welfare workers have about working with children who have been exposed to domestic violence;
3. to discover the role child welfare workers have when working with children who have been exposed to domestic violence;
4. to discover the ideas child welfare workers have about best practice when working with children who have been exposed to domestic violence, and more specifically;
    a) to determine if there is consistency among child welfare workers with respect to their understandings of best practice;
    b) to determine themes regarding the understanding of best practice in a child welfare setting; and
    c) to contribute to ideas and an understanding of best practice in the child welfare system when addressing the effects of children's exposure to domestic violence.

Significance of the Study

According to Statistics Canada's statistical profile on family violence in Canada, 1,140,000 Canadians who had a current or former spouse in 2009 reported experiencing spousal violence in the preceding five years (Statistics Canada, 2011). The number of Canadians reporting spousal violence is equivalent to 6% of the 19,000,000 who responded to the 2009 Social Survey. The reported prevalence of domestic violence in Canada has remained the same since 2004 with the last decrease seen in 1999 (Statistics Canada, 2011). Domestic violence is prevalent across all cultures, as well as all levels of social and economic status (Statistics Canada, 2011).

Considerable work has been put into studying the causes and effects of domestic violence, and determining groups most at risk. Despite advancing knowledge, the prevalence of domestic violence has remained the same. It seems we may never eliminate domestic violence or the magnitude of individual, generational, and societal influences that contribute to the problem. However, as individuals, professionals, and participants in larger systems we have opportunities to influence the practices and policies that govern the responses to domestic violence situations.

In the social work profession accountability is highly regarded and required to ensure continuation of social work as a profession. Guidelines of ethical practice as outlined by national governing bodies, such as the Canadian Association of Social Workers (CASW) and provincial bodies, such as the Nova Scotia Association of Social Workers (NSASW) exist to ensure and maintain the accountability of the profession as a whole as well as the accountability of specific social workers. Child welfare workers are obligated to adhere to their provincial governing body as social workers, and also are held

accountable in their role to ensure the safety of children identified as being at risk. Their accountability is defined by the *Children and Family Services Act* (1990), which identifies a child being at risk when exposed to domestic violence under sections 22 (2) (b), (g), and (i). In the event a child is exposed to domestic violence and the child welfare system is notified, child welfare workers have the responsibility to meet the needs of that child.

This study is socially relevant and has practical importance to the social work profession, as well as individuals, groups, and communities who utilize social work services. The use of evidence-based practices (EBP) or "best practice" (see definition below in the *Definition of Key Terms* section) is one way to encourage accountability as social workers. From my own knowledge and experiences I am aware of evidence-based practices being used in some areas of psychology, health, medicine, and social work. With ongoing use of EBP greater emphasis is being placed on its value and use, which heightens the perceived need for all areas of social work to incorporate these practices. That being said, domestic violence is just one area in child welfare that requires interventions that are effective and result in positive outcomes for children. This study is based on the premise that child welfare workers' knowledge and use of best practices, when working with children who have been exposed to violence, are an important means of determining worker accountability and credibility within both the child welfare and social work professions.

It is hoped that the results will encourage and support ongoing accountability in the child welfare system and the social work profession. In addition, it is hoped that the study will give child welfare workers, who are charged with the vital responsibilities of

minimizing risk for children and providing assistance, a much needed voice. Increasing knowledge of their experiences, their ideas for change as it pertains to their work in the child welfare system, and their role in working with children exposed to domestic violence is a necessary first step. An even greater outcome would be for this study to be used as a gateway for additional research to expand and enhance the findings in different areas of child welfare as well as a continuation of knowledge seeking in the realm of best practices for children.

Definition of Key Terms

Domestic Violence and Exposure

As stated in Nova Scotia's, *Domestic Violence Action Plan* (2009), the Domestic Violence Prevention Committee defines domestic violence as:

> Deliberate and purposeful violence, abuse, and intimidation perpetrated by one person against another in an intimate relationship. It occurs between two persons where one exercises power over the other, causing fear, physical and/or psychological harm. It may be a single act or a series of acts forming a pattern of abuse. Domestic violence can occur in any relationship, however, women are primarily the victims and men are primarily the perpetrators. Children and young people may experience harm by being exposed to violence in adult relationships, being the direct victims of violence, or a combination of the two (p. 1).

Domestic violence can also occur in same sex relationships and exists in transgender and intersex communities (S. Giffin – Intimate Partner Violence Training, Personal Communication, May 9, 2012). The Nova Scotia Department of Justice (2010) defines domestic violence as generally encompassing violent behaviour that causes physical, psychological, or sexual harm within an intimate relationship. It is also stated in *A Statistical Portrait of Intimate Partner Violence* (Nova Scotia Department of Justice,

2010), that spousal violence does not appear as a specific offense under the Criminal Code of Canada however it can be covered under other offenses where there is threat and physical violence.

The term domestic violence is currently the most commonly used term to define violence in an intimate relationship. However other terms such as spousal violence, intimate partner violence, and family violence can also be used. Throughout this study I have chosen to use the term domestic violence because it is the term used in the *Children and Family Services Act* (1990), which is used by child welfare workers in their duties to protect children. At times throughout their interviews participants used other terms interchangeably.

Children's exposure to domestic violence not only includes witnessing the violence as it is happening but also hearing the violence (i.e. yelling, name calling, crying), being told about the violence (e.g. one parent telling the child what the other parent did to them last night), and seeing the aftermath of the abuse and control (i.e. seeing a parent's swollen face, bruises, or wounds, seeing broken objects in the house, holes in walls, or property damage) (Cunningham & Baker, 2007; Meltzer, Doos, Vostanis, Ford, & Goodman, 2009). Ganley and Schechter (1996), outline additional ways that batterers expose children to domestic violence such as: threatening a child's safety by physically abusing the parent who is holding the child in their arms, taking a child as leverage to force the other parent to return home or control their behaviours, forcing the child to watch the assault or even participate in the abuse against their parent, and using the child as a spy through interrogation about their parent's activities and relaying information back.

Evidence-Based Practice

Evidence-based practice (EBP) also termed as "best practice", is a movement towards increased efficacy and efficiency in services that over the past 20 years has infiltrated areas of health and social professions (Charles & White, 2008). According to Chaffin and Friedrich (2004), "funding sources and government agencies are increasingly emphasizing EBP" (p. 1097). With this movement there have been ongoing debates about what best practice is, how to provide it, and its relevance, specifically within our current post-modern landscape. Evidence-based practice in social work is derived from its use in the medical field. With contemporary practice demands there is a need for all professions to prove that what they do actually works (Zayas, Gonzalez, & Hanson, 2004).

Webb (2001) outlines that EBP is about the use of evidence, and the idea that all professional decisions should be based on the best available research. Evidence-based practice in social work utilizes the vast databases currently available to seek out existing research on specific problem areas and specifically social work practices and techniques. EBP seeks universalism and consistency across practices to empirically show effectiveness.

Gambrill (2005) sets out the key steps in seeking evidence-based practices for those pursuing its use. Firstly, one must determine the need for information and determine answerable questions to seek EBP knowledge. The next step is to efficiently find the best evidence to find answers to the questions posed. This evidence is then critically reviewed for its validity, impact, and applicability. The results should then be applied to practice and policy decisions. And lastly, an evaluation of the effectiveness and efficiency of

completing the former four steps should be conducted to determine ways to improve them in the future (Gambrill, 2005).

An assumption of evidence-based practice in social settings is that it involves a process that informs our understanding of the origins and developments of social problems, as well as increases our knowledge of the likely outcomes of service plans put in place for clients (Webb, 2001). In Chapter Four, evidence-based practice or "best practice" will be described in greater detail within the context of social work, its relevance in child welfare, and its presence when working with children exposed to domestic violence.

Common Practice

In my experience working in the child welfare system common practices were passed down between workers within their designated office and at times from colleagues within the larger provincial system. According to Webster's New World Dictionary (1996), the word "common" is defined as widely known or a frequent occurrence. When speaking in regards to common practice in child welfare this would be practices that occur frequently in the context of the work child welfare workers do and that they are knowledgeable about; one example of common practice would be the use of standards of practice in child welfare based from the provincial mandate in the *Children and Family Services Act*. Common practice is not to be confused with evidence-based practice as not all common practices are based upon evidence and research, nor are all evidence-based practices frequently used or known about. In Chapter Three under the heading

Determining practices, common practice will be explained in greater detail as to how it compares to other practice decisions.

Evidence-Informed Practice

Evidence-informed practice is a term used to describe the use of evidence-based practice as a form of obtaining knowledge to enhance practitioner knowledge and experience to make practice decisions (Chaffin & Friedrich, 2004). Evidence-informed practice does not exclusively use evidence-based practice as a means of decision-making. In Chapter Four under the heading *The Best Practice Debate,* evidence-informed practice will be outlined in greater detail as it relates and is compared to evidence-based practice.

Intuitive-Inductive Approach

As compared to evidence-based practice, common practice, and evidence-informed practice the use of an intuitive-inductive approach is a process of acquiring practice wisdom through, "lengthy exposure to similar situations through which unconscious associations are established between certain features of cases" (Scott, 1990, p. 565). In Chapter Four under the heading *Credence Given to Intuitive-Inductive Approach in Social Work Practice,* the intuitive-inductive approach is explained in greater detail and a dialogue is had outlining the importance of practitioner experiences and the wisdom gained from formulating an understanding from identifying inter-relatedness of minor and significant events.

With respect to the organization of this paper, I will first outline the methodology including rationale for the use of a qualitative research method, an outline of the research

design, data analysis techniques, standards of rigour, and lastly the limitations to this study will be provided. Following the methodology, connections and discovery occurs through the analysis of the data and a description of the sample is provided along with key emerging themes of: experiences working with children, knowledge about working with children, role of the worker, challenges and dilemmas, and knowledge of best practice. A literature review follows outlining the effect of exposure to domestic violence on children, an expanded definition of best practice, credence given to intuitive-inductive approach in social work practice, and barriers to following best practice. This paper ends with recommendations identified through the analysis of the data supported by direct statements made by the participants.

CHAPTER 2

METHODOLOGY

This chapter provides an overview of the rationale for qualitative research including a brief comparison to the use of quantitative research. In the research design the sampling strategy, size, and criteria is explained. The sections on recruitment strategies and interview design provide a snapshot of how participants were selected and how the data was gathered. In the data analysis section a breakdown is provided in regards to how the data was analyzed according to qualitative analysis and the strategies used. In the last two sections of this chapter both standards of rigour and limitations are reviewed to outline the trustworthiness of the data along with limitations of the study.

Rationale for Qualitative Research

Qualitative research has become a tool used by researchers to study subjective experiences objectively by comparing the individual experiences between two or more people and formulating an understanding of the interaction (Packer, 2011). With this research I sought to explore child welfare workers' understandings of best practice when working with children exposed to domestic violence. All forms of research have benefits and weaknesses; the question becomes, what will be learned from using a particular perspective? With social studies it can be challenging to quantify thought. One may want to study behaviours of an individual, or viewpoints of a particular group and those types of studies simply would not generate the numbers needed for comparison in quantitative research as was the case with this research study.

According to the American Psychological Association (2003), a common dichotomy between quantitative and qualitative research is that quantitative research is considered scientific, and qualitative research is thought of as relational. Qualitative research places an emphasis on the subjectivity of participant responses and diversity of responses is embraced as a key factor in gaining a "different understanding of truth" (American Psychological Association, 2003, p. 52). With social studies an individual's capacity to express his/her experiences, thoughts, and beliefs can be limited by structured data collection methods found in quantitative studies. With qualitative interview methods dialogue is opened up to allow for a richer context of the topic area being explored. Packer (2011) explains that qualitative research is built upon a philosophical stance that when dealing with human affairs, reality is constructed by those involved and their understanding of reality is based on their backgrounds, and interests. Through the use of qualitative research I sought to gain insight into the similarities and differences of responses each participant had, as well as identify potential variances to their individual backgrounds that could have influenced their understanding of reality as child welfare workers.

With the primary focus being on child welfare workers' understanding of best practice when working with children who have been exposed to domestic violence a research method that could draw out a rich narrative was most desired. According to Webster's New World Dictionary (1996), the word "understanding" is defined as a mental process, intelligence, and having knowledge of and/or familiarity with a particular thing or subject area. This definition suggests a level of subjectivity to the knowledge being sought, as child welfare workers used dialogue to express their understanding and

individual reality. Thus, qualitative research methods were chosen to gain a rich understanding of the experiences, thoughts, and beliefs of child welfare workers when working with children exposed to domestic violence.

Research Design

Sampling

Sampling strategy. For this study a purposeful homogeneous sample (Patton, 2002) consisting of child welfare workers who have worked with children exposed to domestic violence was chosen. This sampling strategy facilitated interviewing as specific criteria could be selected to obtain a sample with enough similarities from which to identify common themes. A reduction in variation amongst the group allowed for simplified analysis with a greater focus on the narrative.

According to Packer (2011), there are three areas within qualitative research in which knowledge is generated. They are: knowledge of the other, knowledge of phenomena, and reflexive knowing (p. 3). This study sought to gain "knowledge of the other" by taking a homogeneous sample (i.e., child welfare workers) and describing, analyzing, and interpreting their worldview, experiences, and language in the context of their work with children who have been exposed to domestic violence.

Sample size. In this study I had a sample size of ten participants from three child welfare offices in Nova Scotia. The size of the sample could be considered a constraint when compared to sample sizes in quantitative research, which typically are based on a comparison of a large amount of data. With qualitative research, sample sizes can range from one participant, for example in a case study that seeks to track changes in an

individual's behaviour when a treatment or technique is introduced, or multiple participants, for example in a study of common beliefs or practices within a specific group. With this study I began with a small number of participants who volunteered to share their experiences with me and I continued to interview more participants until I reached my intended sample size of ten, by this time saturation was achieved as common themes had emerged.

Sample criteria. In order to obtain a homogeneous sample, participants in this study were required to meet specific sample criteria as outlined below:

- He/she currently worked for the Department of Community Services – Child Welfare in Nova Scotia.
- He/she was a registered social worker or social work candidate.
- He/she had worked with at least one family where domestic violence was a presenting problem.

Recruitment Strategies

As a result of my own experiences as a front-line child welfare worker working in the child welfare system in Nova Scotia, Canada and my personal connections, it was decided that this study would take place in the area I worked. This allowed for ease of access between the participants and myself. Four local offices including the one I worked at were selected. The district manager who oversees all front-line child welfare workers of one of these offices agreed to have child welfare workers in the office he managed participate should they wish to. He signed the *Approval for Participation* letter (Appendix D). Information about the study was then shared with the other district managers in the selected locations. Participants from the other offices notified their managers/supervisors of potential participation upon receiving a recruitment email.

The process of recruiting began with a child welfare administration worker sending a recruitment email to child welfare workers in each of the four local offices indicated above. These workers held a variety of positions including: intake, long-term care, family support, children in care, and supervisor/management positions. The content of the email is outlined in the *Email Recruitment Script* (Appendix E). The *Informed Consent Statement* (Appendix C) was included as an attachment to the email and provided details of the study, such as the purpose of the study, procedures, confidentiality, potential risks and discomfort, potential benefits to participants and/or society, payment for participants, participation and withdrawal, and rights of the participant. Child welfare workers were provided with secure password protected contact methods (email, cell phone voicemail) such that if they decided to voluntarily participate in the study they could be assured anonymity. A follow-up email or phone call was made to every child welfare worker who expressed an interest in participating to confirm interest, to assess whether the individual met the sample criteria, and if so to arrange a date and time for the approximately one hour-long interview. Of the four child welfare offices selected I obtained voluntary participants from three.

Interview Design

Data was collected using the interview guide approach (Patton, 2002), meaning the broad topics to be covered in the interview were selected in advance and were covered in each interview, however, the sequencing and wording of the specific questions varied to maximize narrative flow. All questions asked during the interviews were open-ended allowing the participants to share their thoughts and experiences in as much detail as they chose to provide.

In determining the broad topics to be covered in the interview, I first looked to my central research question which was: What are child welfare workers' understanding of best practices when working with children exposed to domestic violence? (see p. 2). I then used the four sub questions stemming from this central research question (see p. 2-3) to provide the basis for the probing questions, which were used to help participants move beyond providing superficial answers to offer data with deeper meaning. The questions within the semi-structured interview guide moved from broad to specific and focused on the following topics: workers' experiences, knowledge of working with children, roles, and knowledge of best practice as outlined in the *Interview Guide* (Appendix A). It should be noted that using consistent topic areas for each interview was helpful during the data analysis process.

To encourage the participants to tell their stories, they were asked to "describe" and "share" their experiences and knowledge. I asked participants general questions initially that were non-directional to avoid leading them to provide me with answers they thought I wanted to hear. When using the probes to ask more specific questions (see the *Interview Guide* in Appendix A), I allowed for a range of answers by asking about

experiences on both ends of a spectrum. For example, the probes associated with the first question concern both the barriers and the factors that facilitate working with children who have been exposed to domestic violence. The probes for the third question concern both the benefits and disadvantages of the services.

The interview guide approach allowed for narrative flow. Participants could weave in and out of the story they created as each question lead into another and built on the existing dialogue. For example, the workers' descriptions of their experiences working with children naturally led to the question pertaining to the knowledge the participant had of engaging children, which then led to a discussion of the participant's role with respect to children and the topic of best practices. Participants had the freedom to build upon their narrative as well as return to points they made earlier if they wished to provide further detail as the earlier point related to the subsequent questions. The final question within the *Interview Guide* (Appendix A) allowed participants the opportunity to process the information provided, and include any additional comments that may not have otherwise fit in the context of the previous four questions.

Confidentiality and anonymity. In this study child welfare workers were asked to share their knowledge and experiences of working with children exposed to domestic violence, the nature of which would be considered typical information that could be shared in professional team meetings as well as outside of their office as a description of their work. Although this study was considered to be of minimal risk there was a possibility that participants could feel uncomfortable sharing professional experiences out of concern of disapproval by management. Confidentiality procedures were put in place to reduce this risk and management was not informed of who participated. Individual

interviews occurred during the participant's lunch break, after work hours, or on the weekend. Participants determined the most appropriate time to meet. Interviews took place in a private room within the agency or away from the office. In child welfare work it is not uncommon for workers to meet with one another regarding cases or for workers to leave the office for lunch or work duties. Hence when child welfare workers left the office to participate in the research or meet with me elsewhere within the office this did not draw attention. Disclosure of participation in the study was left up to the individual participant. All interviews and corresponding interview material were coded numerically and names were not used.

In regards to maintaining the confidentiality of client specific case information, it is important to emphasize that the focus of the study was on the experiences and understanding of best practices from the participant's perspective and not on the specific details of the cases of domestic violence presented. Detailed, identifying, and/or sensitive information about cases was not collected in this study nor shared with others outside of the interviews.

In this study, participants' names or even an alias were not used. However, it could be argued that the demographic information, such as level and type of education, years working in the child welfare system, current role in the child welfare system, gender, age, cultural background marital status, and if they have children, that was collected using the *Demographic Information Form* (See Appendix B) could make participants identifiable. To reduce this likelihood specific demographics were not mentioned in the description of the sample but were introduced in an aggregate form. Also the office locations of the participants were not revealed. Demographics were

gathered and classified using NVivo 8, then analyzed along with the interview data to determine if commonalities could be seen among the participants who shared similar traits, such as level of education, gender, or years of experience. Quotations used in the *Connections and Discovery* section were selected according to their relevance, ability to represent presiding themes or reflect a specific view. A connection was not made between the quotation and the participant who uttered the words nor was a connection made to the demographic group the participant belonged to.

In one circumstance I felt it was necessary to identify a participant's role within the agency to exemplify the significance of what was said. However, prior to including the statements I received the participant's permission to connect his role within the child welfare agency with the quotation. I explained the rationale for doing so and the potential risks in terms of making this particular participant identifiable. The participant stated that he stood by what he said and gave me permission to disclose his position in the child welfare system.

As with all research there can be barriers to anonymity. With this study anonymity may have been compromised by the nature of the content shared. Participants may have been identifiable in their office or community by the views they expressed. For this reason, efforts were made to include workers from more than one child welfare office. In addition, participants were told in the interviews that they could choose the degree and extent to which they answered the questions and could refrain from providing information they felt might identify them.

Data Analysis

A significant difference between quantitative and qualitative analysis is in the development of theory. Quantitative analysis focuses on hypothesis testing whereas qualitative analysis can focus on theory development. The analysis for this research followed the grounded theory approach, which is a qualitative methodology developed by Glaser (1978) that offers a systematic way of producing theory from empirical data. The theory emerges out of the data through the analysis process as the researcher develops general concepts through each stage of the coding process, which Glaser and Strauss (1967), describe as "bring[ing] out underlying uniformities and diversities" (p. 114).

The individual audio taped interviews were transcribed, then coded and analyzed for themes using NVivo 8 research software. I transcribed the interviews and input the data into NVivo 8 then coded the interviews for content and themes. For the purposes of providing guidance with respect to the interviewing process and enhancing the credibility of my findings my supervisor, Dr. Catherine de Boer, reviewed the first several transcripts. She assured me that I was not leading the participants in the interview process and that I was indeed collecting the type of data I intended to collect. She also coded two of the interviews so that we could compare themes and our emerging analysis. This was done to increase the trustworthiness of the findings (see *Standards of Rigour* outlined below). For the purposes of analysis, the demographic information also was entered into NVivo 8 to correspond with the audio recording and transcript of each participant. Through the analysis process connections and themes emerged which are outlined in the *Connections and Discovery* section, yet as indicated above, responses provided were not

directly connected to a particular participant or his/her identifying demographic information.

A multi-stage coding process following the Straussian approach to grounded theory (Strauss & Corbin, 1998) was used. This approach allowed for the development of concepts and the creation of a theory. The first stage involved open coding, which was the process of analyzing the interview transcripts word-by-word, line-by-line, to open up concepts and break them apart further by questioning and comparing what was seen (Strauss & Corbin, 1998). During the open coding stage themes began to emerge and were either eliminated or built upon depending on whether they repeated or were considered one-offs. Some examples of themes that emerged in this stage include but are not limited to: child focus, inability to answer the question, lack of confidence in role with children, narrative experience, need for change, parental focus, patterns, and other ways of practice.

The next stage of the process was axial coding which took the themes identified in the open coding stage and linked them to the relevant subcategories. By way of example I am including one subcategory broken down into its multiple parts:

1. Experiences working with children exposed to domestic violence
    a) Barriers when working with children exposed to domestic violence
        i. Barriers for the social worker
        ii. Barriers experienced by the child(ren)
        iii. Barriers experienced by the parent(s)
    b) Factors that help facilitate when working with children exposed to domestic violence
        i. Facilitating factors as a social worker
        ii. Facilitating factors for the child(ren)
        iii. Facilitating factors for the parent(s).

This then led to the final stage, selective coding where relationships emerged between the data. An example of a relationship that emerged between the data in the axial coding process using the subcategory of, barriers when working with children exposed to domestic violence listed above is as follows:

> There are a multitude of barriers experienced by workers, some of them created inherently by the situation, others by the system and approach taken, and some are experienced on a more macro level within society and the current financial climate.

By integrating the content of the three levels of coding I was able to formalize a theory about child welfare workers' understanding of best practice when working with children exposed to domestic violence. This theory was then enriched and supported using narrative analysis and in particular a socio-cultural version that looks at the interpretive frameworks people use to make sense of particular events in their lives (Grbich, 2007). In this study I was interested in discovering the interpretive frameworks child welfare workers used to make sense of their work with children exposed to domestic violence.

Standards of Rigour

As with all research, whether quantitative or qualitative there is an expectation that the data being presented is trustworthy. The trustworthiness of qualitative data is determined by four components, credibility, transferability, dependability, and confirmability (Andrew & Halcomb, 2009; Glaser & Strauss, 1967; Rossman, 1989). In this section each standard of rigour will be discussed in turn.

Credibility

Andrew and Halcomb (2009), describe credibility as ensuring the integrity of the researcher through the process of self-reflexivity. For research to be considered credible, researchers need "to be sensitive to the ways in which they themselves, in terms of their experience and prior assumptions, and the theoretical and methodological processes, they have chosen, shape the data collection and analysis" (p. 128). It is important that researchers identify their pre-understandings, beliefs, biases, and values about what is being researched at the outset of the study (Andrew & Halcomb, 2009). McLeod (2001) adds, due to the active personal engagement of the researcher throughout the interviewing and analyzing processes of the study it is thought to be inevitable that what is produced will more likely than not, be influenced by the researcher's "approach" (p. 182). This perceived inevitability is encouraged by the belief that the researcher's presence and skill level influences the interviews, and the categories that emerge in the analysis depend on the language and social construct of the researcher.

I was able to reduce the degree of influence on the interviews and data analysis by completing the literature review after all of the data was analyzed and theory development occurred. This diminished the possibility that knowledge I gained from a review of the literature could influence the themes I identified in the data. Once a theory was developed and tested that foundation of knowledge was expanded with information gathered from literature regarding evidence-based practices, and children's exposure to domestic violence. Reviewing literature prior to conducting the interviews could have shaped my understanding of best practices thus influencing the questions asked or the way in which they were asked. If I had specific knowledge from the literature about best

practices the probing questions asked during the interview could have also been affected resulting in the participant being led in a specific direction to get a desired outcome. During the analysis stage, having read the literature in the early stages of research may have prevented me from seeing the perspectives of best practices as they emerged.

Grbich (2007) identifies a criticism of grounded theory in qualitative research when she states, "Existing theories cannot be ignored by avoiding a literature review. The researcher invariably comes to the research topic bowed under the weight of intellectual baggage from his/her own discipline" (p. 81). With that in mind I engaged in self-reflexivity to ensure credibility of the research. One way this was done was by making my assumptions about the research explicit and identifying them at the outset of the research. The assumptions I brought to this research study were:

- What is considered to be best practice in child welfare when working with children who have been exposed to domestic violence is not always done;

- There are discrepancies between what workers see as ideal best practices and what literature says would be ideal.

In accordance with to Strauss and Corbin (1990), I made my assumptions explicit, and thereby laid out discrepancies in thought, enhancing awareness and the ability to critique multiple perspectives. Throughout the analysis I asked myself if what I was seeing was really there or just created by my own knowledge or assumptions. I was able to determine the findings were there by taking each piece of data and the subcategories of the data as a whole and asking myself, what do I learn from this?

Another process I used was expert critique. This is a way to add "to a study's auditability and involves the researcher asking others to examine the data and confirm the

decision-making process and conclusions made" (Andrew & Halcomb, 2009, p. 127). I did this by having Dr. Catherine de Boer review the first several transcripts, as well as code two of the interviews to confirm proper interviewing of participants, and coding of the data sets. Dr. de Boer is skilled in narrative interviewing and qualitative analysis. She is also familiar with the child welfare system and working with children. She ensured that I was not leading the participants and that I was indeed collecting the type of data I intended to collect. By coding two of the interviews we were able to compare the analysis and themes that were emerging. When theory development occurred we shared similarities in thought and came to a common conclusion.

Transferability

Transferability is the degree to which the results of a study in its original context can then be understood and are applicable in other contexts outside of the study area. According to Lincoln and Guba (1985) transferability is established through the achievement of thick description. Thick description could be simplistically defined as the opposite of thin or superficial description. In my efforts to offer a thick description of the data, I described both the experiences of the child welfare workers and the environment in which these individuals worked, such that someone reading this research and who is outside of the system could place the findings with a context. I also found the criteria used by Glaser and Strauss (1967) helpful. I used the criteria suggested by Glaser and Strauss (1967), to evaluate my analysis for substantive formal theory to determine the likelihood of transferability. In this study there is a clear link between the theory and the context within which it will be used to provide insight. However, the theory could have

meaning to those outside of the child welfare system and it could also be applied to other areas of practice in human studies. The theory will empower child welfare workers by providing knowledge to improve their situation. Marshall and Rossman (1989), note that transferability becomes the responsibility of the person seeking to apply the results of a study outside of the original context. Having provided descriptive data regarding the results of my research, the responsibility then falls on the reader to determine if they fit the context of their area of study.

Dependability

In qualitative research, findings are considered dependable when they can be replicated in subsequent studies or if other researchers working independently reach similar conclusions (Lincoln and Guba, 1985). As this is my independent graduate research and an exploratory study I was neither in a position to replicate my study nor was I allowed have someone conduct a similar but independent study with which to compare my findings. What I did to establish dependability was conduct an inquiry audit, which I have described above, under the heading of credibility. The inquiry audit involved having my supervisor examine both the process of data collection (the interview guide and interviewing process) and the products (the transcripts, coding reports, and emerging themes) to determine that my findings were supported by data.

Confirmability

Andrew and Halcomb (2009), explain confirmability as, "whether or not the findings are meaningful and applicable in terms of the reader's own experiences or extend their understanding or personal constructions of a phenomenon being studied" (p. 129). With the use of socio-cultural narrative analysis, each narrative is subject to many readings and interpretations (Grbich, 2007). To ensure confirmability in this study, my supervisor, Dr. Catherine de Boer, reviewed the analysis, themes, and theory developed and she established a greater understanding of the role child welfare workers' assume when working with children exposed to domestic violence along with their knowledge of best practices as compared with common practices in the child welfare system.

Limitations

Purposive Homogeneous Sample

The use of a purposive homogeneous sample in the study could be viewed as a limitation of this study. Black (1999), describes the primary limitation with a purposive samples as being difficult to convey as being representative of larger populations outside of the sample group. In addition to that it can be argued that researcher bias plays a part in the selection of homogeneous sample populations in relation to what the researcher is choosing to study (Black, 1999). With this study I sought sample diversity by sending a recruitment email to multiple offices, and to workers in five different child welfare positions. There were no restrictions placed on gender, age, or culture. Homogeneity was necessary to an extent with this study as I selected this particular sample for a reason - to obtain the knowledge and experiences of child welfare workers. With this study being an

exploratory pilot study it is recommended that further research be conducted in this area, as it would be interesting to see if these findings are consistent across Nova Scotia and even further across all Provinces in Canada.

Interview Guide Approach

A potential limitation of using a semi-structured interview guide could be that the responses by the participants may have been influenced by the need to think of answers on the spot and thus may not have had the opportunity to provide an in depth, thought out narrative. It could also be argued that if participants had more time to ponder their answers in advance they may have provided different responses to convey an ideal image of themselves or the child welfare system. It was my experience in the interviews that participants were providing a genuine response, they responded quickly after briefly pondering the question and gave elaboration to areas they attributed importance to. Participants did not appear to be guarded regarding expressing thoughts that may not be viewed as the most favourable in light of the child welfare system. It was not my experience that participants were being clouded by social expectations or over thinking their knowledge, which was beneficial in obtaining a true understanding of the experiences of child welfare workers. I experienced participants being quite candid with their thoughts, which further supports my belief that the semi-structured interview guide allowed for a true narrative.

An added benefit to the semi-structured interview guide was that it allowed participants to come back to a question that they needed more time to think about, and as they shared their experiences they were reminded of other aspects to an earlier question

and added to it. The interviews were not restricted by time and were estimated as being hour-long interviews based on the amount of questions being asked. Some participants completed their interview in a little over a half an hour and others went beyond the time and shared greater detail of their experiences. The last question on the *Interview Guide* (Appendix A) was, "Share with me any additional comments regarding your understanding of best practice when addressing the effects of children's exposure to domestic violence". Therefore, had any participants struggled with conceptualizing their thoughts on the spot, allowances were given to compensate for different processes of thinking.

CHAPTER 3

CONNECTIONS AND DISCOVERY

This chapter provides a detailed breakdown of the participant demographics along with some connections made in regards to categorical traits shared. Emerging themes are then outlined to further contextualize the experiences and understandings of child welfare workers in their work with children, the knowledge they have working with children, description of their role, challenges and dilemmas, along with their knowledge of best practices. The theory formalized from the analysis findings indicate in child welfare there is a belief that what is not seen or not known does not need to be responded to. This belief has implications on the work that is done with children as well as implications for the individual child welfare workers and the child welfare system as a whole.

Description of the Sample

All study participants (N=10) met the sample criteria, in that a) they were social workers or social work candidates working in Child Welfare within the Department of Community Services in Nova Scotia, Canada, and b) they had experience working with families where domestic violence was a presenting problem. Of the ten participants, three were male and seven were female. The range in ages was 26-62 years, with a mean of 40 and a median of 36. Two participants (20%) were between the ages of 25-29, 2 (20%) between the ages of 30-34, 2 (20%) between the ages of 35-39, 1 (10%) between the ages of 40-44, 1 (10%) between the ages of 45-49, 1 (10%) between 50-54 years old, and 1 (10%) in the 60-64 age range. During analysis I recognized that although participants in the age ranges of 25-39 questioned the benefit of some of the common practices and the

structure of the child welfare system, it was those in the age ranges of 40-54, and 60-64 that acknowledged that the structure of the system needs to change along with the way they are working with children. Those in the latter grouping extended the conversation to possible solutions and a desire to seek alternative practices.

All participants had the minimum educational requirements to be designated and hired as a social worker in child welfare, which in the province of Nova Scotia is a Bachelor's degree in Social Work. However, one participant's highest degree was a Doctorate Degree, while the others had obtained Bachelor degrees. What was more telling than educational levels were the number of years of experience. There was an interesting mix in terms of the number of years of experience each participant had practicing child welfare after they had obtained their highest level of education. Two participants (20%) had more than 20 years experience, 2 (20%) had 10-12 years, one participant (10%) had 4-6 years, 4 (40%) had 1-3 years of experience, and only one (10%) had less than a year. There was less of a spread when identifying the number of years of experience each participant had in their current child welfare position with only one participant (10%) having more than 10 years experience, 1 (10%) with 4-6 years experience, 4 participants (40%) with 1-3 years experience, and 4 (40%) with less than a year experience.

For five participants (50%) their current child welfare position was their first social work position. It was noticed that this group spoke about more creative ways of practice and they did not feel as comfortable with the tendency in child welfare to give a prescribed method of practice. The remaining five participants (50%) have worked in other social work positions in addition to the positions held during their years in child

welfare. These positions included addictions counselling, community development, non-profit work, and corrections/youth care.

The current positions held by the participants included: 1 Intake Worker (10%), 5 Long Term Care Workers (50%), 1 Children in Care Worker (10%), 1 Family Support Worker (10%), and 2 Supervisor/Managers (20%). There did not appear to be a significant difference in experiences, opinions, or practice based on the participants' current position, which could be due to the fact that 60% of the participants had also worked in child welfare positions other than their current position. It is assumed that in the interviews, participants were drawing on their overall experiences in child welfare not just the experiences in their current position. Other positions held have been in the areas of Intake Worker, Long Term Care Worker, Children in Care Worker, and Supervisor/Manager.

With respect to the cultural backgrounds of the participants, 8 (80%) identified as Caucasian. The remaining two participants (20%) fit the physical descriptors of being Caucasian, yet they identified with the specific European locations, from which either they or their ancestors had originated. Likewise these two participants identified as being a cultural minority, while the other eight did not. With such cultural homogeneity I anticipated very little variance in the participants' responses to the role of the social worker, responses to domestic violence, and practices put in place for children based on cultural beliefs. Nothing stood out in the analysis that could be explained solely by the difference in cultural background of those two participants as compared to the other eight.

The majority of participants (70%) were married, with the remaining (30%) identifying themselves as single. There did not appear to be any significance in this trait

when analyzing the participant responses. Fifty percent of the sample identified as parents and of those participants, four had an awareness of the gaps in service and practice provided to children. However their common practices as a whole did not appear to stand out as being different than the fifty percent that did not identify as parents. Of the fifty percent of participants who did not identify as parents, two had an awareness of the gaps in service and practice provided to children.

Emerging Themes

Throughout this section the themes that emerged from the data analysis will unfold and examples will be provided through the use of transcript excerpts from the interviews with participants. In this section themes of participants' experiences working with children will be explored along with their knowledge about working with children exposed to domestic violence. An overview of the themes presented regarding participants' roles in the child welfare system is provided along with the challenges and dilemmas they face within those roles. Lastly, emerging themes regarding participants' knowledge of best practice are explored and all themes within this section are connected through the theory that emerged from the multi-stage coding process and narrative analysis.

Experiences Working with Children

The number of domestic violence related cases each participant had been involved in was positively correlated with the number of years worked in child welfare and more specifically the number of years worked in a front line protection position such as Intake, Long-Term Care, and Family Support Work. A participant in a supervisor/management position gave an overview of the frequency of domestic violence related cases within the context of resource needs and allocation when he said:

> Family violence was probably there in the 70s and 80s, but it wasn't until the 90s that we started to notice it, but it has become the predominant child welfare issue compared to everything else. Sexual abuse is maybe about 10% of our cases, child physical abuse maybe 15 or 20% of our cases, and some of them crossover and are multiple issues/abuse and neglect issues. Family violence is 60% of the cases we are involved in and there are other factors and things going on there. But there's no question that it should be, if that is predominantly where the child welfare issues are then that's predominantly where we should put our resources, and intervention, and help (Interview 008).

Participant 008 also gave a summary of his experiences working with children exposed to domestic violence and the varying intensity of harm that can occur, when he described the following:

> You can hear from the children exactly what they saw, what they heard, what they fear, what they sense happening. I saw them living in homes, some of the, most of the cases the kids were left in the home where there was family violence with concerns of physical and emotional harm. It was trying to weight that, what's the risk of physical harm? I have only seen one child that I know that was [physically] harmed because he got in the way of mom and dad and that was clear. I never otherwise have seen that in all of my years, or known of that as a supervisor as I can recall.

When asked to share their experiences specifically of working with children exposed to domestic violence, only one worker gave a detailed and child focused account. She described the two young children being witness to verbal and physical abuse towards

their mother by their father. She stated, "In a few instances they witnessed her being slammed into the wall and him grabbing her around the neck" (Interview 002). When interviewing the children she discovered that one child had seen the violence whereas the other heard it. One child spoke of her mother telling her to go back to her room. Throughout the research interview this worker continued to refer to this example and in so doing provided a child-centered and detailed narrative.

This worker's descriptive and child-centered account stood in contrast to the other nine workers in the sample, who seemed unable to speak about their work with children with any degree of specificity. It should be noted that when conducting the interviews I made frequents attempts to obtain more detailed narratives by asking for examples; despite my attempts participants responded in generalities. They chose to focus instead on the roles they might typically play or the work they might typically do when working with children. Their narratives were not based on describing actual events but rather the standards of practice. For example, one participant shared, "I would have experienced interviewing them to see what they see, what their take is, how they feel during those moments. Where they feel safe, who they can go to, to talk to" (Interview 004).

The direct interactions with children that were mentioned by the participants included: interviewing the children about the domestic violence incident, spending time with the older kids, and sometimes taking them to appointments (such as counselling). That said, there were few examples provided of direct interactions between the worker and the child and one participant exemplified this when he said, "That depends on the age of the kids, it's really difficult, I think you can spend time with the older kids and whenever they need a program they go to it, but it's a lot to do with the parents"

(Interview 006). Another participant, unable to describe her interactions with children, offered justifications for her limited contact instead. She explained, "Barriers are just time, the amount of workload you have, and the time to get out there and see the kids, talk to the kids, more so talk. I only interact with the kids if I have to, like if there is an interview or something." She goes on further to say, "There's not a whole lot of time to do preventative work, or the deeper work with the kids" (Interview 004). A similarly concerning response by another participant occurred when she too was unable to answer the question and could not provide any information about her direct experiences working with children exposed to domestic violence. She said:

> So I would say I have on my caseload, I have probably dealt with four or five families that have experienced domestic violence. Actually, since I have started I have probably dealt with ten families and with their children and so most of it has been kind of after the fact like the incident might have happened during intake and then I would have gotten the file as a long term worker so I am mostly just working with them with services after the fact. I've only had maybe three cases that have happened on my caseload at that present time that I've gone in and dealt with the kids at that time. And, that's specifically I guess it (Interview 003).

These participants are drawing a connection between their limited contact with children and work place realities, such as high caseloads and limited time. These work place realities are important themes and will be discussed further in the *Challenges and Dilemmas* section in this Chapter.

The child welfare workers that participated in this research described domestic violence as being the most frequently occurring problem in the families they work with and posing risks to children. It therefore seems ironic that these same child welfare workers' direct experiences with children were limited. They had difficulty speaking about experiences specific to the child, and most struggled to remain focused on the child

when sharing their experiences. Focus quickly shifted to parents as that seemed to be an area of greater comfort to speak about, as this is where the majority of their work occurs. During the interviews I used the *Interview Guide* (Appendix A) with all of the fundamental questions intentionally having a child focus, yet the participants' focus frequently shifted to the parents and at times they made no mention of the children. One participant expressed this very challenge when he said:

> We don't do a lot of work with kids. We never have done a lot of work with kids, whether they are at home or temporary care of permanent care. I don't think there is specific recognition of what intervention helps kids. As I've already said we know where we probably want to go with adults, we know with adults you can focus on certain things, we know there is family violence; there are stresses in the home, what can be done to address it, there is family violence, there is substance abuse, there is alcohol, there is drug abuse, there is mental health and you find out why they aren't getting help, all those things contribute to family violence and the relationship between adults. So what do you do with kids? Most of our attention has not been there (Interview 008).

Further narrative dialogue was had with this same participant about the difficulty answering the questions:

> Participant: I don't know if I am answering your question, I am kind of going in and around it… see the problem with your questions, and I don't know if you have run into it with other staff is, and I think this is telling as far as what your thesis is, is that we don't focus on the children, we focus on adults.

It can seem ironic that the participants in this study, who are called child welfare workers and who work for child welfare agencies had difficulty describing experiences working with children and had trouble keeping their interviews child-centered. One participant gave an explanation for this irony when she stated:

> A lot of workshops that I have done are more in regards to working with the parents, again not specific to the children. I guess the idea is that if you change the dynamic with the parents and how they respond to each other and the children, it will benefit the children. When parents do make changes the kids respond, it's a dance; I move you move (Interview 009).

It is believed that providing services to only the parents is sufficient and resources typically are not put in place for the children. The hope in child welfare is that with the right interventions parents will make changes and reduce risk of harm to their children. This may be true but what about the harm that has already been done, how do children process that? What happens when the parents are not able to make adequate changes, where does that leave the children? If child welfare workers don't receive knowledge and training specific to working with children exposed to domestic violence, how can we expect to see change in future generations as these children grow up? These are just some of the questions I am left with and which are heightened by the statement made by a participant commenting on her experiences working with children exposed to domestic violence:

> A lot of the time, for me as an intake worker the work is with the parents, not so much the child. I mean my focus is to make sure that they are safe but I have to do that through the protective parent that is available. So, sometimes that is more so the focus, but I don't find we have enough training or information about that so we can't even provide it to the parents so that they can implement it with their children (Interview 007).

Knowledge About Working with Children

Knowledge of the effects of exposure to domestic violence. Although all the child welfare workers in the sample indicated they knew exposure to domestic violence has negative effects on children, only three participants (30%) were able to identify and discuss what these specific negative effects were. The effects shared by these participants included: increased anxiety, sensitivity, and restlessness, improper or inadequate brain development and changes in brain chemistry, behavioural issues later in life, fear, elevated cortisol levels, physical illnesses, physical harm from getting in between the abuser and the victim, poor social skills, prone to violent and aggressive behaviour, and social withdrawal (Interviews 001, 004, 005). It is noteworthy that these three participants were all currently working in long-term care positions, which can provide an increased level of direct involvement with the child compared with other front line protection positions. Perhaps the increased involvement led to a greater awareness. Even though these three participants were able to identify the effects of exposure to domestic violence on children, it is noteworthy that their answers were also quite limited. For example, the effects they identified are just some of many that can be experienced by children exposed to domestic violence (see Table 1, *Effects of Domestic Violence on Children by Type* in Appendix F, which outlines a comprehensive list of effects of exposure to domestic violence).

Most participants expressed a general understanding of the effects of exposure to domestic violence on children and expressed gaining this understanding from their social work education and child welfare training that "touched" on it. Half (5 of 10) of the participants stated that they sought knowledge on their own by reading books and current

research due to not having enough knowledge in this specific area from social work education and child welfare training. Aside from recognition that domestic violence can have an affect on children of all ages, specific age-related effects were not touched on, nor were gender-related differences. One participant stated, " I understand the immediate and life-long impacts children of all ages/development face when they are exposed to domestic violence can be detrimental. I understand some research suggests it can be greater than most other forms of abuse" (Interview 010). Another participant spoke about Dr. Peter Jaffe's work regarding the impact of family violence on young children, yet this worker was unable to describe specific effects for that particular age group (Interview 008).

One comment was particularly telling in that a distinction was made between effects that can be seen versus those that are invisible. The participant said, "We know that it does have an impact, and it's very difficult because when kids are very young you don't see that impact until they're older, where their behaviour changes or they need some sort of counselling to deal with the trauma that they experienced from hearing or seeing [domestic violence]" (Interview 006). It became a common theme amongst child welfare workers that unless they were able to physically see the trauma or were explicitly informed about it they were quick to accept that the effects may not be there and hence did not require a response. A participant expressed this belief when she said, "Sometimes I see that kids don't appear to be showing any sign of effect of being exposed to it" (Interview 007). Another participant shared, "Children are resilient, some can deal well with that and some don't, and some it's very detrimental, we see the behavioural outcomes from being exposed" (Interview 008). It was common for the emphasis to be

put on the effects experienced by children that can be seen or cause disruptions for others. One participant shared:

> My experience is that some children you just get the whole gamut; you get the whole gamut of kids that don't seem to respond to it at all, that I suspect they certainly are underneath, and then you get the other kids that are acting out. So what I hear about are the problems of the kids that are, the behaviours that I may suspect are as a result of observing domestic violence. But I often hear the complaints from the parents, or I will hear from the school (Interview 009).

The behaviours that were less "loud" and less disruptive for parents and schools were not necessarily identified by the participants as symptomatic of trauma caused by exposure to domestic violence. The behaviours that do not cause a disruption can be both missed and dismissed. Examples of these types of effects that can be missed are: withdrawal, problems relating to other children, insecurity, lack of affection, depression, low self-esteem, overachievement, taking on of caretaking roles, family shame, belief that violence is normal, and acceptance of abuse (See Table 1, Effects of Domestic Violence on Children by Type – Appendix F).

Sources of knowledge. It is possible the challenge in identifying the effects of domestic violence on children is related to the feeling of not having enough training in recognizing the effects of exposure and addressing domestic violence. A lack of training was also noted in the interviews. For example, one participant noted, "I feel that I should know more about the effects" (Interview 003), while another shared her experiences with training and stated, "[I] would have benefitted from more shadowing and more training initially and not later. The training I got regarding domestic violence, I got, I think I was already working a year and a half in the field so I would [have] benefit[ted] from that more earlier on" (Interview 001).

These themes of either the inadequacy of training or in some cases the absence of training, and the improper timing of training might be best understood within the context of the training that is typically provided to child welfare workers within the province of Nova Scotia. All participants in this study had been employed by child welfare prior to May 2012. This date is significant because prior to May 2012 the only mandatory domestic violence training for child welfare staff was an online self-directed module delivered by the Nova Scotia Justice Learning Center. The training was not child welfare specific and took approximately two hours to complete. In May 2012 the Nova Scotia Department of Community Services rolled out a new training workshop entitled, *Intimate Partner Violence Training for Child Welfare Staff.* The two-day training covered a variety of topic areas specific to child welfare workers recognizing domestic violence and reviewing practices to address the violence. The effect of exposure to domestic violence on children was one of the topics covered in the workshop and material was provided including an extensive list of effects by age and gender (Bridges, n.d.). However the primary focus of the training was concentrated on working with the parents. Significant time was spent on educating workers about case plan development and practicing that skill in groups. Although material was provided regarding restorative practices such as using a solution-focused approach in child welfare, it was felt by child welfare staff attending the training that insufficient time was given to the actual intervention (Child Welfare Staff – Intimate Partner Violence Training, Personal Communication, May 10, 2012).

The comments made by child welfare workers about their lack of training seems legitimate as the workers' inability to keep the focus on the child seems to be a reflection

of the training they have received. The *Intimate Partner Violence Training for Child Welfare Staff* did not provide education of child-focused interventions nor how to engage with children who have been exposed to domestic violence. This left child welfare workers with unanswered questions regarding their work specifically with children who have been exposed to domestic violence; one of those questions was in regards to assessing the effects of exposure to domestic violence.

During the study interviews, the only form of assessment identified by participants was the *Risk Factor Matrix*. In Nova Scotia current standards require child welfare workers to use an assessment that was developed in Washington in 1986. This assessment is originally known as the *Washington Risk Assessment Matrix* (WRAM). This is a tool used to determine the likelihood that a child will be abused or neglected in the future, ultimately assessing the level of risk for children within a family to determine the child welfare services to be provided to the family. This assessment can also be used throughout the various stages of the family's involvement with child welfare to indicate if/when risk has changed. The assessment tool is a means of gathering and organizing information to determine the level of risk based on key factors including: child characteristics, severity of child abuse/neglect, chronicity of abuse/neglect, caretaker characteristics, caretaker/child relationship, socio-economic and environmental factors, and perpetrator access. This tool is not specific to the child's needs, rather measures the overall level of risk of harm and does not specifically outline effects of exposure to domestic violence unless they are recognized by the child welfare worker completing the *Risk Factor Matrix*. There is no specific identification process of the effects of exposure to domestic violence other than personal observation and second or third hand reports.

There is no measurement tool used within the *Risk Factor Matrix* to assess the effects of exposure to domestic violence. Child welfare workers completing the assessment learn that there are two methods that can be used to assess risk, an intuitive method and an analytical method both of which form this consensus based model of assessing risk. One participant identified the need for a tool specific to a child's outcomes, he identified:

> I think a specific tool that some of my social workers could do to help them find information about the child and getting an idea, because our legislation talks about repeated, Section 22 (2) I, although that's not really helpful. So if there was something that could help us measure the emotional harm of what's occurred already and the emotional harm of future exposure to violence I think that would be helpful. I think our risk assessment that we do, like the matrix, is probably not specific enough. If we had something that was family violence specific about a child's impact, a child's outcomes specifically, that would be helpful (Interview 008).

The fact that the needs of children exposed to domestic violence are invisible at times to child welfare workers as well as within a commonly used assessment tool, goes to show that a child welfare worker's lens may be deeply rooted in the agency's context.

Knowledge of interventions. Child welfare workers provide interventions to the parents in an attempt to facilitate change within the family system. This common view is very clearly outlined in a statement made by a participant when she said:

> And as far as the children part of it goes, I find it's hard to get services for them; I guess it's especially if they are not in care, trying to request that they need services. Especially if it's just an incident where there's been just emotional, like the yelling and screaming of mom and dad and the impact that that can have on them. I find that it's kind of overlooked, even though we know that that impacts children and just getting them to have the need met and to make sure they are okay. I find that our services are looking at mom and dad and not necessarily at the children (Interview 003).

Another participant expressed the importance of not pathologizing the situation for the child however, shared the same view that services may not be provided where needed for the child when focus is only put on the parents:

> I think that we often sometimes forget about the child in working with the parents. I think there are times that if; I think there's always risk with the children pathologizing the whole thing and so I'm glad when we don't do that and at the same time we often tend to be ignoring the kids, and the impact it has on them. So we have to be able to find a balance there. When do they actually need to have an outlet to be able to talk, or play therapy, or play group, something? And we do have some services available, I'm not sure that we are using them as much as we could (Interview 009).

It is thought that by working with the parents, the benefit filters down to the children, yet child welfare workers are seeing domestic violence as a major presenting problem in generations of families. Child welfare workers acknowledge limited services put in place for the child however express being unaware of an effective way to address the gap in intervention. One participant made a profound comment when she spoke to a lack of confidence in working with children exposed to domestic violence:

> I think we need to look at, I don't have the answer as to what our approach should be, and I just don't necessarily know that we're doing it right. I don't know that we're meeting the needs of our clients, the mom, the dad or whatever, and the children by what we do (Interview 003).

Role of the Worker

Child welfare workers have a socialized belief that they are there to ensure the safety of children. The *Children and Family Services Act* sets out a mandate to be followed by professionals, mainly child welfare workers, which identifies examples of when intervention is required by child welfare agencies to protect children and reduce the level of harm. When it comes to the protection of a child, child welfare workers have an

authority greater than the RCMP to provide intervention. For example, the RCMP do not have the authority to remove a child from their home without the presence of a child welfare worker nor can they search a home without a search warrant. In the event that a child's safety is at risk a child welfare worker can enter a home, if required, as a means to gather information during an investigation.

Child welfare workers take on a professional responsibility in their work with children and families when addressing domestic violence. When asked what their role was when working with children exposed to domestic violence, study participants described their roles as being primarily to ensure the safety of the children and finding services to alleviate future risk to the child. Seventy percent of the participants responded in general terms and stated such things as, "My role would be to assess the situation then direct to services" (Interview 001), "Providing services to the family, ensuring that there is no further violence, and assessing risk" (Interview 002), "My role is to first of all ensure that they're safe depending on the situation and to constantly assess that that has happened and they're to be safe" (Interview 003), and "My role primarily has been to ensure their safety in their home" (Interview 007). However, 30% of the participants went in to greater detail to explain the work they do and the role they assume with children. They expressed such things as:

> So for children, if the children are expressing any sort of emotional reactions or physical reactions (this one child is saying when they start fighting he throws up) you would want to match them up with resources that can help that. So, a counsellor, or a physician, or a children's group through Chrysalis House, or one-to-one therapy, those kinds of things seem to work... Have a plan with them asking, "what things can you do when those kinds of things start happening, where can you go, can you call someone, can you go to someone's house?" Those things can be empowering for the child (Interview 004).

> My role as a child protection worker is to eliminate or minimize their exposure to domestic violence so that may be enforcing that the parents not be in the child's presence together (Interview 005).
>
> My job is to ensure the immediate safety of the child, so my role is to do that and it often means that you make the home safe immediately; that could be the kids leave or the person causing the violence leaves. So it's a short-term fix, in the past [within a different child welfare position] when working with families obviously you do more, you're accessing services (Interview 006).

The first three participants stated their role when working with children exposed to domestic violence was to assess the risk and then provide services to the family to help alleviate future risk. The fourth participant conceded by stating, "At the point that the file would come to me, it would already have been assessed for risk; so I would look at the concerns and try to match up the ways to alleviate those concerns" (Interview 004), then continued to go on into further detail. The fifth and sixth participants had a slightly different take on their initial roles with the child and spoke about the need to reduce the risk of exposure through separation of either the parents together or the children from the family home. The seventh participant touched on a more emotional connection with the child in stating, "My role primarily has been to ensure their safety in their home and that they have the sense of feeling safe and knowing that there is a parent that's going to take steps to protect them" (Interview 007). The following participant spoke more to the second role child welfare workers identified with services when he stated, "My role now as the administrator is to make sure the resources are there so that we can focus the resources to address it whether it's investigation, or with long term, what is involved in intervention, or whether it involves services" (Interview 008). Participant 009 identified her role differently when she commented, "Most of my work is with the parents, it's

really helping the parents to respond to whatever the behaviours are and to their own. I wouldn't say I work much, correction, I don't directly work with the kids very often". The last participant provided details that touched on the challenges imposed by the role of the child welfare worker when working with children exposed to domestic violence; she identified this when she said:

> My role involved investigation and assessing the risk to children. The role of the worker in these cases normally works with the parents, providing education and referral for other services/counselling. The role also involves assessing the parents' change and ability to prevent the children from being re-exposed. This sometimes involves enforcing limitations on families that causes other struggles and the worker needs to be willing and able to address the secondary concerns (Interview 010).

In summarizing the participants' understandings of their roles, they can be broken down into four categories: assessing risk or harm, identifying effects of exposure, making decisions regarding parental separation, and making decisions regarding services. Learning about the workers understandings of their roles leads to a greater understanding about how decisions are made in child welfare. Although the participants spoke about their individual roles, emphasis was continually placed on the connections between individual roles and responsibilities and role and responsibility of the team. For example, all participants shared that decisions regarding a particular family are made in a team setting or in consultation with a supervisor. Only one participant (10%) included the practice of involving the individuals that she works with in the decision making process:

> I do a lot of consultation with my client. To figure out, I have an idea of where I want to go, but if I can't share a goal with them I'm not going to get very far. So it's finding and sharing the goal. Then I put my intervention in place and we are moving in the same direction. I do consult with my clients a lot (Interview 009).

This leaves me with the question, Why did only one participant speak of collaborative work with the parent(s)? Even more concerning, it is noted that none of the participants spoke about involving or informing children (where age appropriate) in the decision-making process, once again indicating the invisibility of children. The reason behind including clients in the decision-making process is not a new idea to social work. Section 1.3.1 of the *Canadian Association of Social Workers (CASW) Guidelines for Ethical Practice* (2005) indicates, "Social workers promote the self-determination and autonomy of clients, actively encouraging them to make informed decisions on their own behalf" (p. 4). Having individuals take ownership of and create their own goals is a factor that helps motivate change and create security with a transparent and predictable process. Why does it appear that collaborative practice with children and families, the hallmark of good social work, is not reported by the participants in this study?

Challenges and Dilemmas

Participants spoke about challenges and dilemmas they faced as social workers in the child welfare system and common themes emerged that were directly related to the discussions about the work they do with children. The most predominant challenges were internal to the system they work within. When participants spoke about where the system structure broke down and impacted their work with children, they identified four common areas: high caseloads, limited finances, rigidity of the system structure, and the reactive nature of the system with limited options for preventative work. Each will be discussed in turn.

High caseloads. The most noted challenge faced by the participants was one created by the workload, including: high case numbers, complexity of files, heavy paperwork demands, and the burden of being responsible for the outcome of each family they work with. Child welfare workers expressed the desire to do things differently and practice in other ways that they feel is best practice, but it was felt that workload challenges typically got in the way of that happening. A profound and refreshing statement was made by a participant in a supervisor/management position, who acknowledged the struggles experienced by child welfare workers on the "front-line" working with children and families and the need for change:

> I think their biggest pressure is caseloads and pressures with the numbers of the cases, the complexity of the cases, the multi-issued cases, and how they manage their time and put attention to cases. They would assess them ongoing and that comes from intake, and there is crisis but once things are put into place and it is not crisis driven then the real difficulty would be how do you maintain good service and quality assurance. The biggest breakdown is the numbers, when the case numbers are high it's hard for them (front-line workers). I also think that a big breakdown is, I've seen it more in the last few years, but there is less direct one-to-one contact with children and with clients directly. There seems to be more, we seem to be driven today more than we have in the past by paperwork, and by making sure we meet standards and documentation, following up with psychologists, and doctors. So we seem to be doing too much social work on the phone and that's not good (Interview 008).

Child welfare workers supported this understanding with their statements about high caseloads. These are just a few of the comments made:

> We would perhaps have limited capacity of doing unannounced home visits because again we are just having a lot of files, caseloads being high (Interview 001).

> I find the paperwork around making the Policy 75 [Policy for contracting out and funding external services] and all that sometimes hold me up (Interview 003).

> I mentioned that the system is ridged, the lack of... the business and I don't mean busy work, just that it's so hectic here sometimes maybe we don't get to talk even

> though I am pretty good at tracking people down if I need to talk to them, but I think sometimes that everybody is so busy that it can be a hindrance to our clients (Interview 009).
>
> A little earlier I said that I think the high caseloads prevent us from including clients in the decision making on their own files, that is one of the biggest areas of the system breaking down because it impacts on the quality of work and the ability to apply best practices. Often times I felt I wanted to do more on my files or try something different but sometimes it just becomes more time efficient to use the same services and put the same plan in place that has been tried out before with other families where domestic violence was an issues (Interview 010).

Limited finances. Limited finances were a topic of debate and viewed as a challenge. For example, one participant said, "financial issues contribute to a lot of weakness in the system" (Interview 001). There was however an interesting contrast of viewpoints expressed between a front-line child welfare worker and a participant in a supervisor/management position. The front-line worker stated:

> There is certainly a lack of services in the community. Money is an issue. There is not enough money to create the programs. The system is more the Provincial agency having the funds and knowing where to put the money when it comes to domestic violence. It's a big big discussion and I've got to say this on tape that first the Department of Community Services is an agency that doesn't have a lot of money; so that in itself is a problem. Unfortunately right now if there are programs there's not going to be more, there's not enough. We need to probably do more child welfare on teams, maybe there needs to be more training. There needs to be more money spent on the whole topic (Interview 006).

In contrast, the participant in a supervisor/management position said very confidently that, "Money is not a barrier, because we will find it, if the services have to be provided we will provide it" (Interview 008). These differing views create curiosity about how and why the messages about finances are viewed in such a different way by front-line and management levels. What are the front-line child welfare workers experiencing that have

lead them to express finances as a significant barrier in the work they do with children exposed to domestic violence?

Rigidity of the system structure. The structure of the child welfare system was seen as a benefit by 70% of participants specifically in regards to having a mandate through the *Children and Family Services Act*, allowing workers to intervene to ensure the protection of a child. However participants questioned the effectiveness of following a mandate that comes with rigid policies and standards of practice for children and families. One participant spoke of this struggle and a desire for an answer of what would be best for children, she said:

> The breakdown occurs in the bureaucracy and ability to be adaptable with each case, I think the rules are the rules and policies are policies and it's difficult to stray from that any, and you really try to stick with what's been laid out. I think we need more flexibility with that, although I also see the danger in that. My opinion may be different than somebody else, so you do need some rigidness but it would be nice if we could gain more studies on kids who have grown up in domestic violence homes and asked them: Was this good for you? Was that a good thing that happened? Was that a turning point in your life when he was sent to leave? (Interview 004).

Another shared the struggle of working within a rigid system regarding policies and procedure when she shared:

> We're all of a sudden saying that you can't be together. Then how does that parent get access to the child, and do they need to be supervised, and the child all of a sudden has dealt with this domestic and now we're separating which is another crisis. In some cases it's very necessary and I get that and I would totally enforce that but, it's when sometimes that might not be necessary but we don't have that leeway of necessarily, cause we're stuck by our standards required of us and we have to show that we're meeting that risk and that we're doing all these things to alleviate risk (Interview 003).

Reactive nature of the system. Another challenge experienced by the child welfare workers, which subsequently has an impact on the children they work with, is the availability of services and more specifically preventative services. Participants questioned the effectiveness of the services provided for children. One participant acknowledged the challenge with services when he stated:

> This is a difficult area of work to respond to as a child welfare worker, especially if you're on intake because you make sure of the child's immediate safety, which is important but it's really getting the family or the children the help that they need. So the first thing for me is just the fact that there is not a lot of consistency in how to deal with it, how to respond to it. I mean it's very structured as far as being an intake worker but really from the bigger picture how do you respond to these situations, what services are out there for families who need to pull through and repair themselves? (Interview 006).

Another participant expressed a need for a different way of practice and greater availability of services when he said:

> We rely on reports in the community, so we are really reactive rather than proactive. I know that we are just part of the system and there are proactive elements out there but in my experience they are far and few between and underfunded. So we are a well-funded reactive part of the system so we are coming in after the fact rather than doing it much proactively as far as developing community awareness around the risk of domestic violence. So that's a big hole that we are reactive, and we're relying on one we close a case we just go back to the reactive system where there's not much follow up or there's not that where we can hand things back to the community that parents can go to, we only pay for it while the risk is there and we are satisfied that the risk has been alleviated. There's not much in the community that parents can go to when things are in trouble and they go back to being at risk, to falling apart. That's not just domestic violence that's for all kinds of things across the board. Those are a few of the cracks I see (Interview 005).

A third participant spoke about services in connection to the difficulty providing services to families that voluntarily request help:

> I'm there to reduce risk in the home so children can be safe. The system, it comes in and it's got to fit under the act. If it doesn't fit under the *Act* we're not there as much as voluntary services. This office is busy so, we aren't able to meet the

> request for voluntary service very often, unless we connect it to a clause (Interview 009).

Determining practices. One dilemma faced by child welfare workers is that of whether to follow standards of practice including common practices, an intuitive-inductive approach, evidence-informed practices, or evidence-based practices. Standards of practice include the standards and guidelines outlined in the *Children and Family Services Act* (1990). Common practices are developed from the interpretation of the *Act* as well as practices that have been shaped over time by the child welfare workers, supervisor/management staff, and the culture within individual child welfare offices. In regards to an intuitive-inductive approach, I have learned that intuition is a combination of knowledge and experience (L. Bird – Professor, Personal Communication, February 2005). Schon (1983) describes the intuitive process as first, "knowing in action" which involves spontaneity of skillful practice with some knowing in action being based on knowledge that has become internalized (p. 51). Secondly and most importantly this intuitive process involves, "reflection in action" which involves improvising or "thinking on one's feet when faced with an uncertain or unique situation" (Schon, 1983, p. 68 as cited in Coady & Lehmann, 2008, p. 59). Schon (1983) describes the intuitive process of "reflection in action" as inductive reasoning to "construct a new theory of the unique case" (p. 68). And lastly the use of evidence-based practices is a process of policy and practice development based on techniques and practices, which have been shown to produce effective outcomes through the use of research (See *Literature Review* section).

A trend emerged from the study interviews. Participants spoke most frequently of standards of practice and common practices ignoring their own ideas and an Intuitive-

inductive approach. That being said, they questioned the effectiveness of common practices, yet did not seem to have a true understanding for evidence-based practices emerging through research. When making decisions regarding separation of parents after domestic violence incidents, service delivery, and child welfare intervention participants often had ideas of what may be "best practice" based on their knowledge and experience however this was ignored and replaced by common practices such as immediate separation of the parents in the presence of the child, implementation of the same community services regardless of waitlists, and reactive approaches to child welfare intervention. In summary, the themes regarding the understanding of "best practice" in a Child Welfare setting included:

- Child welfare workers looked to what the system tells them and what others are doing before they listen to their own intuition.
- Although common practices are not always felt to be best practices, child welfare workers continued using familiar models.
- Ideas around best practice when working with children exposed to domestic violence were built around working with the parents and not the children.

Knowledge of Best Practice

With this research I sought to discover the knowledge child welfare workers had about best practices when working with children who have been exposed to domestic violence. I found a significant discrepancy between what child welfare workers believed best practices to be versus what their common practices were. Their ideas of best practice were wrapped up in social work values as well as their personal values, and the situations at hand. An example of this is shown in the dialogue one participant shared when she spoke about her understanding of best practices:

> I would say to be flexible, you have to be adaptable, and so it depends on the situation. Sometimes I feel like when things are heated if I'm there and the guy is being very defensive, sometimes it can be an empathetic approach with him to try to just get him to calm down and start to agree to maybe going to a service and trying to get him to look at it that it's going to benefit you, "How is this going to benefit you?" For the female it's empathy in that, "Tell me how you're feeling tell me how difficult this is," and trying to empower her. I think really being truthful in what the risks are for them, what the consequences may be I think that's best; to pussyfoot around is not doing them any good. To really set it out for them, so this is what the effects are going to be on your kids if that continues and this is what we have to do, those kinds of things like, "you could die, it's that serious", is definitely what is needed; a more upfront approach. I think being able to not get caught up in the emotions and being able to keep your own calmness and try to not automatically believe everything that is being said, but take it into account, there are always three sides to every story. It's never just that way it's presented by one person. There is always a third truth. I think really constantly keeping in mind what is best for the child, what do they need. And a strengths approach too, trying to work on those things, and a lot of times domestic violence I find that it's environmental factors that are creating so much stress on the home that's the reason which most often is the finances. You can't pay your bills, you're stressed out at home, you can't meet the needs of your kids, then they just start fighting with each other (Interview 004).

However, when that same participant shared her role as a child welfare worker and what is done regarding best practices she reverted back to system driven practices that were stated more like a checklist rather than a rich narrative:

> My role would be primarily to try to alleviate the risks that have already been assessed but most of the time when it's a long-term file another referral may come in, another incident may come in in the middle of it. So then, my job would be to investigate that. I would talk to the child, interview the child, find out what they saw, what they felt, what they heard. Then the cycle begins again of assessing that risk. My role would also be that if the risk is too high and the parents aren't co-operating or unable to co-operate we may have to take it to court so my role would be to represent the Minister in trying to take care of the best interest of the child at court and representing our side to the judge...
>
> Safety plan, safety plan for both the male and the female, what's he going to do, and that's another assumption. I'm assuming that the perpetrator is the male. But for whoever the perpetrator is safety plan of what are you going to do when you start getting frustrated, are you going to walk away, where can you go, can you stay at someone's the night, what can you do besides hitting and punching? For the female, when you start recognizing it's working up where can you go, how can

> you stop it, if she's trying to leave the situation what are you going to do when your phone rings and you realize it's him, what are you going to do to keep him from coming to your house, thinking about being bored and wanting to call him. For the child same thing, what are you going to do when you hear the yelling, where are you going to go to, who can you tell, where can you go to stay safe, can you go to a room? (Interview 004).

It should be noted that common practices are not necessarily best practices and vice versa. When expressing their ideas around best practices I experienced that participants were speaking of practices that would ideally be done however, it was stated that this is not always the case. Participants expressed best practice techniques that child welfare workers can acquire in their work with children to be: being flexible, not using the same approach with every family; offering practical supports such as transportation, child care, financial support for resources in the community; showing empathy, being understanding and non-judgmental of choices made; being honest, explaining the process from the beginning and what can be expected; staying neutral and calm, not taking sides and being open to new points of view; using a strengths based approach, acknowledging what parents are good at; remaining client-focused, asking parents and children what they need and what would be most helpful for them; allowing/creating a safe environment for children to talk and spending time with the children in that safe place; incorporating humour, life doesn't always have to be so serious; taking the least intrusive measure, not jumping to the immediate reaction of removing a child from their home or separating their parents; allowing for self-determination, including individuals in creating their own goals and identifying the services that would be most helpful for them; providing supports for children, not forgetting about the children when it comes time to implement resources;

and developing good quality service plans, do not give families a prescribed list of services tailor the resources to the family's individual needs.

Similarly practices that can be accepted by the child welfare system to support best practices carried out by child welfare workers are: weighing the impact of every decision being made as to how will it impact the children; and trying a holistic approach, working outside the child welfare system collaborating with other disciplines in a more proactive manner. The child welfare system determines the assessment approaches used by child welfare workers and participants expressed assessment as a component to best practices. The assessment approaches participants determined as being essential to best practice are: monitoring and assessing risk to ensure the child's safety, ensuring that things are done in the best interest of the child, developing consistency in assessments and practice, and developing or implementing an assessment tool for children.

When speaking of their common practices with children exposed to domestic violence eight participants (80%) reverted to speaking about standards of practice and what is "typically" done according to guidelines. For example, one participant said,

> Short-term intervention is to not have the parents be together and then offer services that will alleviate the risk of domestic violence re-occurring, with the goal of the child returning home provided that the risk can be alleviated. If it's not alleviated then we have to look at more permanent planning for the child which may include a separation, or if the parents aren't willing to separate then permanent care in the long term (Interview 005).

Only two participants (20%), "stepped outside the box" and spoke about what the child welfare worker can do specific to meeting the needs of the family and child. This dialogue encompassed values with a client-focus, and provided examples of personal qualities needed by the child welfare worker to meet the needs of their clients. The

comments of these two participants were more reflective of best practices than common practices. For example, in Interview 003, the following was shared:

> I try to build a relationship with them. I don't just rely on the services; I try to see what I can offer them as a protection worker as well and what they need from me. I try to build that relationship with them and the children. So if there's been even something like a verbal domestic, my recent experience is that, "oh there's a domestic and they need to separate, and they need to deal with these issues." I find that sometimes that might not always be in the best interest of the child. Often by asking parents to leave, that presents a whole realm of issues; now they've gone from a two-parent home to a single parent home and there are so many things that come along with that.

The other participant expressed similar ideas about the need for flexibility:

> I would say to be flexible, you have to be adaptable, and so it depends on the situation. Sometimes I feel like when things are heated if I'm there and the guy is being very defensive, sometimes it can be an empathetic approach with him to try to just get him to calm down and start to agree to maybe going to a service and trying to get him to look at it, that it's going to benefit you, "How is this going to benefit you?" For the female it's empathy in that, "Tell me how you're feeling, tell me how difficult this is," and trying to empower her (Interview 004).

The majority of child welfare workers spoke about what is done with the parents not the child and decisions they make based on policies, standards, and guidelines. These ideas about best practice are passed on to new workers, who then tend to assimilate those ideas into their own best practice model. Even though many of the child welfare workers spoke of a common practice being to separate the parents in the presence of the child until services are completed, many shared feelings of not knowing whether the best practices imposed by the child welfare system were in fact in the best interest of the child. It was said that setting up a referral for services could take weeks to months then followed by months to complete the services. Child welfare workers wondered if the prolonged separation of parents and the added stresses that comes with single parenting increased

the trauma experience for the child. Examples of this quandary are reflected in the following two quotations:

> We're all of a sudden saying that you can't be together; then how does the parent get access to the child, and do they need to be supervised, and the child all of a sudden dealt with this domestic violence and now we're separating which is another crisis (Interview 003).

> So if we've separated families, then there are expectations that services are put in place in a timely fashion, and I think that in the best interest of the child, I sometimes wonder if having separations for the lengths of time that sometimes occur are really in the best interest. It's a question... (Interview 009).

The child welfare workers who participated in this study had ideas for best practice that were very much aligned with the social work code of ethics. However, they found themselves not following an intuitive-inductive approach due to time restraints, high caseload demands, and policies of practice imposed by the system. Their intuition was often ignored. Child welfare workers spoke out about a different way of practice however they felt as though the structure of the system and the demands of the job were preventing them from implementing their ideas of best practice. This feeling was strongly expressed when the following participant said:

> A little earlier I said that I think the high caseloads prevent us from including clients in the decision making on their own files, that is one of the biggest areas of the system breaking down because it impacts on the quality of work and the ability to apply best practices. Often times I felt I wanted to do more on my files or try something different but sometimes it just becomes more time efficient to use the same services and put the same plan in place that has been tried out before with other families where domestic violence was an issue. I also said earlier that the worker client relationship is an important factor that benefits the work being done and with a system that supports high caseloads you don't have the ability to build those relationships and therefore the outcome may be different for families (Interview 010).

Child welfare workers know that best practice when working with children who have been exposed to domestic violence is about ensuring the safety of the children.

However beyond that they lose sight of what other practices can be put in place to benefit the child in a proactive way. Participants had difficulty sharing their knowledge about working with children exposed to domestic violence. For example, the following participant was unable to identify and share her knowledge of best practices and instead referred to where she gained the knowledge while also expressing her perceived lack of knowledge:

> Once again that is just kind of gained from our core training; I would have got some information there. I took a child development course in university. It was touched on there; I think it is an area I want to know more about. I feel that I should know more about the effects. I guess too I sat in on a meeting with one of the counselors that does the Boyd and Pick thing [Positive Relationships Program] and just talk about what they tell clients and the type of information they give so that was really beneficial for me (Interview 003).

Participants showed they were lacking this knowledge and expressed feeling under trained specific to working with children exposed to domestic violence due to the limited focus in the training they do receive for the job. When asked about her knowledge working with children exposed to domestic violence a participant reported, "The training that we get through the job like core training teaches us about working with families. I don't think there was specific focus on domestic violence though. I know that it impacts the children in a lot of ways, behaviourally sometimes and fear" (Interview 002). Another participant voiced the following:

> I don't think that there is enough out there to help us work with children. In my opinion, I don't think I have enough. I find that that is something that is lacking in the training or support services that we have. Sometimes it's kind of through exposure (Interview 007).

Child welfare workers shared their perspective about their knowledge or lack of it in some cases, their ideas around best practices and common practices along with their

views of what was or was not in the best interest of children. They shared information about what helps them to do their job along with the benefits to children and families, and they also shared their challenges and the dilemmas of whether to follow standards of practice or incorporate an intuitive-inductive approach. From their narratives I am left with an understanding that child welfare workers are still social workers and that being said, they have an immense capacity to support and encourage change through their knowledge and experiences, beliefs and values. What I am stuck with is the question, if social workers have the capacity to support and encourage change, and they have a desire and see a need for change, why are things remaining the same?

Ignorance is Bliss

In 1742 a man named Thomas Gray wrote a poem ending with the phrase, "Thought would destroy their Paradise./ No more; - where ignorance is bliss,/ 'tis folly to be wise" (Mitford, 1836, p. 10). The saying, "Ignorance is bliss", has stood the test of time and to this day continues to be a saying used in modern dialogue, philosophical debates, and as a common proverb. The phrase, ignorance is bliss suggests that a lack of knowledge in some instances increases happiness, or that you cannot be hurt by what you don't know. This sentiment, ignorance is bliss serves as a suitable summary of what was disclosed throughout the narratives shared by the child welfare workers when speaking of their work with children exposed to domestic violence. Even though one could argue that if there is recognition of the problem there cannot be true ignorance, it can also be said that the choice to ignore is ignorance in itself or a willed ignorance.

The theory that emerged from the multi-stage coding process and narrative analysis can be summarized in the following way: what is not seen, acknowledged or claimed as knowledge does not need to be responded to, with that, ignorance is bliss. This theory is reflected in the language and the actions described in the interviews. Specifically, when the needs of children who have been exposed to domestic violence are not seen, acknowledged, or claimed as knowledge by child welfare workers, these workers do not then need to take the responsibility of responding to them by providing services, treatment, or meeting the needs of the children. A participant in a supervisor/management position stated:

> You get the barrier of not knowing what they have been exposed to, the extent of it, and the extent of emotional harm. For social workers there are not enough of them, and there is not enough time so they end up doing work that is compromised (Interview 008).

There is a sense that there is more that needs to be done, or a different way of practicing. However, there is a willed ignorance on the part of the system by failing to make the changes necessary and on the part of the child welfare workers by continuing to work within the confines of the system. Agency protocols, whether intentional or not, are working to keep workers ignorant and protect them from "seeing" and hence being responsible. When examining the theory that within child welfare it is believed that ignorance is bliss, my mind reverted back to a short answer quiz I wrote in a philosophy class in 2004. My conclusions now are very much the same as they were then, when I wrote:

> Bliss could be defined in many different ways depending on someone's subjective opinion. It could be defined as a continuous state of the emotion of feeling happiness, being carefree, peacefulness, contentment or not worrying. Regardless of how it is perceived there is a general consensus that it is a continuous positive

> feeling. When defining ignorance it is seen as a lack of knowledge or understanding. Some people may believe that ignorance is bliss because there are some things they would just rather not know about; they may claim, "Whatever I don't know won't hurt me". Choosing to ignore something does not mean it doesn't exist... If you choose to ignore or not believe something regardless of the facts it is then considered willed ignorance. The lack of knowledge may make you feel carefree or contentment, but the feeling only lasts for a short period of time as awareness is gained. Eventually the feeling fades away therefore ignorance is not a state of bliss (Curiosity, Imagination, & Thought Quiz, December 2004).

Child welfare workers are aware of the effects exposure to domestic violence can have on a child, and express being aware of the need for services for children yet there is a lack of recognition or knowledge of services available and even less dialogue about their use with children. This further accentuates that children have become invisible within the child welfare system and best practices for children are not understood. Participants have, and continue to experience the challenges as child welfare workers including the challenge of whether to follow common practices using the guidelines of policies and standards, or an intuitive-inductive approach and knowledge of best practices. The notion that what is not seen or known does not need to be responded to gives a false sense of not having to take responsibility for the outcomes of children. The guise of providing services only to the parents to address multi-generational issues gives a false sense of reassurance that the problem has been addressed. And the compliant nature of working within a system that creates barriers for competent work gives a false sense of not having a professional obligation to children. In the world of child welfare, ignorance is not bliss.

CHAPTER 4

LITERATURE REVIEW

In this study I chose to conduct the literature review after the collected data was analyzed and my theory was developed to reduce the degree of influence on the interviews and data analysis. I did not want the knowledge I gained from the literature review to influence the themes I identified in Chapter Three. When conducting qualitative research there are two schools of thought guiding literature review. Shank (2002) and Glaser (1978) outline the different approaches that can be taken with one being a review of the literature before collecting the data, and the other being a review done simultaneously with the data collection as well as after. As with most methodological decisions in research, the timing of the literature review is dependent on the purpose. If the literature review is required to assist in formulating the research question it needs to be conducted before the data collection (Shank, 2002). Glaser (1978) outlines the alternative suggesting that if the literature review is required to stimulate new insights it needs to be conducted after the data collection. This approach also helps to enhance the credibility of a study (see *Standards of Rigour* section above) as well as protect against bias, which were the main reasons why this approach was selected.

From the findings in this study I was able to determine areas, which required further exploration. This literature review has served to stimulate new insights and support the findings in the following topic areas: effects of exposure to domestic violence on children, best practices, intuitive-inductive approach, barriers to following best practice, and child welfare workers' experiences in addressing domestic violence. The first topic area explores the types of effects experienced by children exposed to domestic

violence, which include mental, physical, and emotional/social effects. The second topic defines and compares best practices as a social worker and child welfare worker specifically when working with children exposed to domestic violence. The third topic explores the role of an intuitive-inductive approach within best practice, and the final two topics navigate through the barriers of using best practices within child welfare and specifically when addressing domestic violence.

As I explored the literature I found there is a substantial amount of research on the prevalence and implications of domestic violence however, very little that speaks specifically to interventions for children exposed to domestic violence. In Nova Scotia there is a *Domestic Violence Action Plan*, and *A Statistical Portrait of Intimate Partner Violence*, but no working model of best practices when working with children who have been exposed to domestic violence. From this study it is evident that child welfare workers have a desire for information about best practices when working with children yet they experience barriers that prevent them from actively moving forward in gaining that knowledge.

Effects of Exposure to Domestic Violence on Children

Research shows that children's exposure to domestic violence causes consequences that last a lifetime. Osofsky (1995) outlines that children learn behaviours from their environment and when they witness violence in their home it may become a precursor for violent or high-risk behaviour later in life. Violence becomes an accepted means to interact in intimate relationships, and resolve conflict, which then becomes a "part of an intergenerational cycle of violence" (Osofsky, 1995, p. 5). Participants in this

study recognized this intergenerational cycle of violence as they expressed the prevalence of domestic violence in child welfare. Meltzer et al. (2009) identify circumstances that are independently associated with an increased chance of being exposed to domestic violence, which include: older age groups, mixed ethnicity, physical disorder, multiple children in the family, divorced parents, living in a rented accommodation, living in low economic status neighbourhoods, their mother's emotional state, and additional family dysfunction.

When assessing the effects of exposure to domestic violence on children there are according to Osofsky (2003) a number of factors that must be considered. These include the "proximity to the violence, familiarity with the victim/and or perpetrator, the child's temperament, developmental stage, severity and chronicity of the violence, and support available to moderate the effects of violence on the child" (Osofsky, 2003, p. 164). Participants in this study spoke about an "assessment of risk" also known as the *Washington Risk Assessment Matrix* (WRAM) which includes similar factors, however, the assessment tool measures the level of risk to a child and is not specific to assessing the effects of exposure to domestic violence. It was suggested by some participants that an assessment tool specific to children is needed in child welfare.

It is important to note that the negative effects experienced by children who live in homes where domestic violence occurs are not only caused by witnessing the violence. Effects are also caused by the child trying to make sense of violence occurring between people they trust, seeing the effects on the victim (wounds/bruises), seeing damage to the home (holes in walls/doors or disarray), living in a stressful and non-nurturing environment, having contact with child welfare services/law enforcement/hospital

personnel, and trying to figure out why the people who are supposed to protect and nurture them are placing them in harm's way (Carpenter & Stacks, 2009; Osofsky, 2003). These considerations are not always made through the use of the WRAM as the information gathered can be quite subjective and often includes details that are observed or voluntarily reported.

Baird and Wagner (2000) found that the WRAM did not perform very well in predictive validity testing. This means the WRAM did not effectively predict a particular outcome nor accurately classify cases into low, medium or high risk groups as also reflected in the study by Camasso and Jagannathan (1995). When testing convergent validity, English and Graham (2000) conducted a study that tested 9 of the 37 items on the WRAM and only four positive associations were found. This means that when factors of the WRAM were compared to other measurements with similar factors there was approximately 44% correspondence found from the small sample tested.

One of the most alarming performance tests conducted with the WRAM concerned inter-rater reliability, which refer to the degree to which use of the WRAM resulted in similar decisions on similar cases when different workers assessed the cases. Baird, Wagner, Healy, and Johnson (1999) found that the WRAM performed poorly with respect to inter-rater reliability. In their study four workers were asked to assess risk on the same 80 files using the WRAM. Less than 14% of the time there was consensus between all workers (Baird, Wagner, Healy et al., 1999). Baird, Wagner, Healy et al. (1999) used a procedure called a "kappa" score, which corrects for agreements due to chance. Kappa varies from -1 to +1 and a kappa score of 0 means the performance of the tool is no better than chance. In their study the WRAM had a kappa score of 0.18. A

kappa score in the range of 0.5 to 0.6 would be considered acceptable. Therefore it is surmised that the WRAM's performance as an assessment tool is no better than chance (Baird, Wagner, Healy et al., 1999).

When working in the child welfare system I questioned the subjectivity of the assessment of risk used, yet it was the only assessment tool available to use according to common practices and procedures. The WRAM is the same assessment tool that participants in this study spoke of using when assessing the risk of children, determining the direction of a file, and actions taken by the child welfare workers and the child welfare system. When considering the information that can be missed it is both alarming and suggestive of how important it is that assessment techniques are acquired for assessing the effects of exposure to domestic violence on children.

Multiple studies show that exposure to domestic violence may influence later outcomes for children. Meltzer et al. (2009) through a meta-analysis of 118 studies found that "children who witnessed domestic violence had significantly worse outcomes relative to those who had not" (p. 492). They further state, "The psychosocial outcomes of children witnessing domestic violence were not significantly different from those of physically abused children" (Meltzer et al., 2009, p. 492). Shakoor and Chalmers (1991) found in one study that children and adolescents who witnessed violence were more likely than those who were not exposed, to become perpetrators of violence themselves. Jenkins and Bell (1997) made a link between witnessing family violence, and more specifically spousal abuse, and children's physical aggression. Bell (1995) believes that more high-risk behaviours are seen in youth exposed to domestic violence.

Children of all ages and both genders experience the effects of exposure to domestic violence, however, a connection has been drawn between a child's age and gender and the degree of problems associated with exposure to domestic violence (Meltzer et al., 2009). Meltzer et al. (2009) found in their meta-analysis that children in older age groups, although having an increased chance of being exposed to domestic violence, exhibited fewer problems associated to the domestic violence exposure than children who were exposed to domestic violence at a younger age. With gender, Meltzer et al. (2009) found it to be more typical of boys to display externalized behavioural problems such as aggressiveness or disobedience as a result of domestic violence exposure, whereas girls tended to internalize their problems in the form of anxiety or depression.

The outcomes for children exposed to domestic violence are vast and the effects experienced can span from mental to physical, as well as emotional/social. These effects are not always easily detectable and are not synonymous with domestic violence exposure, meaning there can be other causes for these behaviours, thus creating challenges for early detection and assessment (Meltzer et al., 2009).

Participants in this study identified some effects of children's exposure to domestic violence however others were invisible to them, as they were not easily "seen". Table 1 (Appendix F) is a compilation of seven sources of literature outlining the effects of exposure to domestic violence on children, Table 1 displays the effects of exposure to domestic violence on children according to type whether mental, physical, or emotion/social. In addition, the effects have been sub-divided by those that are easily seen and those that can be missed. Domestic violence can impact a child in many ways and

early detection and response may lead to better outcomes for children; it is important that when working with children exposed to domestic violence, child welfare workers are looking beyond what they can see or what is presented to them. It may take deeper exploration and more time spent with the child to gather a clear picture of the impact. It was evident from the findings that this is an area that needs improvement as children often became invisible in the child welfare system and direct intervention does not often include the children.

Table 1. Effects of Domestic Violence on Children by Type

Effects of Exposure	Those that are more easily seen by child welfare workers…	Those that can be missed by child welfare workers…
Mental	- Failure to thrive; - Delays in development.	- Being Traumatized; - Sleep disturbances and bad dreams; - PTSD Symptoms; - Learns that men are violent or male violence is normal; - Learns to disrespect women or that women get no respect; - Anxiety; - Psychological issues; - Difficulty concentrating; - Attachment issues; - Impact on in utero brain development; - Neuron degradation.
Physical	- Physical injury; - Death; - Delays in development; - Being colicky or	- Eating problems (doesn't eat or overeating); - Feels tired often; - Has head and

	sick; - Speech problems; - Verbalizes witnessing abuse; - Acting out violently; - Cruelty to animals; - Clinging to a parent; - Becomes pregnant; - Drop out of school; - Suicide; - Oppositional; - Destructive of property; - Aggressive behaviours.	stomach aches; - Delayed toileting; - Running away; - School Problems; - Becomes an over-achiever; - Bed wetting; - Sexual activity; - Becomes caretaker of adults; - Uses violence in his/her own relationship or accepts abuse; - Alcohol or drug problems; - Bullying; - High risk behaviours; - Perpetrators of violence as adults; - Victims of violence as adults.
Emotional/Social	- Fright; - Listlessness; - Crying a lot.	- Withdrawn; - Lack of affection with caregivers; - Problems relating to other children; - Being nervous, or jumpy; - Insecurity; - Low self-esteem; - Depression; - Early interest in alcohol or drugs; - Social problems; - Tendency to get serious in relationships; - Emotional distress; - Guilt or sense of responsibility for the violence; - Embarrassed about

		being male or female; - Family shame; - Relationship difficulties; - Fears being left alone; - Angers/upsets easily; - Difficulty trusting others; - Does negative things to get attention; - Overreacts to little things; - Has a don't care attitude; - Has trouble making/keeping friends; - Inability to express emotions.

Adapted from: Bridges (n.d.); Carpenter & Stacks (2009); Cohen (n.d.); Cunningham & Baker (2007); Holt, Buckley, & Whelan (2008); Meltzer, Doos, Vostanis, Ford, & Goodman (2009); Osofsky (2003).

As can be seen from Table 1, exposure to domestic violence affects children on many levels and can have effects that carry into adulthood. However, as Cohen (n.d.) identifies, "none of these negative effects have to be permanent" (p. 6). Domestic violence exposure can cause later relationship difficulties, violent and deviant behaviours, and psychopathology all of which exemplify the need for effective intervention strategies for children exposed to violence (Osofsky, 2003). Osofsky (2003) asserts that, "the impact on children must be dealt with by a continuum of professionals that include among others judges and police, home visitors, staff in battered women's shelters, early intervention providers and evaluators, child welfare professionals, physicians, and mental

health professionals" (p. 161). She continues to state that a positive long-term impact is likely to be had by children who are provided with supportive community resources (Osofsky, 2003). Given what the literature tells us about the effects of exposure to domestic violence for children, how is it best to respond as child welfare workers?

What is Best Practice?

Evidence-based practice (EBP) or "best practice" is seen as a relatively new type of practice in the medical and social service systems, resulting from the identification that common practices in health care and social services were primarily based on clinical experience and traditions, more so than scientific outcome research (Chaffin, & Friedrich, 2004). The practice of using scientific research and evidence to prove effectiveness is known as evidence-based practice. A goal of EBP is to push service delivery into a direction of using the "best-available clinical service and promote practices which have been demonstrated to be safe and effective" (Chaffin, & Friedrich, 2004, p. 1097).

The use of EBP is a conscious process that after a specific area of practice is identified, includes multiple steps to determine effective practices in that area. According to Gambrill (2005) there are 5 steps in evidence-based practice and they are as follows:

1. Convert information needs related to practice decision into answerable questions.
2. Track down, with maximum efficiency, the best evidence with which to answer them.
3. Critically appraise the evidence for its validity, impact, and applicability.
4. Apply the results of this appraisal to practice/policy decisions.
5. Evaluate our effectiveness and efficiency in carrying out steps 1 through 4 and seek ways to improve them in the future (p. 258).

Chaffin and Friedrich (2004) identify one risk of the increased emphasis EBP has gained with funding sources and government agencies as EBP remaining or becoming a mis-understood, ill-defined slogan for social service and health practitioners that is rarely practiced to the level it is intended. Evidence-based practice obtains knowledge from well-designed, controlled clinical research, and this knowledge base is available to anyone willing to read the published scientific research, which is different from traditional clinical methods that are passed down from those with immense experience (Chaffin, & Friedrich, 2004), which was one way participants expressed obtaining their knowledge. EBP is founded on a systematic approach that brings predictability based on outcome-focused research, and is applied ideally through the use of a work-group to collaborate and summarize a vast compilation of research and meta-analysis (Chaffin & Friedrich, 2004). I found it interesting that the participants in this study did not make any reference to this understanding of EBP or "best practice". None of the participants spoke of using the steps according to Gambrill (2005) to acquire EBP to inform their practice nor their interactions with children exposed to domestic violence.

The Best Practice Debate

Some individuals raise the question as to whether EBP can even be utilized in psychosocial interventions, as it is intended. Some traditional practitioners argue that psychosocial interventions are too complex, and subjective to be evaluated by scientific measurement (Clemens, 2002). Other clinicians accept EBP as only one form of obtaining knowledge to enhance the clinical experience and inform their practice. In these situations evidence-based practices are reviewed, weighted, and combined to creatively develop

case-by-case interventions and are not accepted as a universal approach (Chaffin & Friedrich, 2004). This use of EBP is termed "evidence-informed practice", or "evidence-suggested approach". Chaffin and Friedrich (2004) assert that evidence-informed practice is vastly subjective and driven by personal values, changes in practice traditions, prevailing theories, and social trends as compared to EBP. A critique of utilizing evidence to inform practice theories rather than evidence as the basis of practice is that it becomes very difficult to know what is not described and indirect evidence can be cited to support nearly any intervention (Chaffin & Friedrich, 2004).

EBP strives to achieve a systematic approach with little variability. It is an attempt to bring some of the control and consistency found in research labs into field practice. This has led to evidence-based practice being criticized, as an inflexible prescribed method that does not take into account individual client needs (Chaffin & Friedrich, 2004). It is argued that even in scientific method and trials a very humanistic experience is had as the researcher experiences complications, surprises, and complexities that arise with case-by-case variation. In EBP interventions the protocol and method that has been proven is maintained, however, slight alterations can be made (Chaffin & Friedrich, 2004).

Chaffin and Friedrich (2004) do identify changing values and trends along with social consensus as having a place in the development of practice. However that place is in setting conclusive goals for programs rather than the interventions to meet those goals. They identify scientific method as the means to determine an effective approach to achieve the outcomes identified by social ambitions (Chaffin & Friedrich, 2004). Traditional clinical practice and evidence-based practice are similar in that they are

governed by codes of good practice and ethical standards. There is also recognition by both that certain practitioner characteristics are important to the delivery of interventions and impact efficacy such as: having the ability to establish a working client-practitioner relationship, possessing good interpersonal skills, and respecting client dignity and self-determination (Chaffin & Friedrich, 2004).

Lastly, it should be known that recognition is given to the fact that not all areas of practice will be equally informed or researched, therefore it is not expected that all interventions or methods of practice will have a rigorous body of research supporting them. Evidence-based practice is a method of favouring the best-supported practices through available research and meta-analysis (Chaffin & Friedrich, 2004).

What are Social Work Best Practices?

What is considered to be best practice for social work is derived from a formal code of professional ethics emerging from the mid-20th century (Waltz & Ritchie, 2000). "Ethics refer to the values, norms, and moral judgments that guide professional behaviour of social workers as practitioners with clients and as a collective profession" (Walz & Ritchie, 2000, p. 214-215). With a wide range of career choices in social work it would be a challenge to outline specific expectations and evidence-based practices to be followed by every social worker. Constable (1983) identifies religious tradition in the Western culture as the derivative of definitions of human worth, as well as obligations of individuals and society. These definitions have been transformed into what social workers now refer to in providing ethical practice to individuals and families. The *Canadian Association of Social Workers (CASW) Code of Ethics* (2005) outlines social worker

values and principles, along with guidelines for ethical practice. For social workers this is what is termed "best practice" on a professional association level. Evidence-based practices can then be incorporated into professional practice within specific fields of social work as research relates to individual topic areas or desired outcomes.

Rights of the child. When working with children there are a variety of codes, acts, and policies that inform practice. The most crucial are the CASW *Code of Ethics* (2005), the *Children and Family Services Act* (1990), and the *Declaration of the Rights of the Child* (1959). The *Declaration of the Rights of the Child* has been recognized since 1924, and declares that, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth" (1959).

The declaration sets forth ten rights of the child and of those ten, the second particularly stands out in regards to this topic of a child's exposure to domestic violence. The second identified Right of the Child reads as follows:

> The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration (Declaration of the Rights of the Child, 1959).

When children are exposed to domestic violence their ability to "develop physically, mentally, morally, spiritually and socially in a healthy and normal manner" is compromised. In an environment laden with exposure to domestic violence one cannot say that the best interests of the child are being given paramount consideration. This exemplifies the need for social workers and more specifically child welfare workers to

become knowledgeable about the most effective ways to ensure the future safety of children as well as assist in a child's ability to regain normal, healthy development.

What are Best Practices in Child Welfare?

Chaffin and Friedrich (2004) acknowledge, "the decision to adopt evidence-based practice is often an agency-wide or program-wide decision, rather than an individual therapist or interventionist decision" (p. 1105). That being said however, practitioners can take an interest in and become versed in the process of EBP and use their knowledge to encourage those with the ability to make decisions. Those in roles of program development can also incorporate an EBP approach to develop interventions for families in the Child Welfare system and front-line workers can work towards incorporating these interventions in their practice (Chaffin & Friedrich, 2004).

The Kauffman Best Practices Project (2004) outlines that there is limited awareness of available EBP models and few front-line child welfare treatment agencies are offering EBP services, or have even heard of them. Chaffin and Friedrich (2004) conducted a meta-analysis of evidence-based practice models used with child abuse and neglect cases, which identified several interventions that are considered EBP in Child Welfare in the United States. These interventions include the following as they relate to different areas of child welfare: the Nurse Family Partnership model (preventing physical abuse and neglect), Stop It Now! Program (preventing sexual abuse – perpetrator prevention), Project 12-Ways/SafeCare model (child neglect), Parent-child Interaction Therapy and Cognitive-behavioural Treatment (physically abusive parents and physically abused children), Trauma-focused Cognitive-behavioural Therapy (sexually abused

children), and Parent Management Training (children in foster care). Of the interventions and specific programs identified, none specifically pertain to domestic violence, which left me with the question, what are best practices when working with children exposed to domestic violence?

What are Best Practices Working with Children Exposed to Domestic Violence?

During the review of literature I made an interesting observation about the quantity of research that focused on intervention. Most research pertaining to exposure of domestic violence focused on the precursors, risks, and effects. The study by Chaffin and Friedrich (2004) titled, *Evidence-based treatments in child abuse and neglect* exemplified this as it identified EBP models in six areas of child welfare, none of which were domestic violence. Some literature (Chrysalis House, n.d.; Cohen, n.d.; Holt, Buckley, Whelan, 2008; Meltzer et al., 2009; Osofsky, 1995) identified tasks to be completed by the child welfare workers or agencies that would lead to greater service provisions and outcomes when addressing domestic violence. Based on my knowledge of EBP these tasks would make great goals, which would then warrant evidence-based practices to be sought. I have summarized these tasks as follows:

- Completing comprehensive assessments regarding protective factors of the children and the effects of domestic violence to inform decision making regarding types of services and interventions;
- Utilize a holistic and child-centered approach to service delivery, derived from an informed assessment;
- Doing direct work with the child to identify feelings and deal with anger, gain conflict resolution skills, build self-esteem, build social skills, and explore gender stereotypes;
- Incorporating a systems approach to practice, bringing all service providers together in a collaborative way to meet the needs of the children and family;
- Improve safeguarding procedures in relation to the parents and children;

- Integrate family support and non-statutory children's agencies into care plans;
- Identifying and building resiliency factors for a child;
- Obtain behavioural support from schools with an inter-agency context;
- Connect children and families with tertiary prevention services such as mental health services, and counselling/therapeutic services.

(Chrysalis House, n.d.; Cohen, n.d.; Holt, Buckley, Whelan, 2008; Meltzer et al., 2009; Osofsky, 1995)

Of the minimal research that touched on specific EBP interventions for children it was noted that young children could benefit from early intervention and skills training. Lawrence (2002) created a *Domestic Violence and Welfare Policy* that outlines what the focus of interventions with children exposed to domestic violence should be. Interventions that include a two-generational approach are identified along with conflict resolution and antiviolence/peace programs, which were noted as being effective in school systems at decreasing violence and aggression and increasing resilience to violence. It is said that programs for children exposed to domestic violence should promote social norms against violence, provide opportunities to learn and develop skills for interpersonal problem solving, and help children establish peaceful relationships (Lawrence, 2002).

Research conducted in the area of childhood trauma discusses the adverse effects that occur both in childhood and later in life as a result of the experience (Ippen, Harris, Horn, & Lieberman, 2011). These adverse effects are the same as those seen in children exposed to domestic violence, as that too is a traumatic event for a child. Cohen, Mannarino and Murray (2011) identify one evidence-based treatment for children exhibiting a traumatic stress response and that is, Trauma-focused Cognitive-behavioural therapy (TF-CBT). They explain that TF-CBT enhances child/youth resiliency-based coping skills and develops a narrative with the child/youth to cognitively process their

personal trauma experience (Cohen, Mannarino & Murray, 2011). With the use of a collaborative community service approach, TF-CBT can also be used with the non-offending parent and child in cases where there is risk of continued exposure to trauma. This evidence-based trauma treatment focuses on three strategies when there is ongoing trauma exposure:

- Focusing early and as needed on an ongoing basis during therapy on enhancing safety for youth and parent that is appropriate to the youth's developmental, emotional, and situational context;
- Enhancing engagement strategies for parents who are experiencing ongoing personal trauma exposure;
- During the trauma narrative and cognitive processing component including focus on enhancing parental acknowledgment and support of the youth's ongoing trauma experiences, addressing maladaptive cognitions about these experiences, and differentiating between real danger and trauma reminders (Cohen, Mannarino & Murray, 2011).

Another evidence-based intervention for children who have experienced trauma is child-parent psychotherapy. This intervention focuses on the parent-child relationship as the means to improvement for the child (Ippen, Harris, Horn, & Lieberman, 2011). With the Ippen et al. (2011) study the primary focus was on children who had been exposed to domestic violence. Following the exposure they were referred to treatment along with their parent. This form of intervention was shown to not only benefit the children and reduce their psychological and somatic symptoms but the mothers who attended psychotherapy with their children also experienced the benefits; it was found that these mothers experienced a significant post-treatment reduction in depression (Ippen et al., 2011).

It is not uncommon for child welfare workers to have a desire to know the long-term outcomes of child welfare involvement for children who have been exposed to

domestic violence, and whether as a worker they could have done something different to have a greater impact. One participant expressed this exact desire when speaking about her work with children. I found one report that focused on just that. McGinn and van den Bosse (2009) interviewed twelve participants who worked as child welfare professionals and had been exposed to domestic violence when they were children. Participants in that study suggested that before children can gain the benefits of interventions that help the process of healing from domestic violence exposure, physical and emotional safety in the child's surroundings needs to be established (McGinn & van den Bosse, 2009). The factors that can facilitate this type of environment are: structure, limits, predictability, strong bond with the non-abusing parent and siblings, an understanding that they are not responsible for the care of others, and safe contact with the parent who perpetrated the violence (McGinn & van den Bosse, 2009). This is where the work with parents is important in helping to create the physical and emotional safety for the child as well as building support networks between families, schools, and community services to increase resiliency for the child. Working with parents is an aspect of practice that participants in this study had a wealth of knowledge about and where the majority of their interventions were placed. The findings of this study support this as workers continually reverted to discussions about the work with parents in an effort to provide safety, structure, and predictability for children.

McGinn and van den Bosse (2009) outlined that when speaking about interventions only two participants received direct intervention in the form of counselling services paid for by child protective services and it was felt that "equal emphasis should have been placed on the children's recovery as well" (p. 58). Participants spoke about

things that were not done and that they wished would have been done when child welfare was involved with their families (McGinn & van den Bosse, 2009). These things included:

- The professional forming a relationship with the child built on safety and trust.
- Ask a lot of questions because as children they didn't volunteer anything, they were taught to keep secrets.
- Don't expect a child to open up and talk about the domestic violence in family counselling when their parents are present in sessions.
- Don't scapegoat the children as the "problem".
- Let kids know, "It's not you. There are some things happening in this house that are devastating you, that are making you feel like this" (McGinn & van den Bosse, 2009, p. 59).

The findings of this study indicate that child welfare workers have a desire to provide more direct contact with children including forming a relationship with the child yet it was felt that barriers such as high caseload demands prevented this. However, one point of contrast expressed between child welfare participants in this research study and the adult children with a history of exposure to domestic violence in the study of McGinn and van den Bosse (2009) concerns the area of common practices and system structure. Participants in this study spoke of the common practice of separating parents or removing children to eliminate the possibility of the parents to have contact in the presence of the children after a domestic violence incident. It is believed by participants in this study that this is a first-step measure to be taken to ensure the immediate safety of the child when domestic violence has occurred. McGinn and van den Bosse (2009) proclaim, "Most participants were clear that interventions, such as out-of-home placement, would not have improved their lives", as participants stated, "There were enough resiliency factors in our family" (p. 59). This falls in line with the emphasis Carpenter, and Stacks (2009) make

regarding the importance of recognizing what the caregiver has done to protect him/herself and the children. "By listening to the caregivers and validating strengths and positive steps, their children will also begin to feel a stronger sense of control and hope in their lives" (Carpenter, & Stacks, 2009, p. 839).

A key first step in helping children exposed to domestic violence is to provide them with a safe place to express their feelings and share their stories, as well as re-assuring them it is not their fault. Cohen (n.d.), in his presentation on *Children and Domestic Violence*, outlined goals in working with child witnesses of domestic violence that can easily be integrated into common practices for child welfare workers working with children exposed to domestic violence. These goals are:

- Define and explore feelings: what they are; how to identify them; how to deal with unpleasant, stressful, and angry feelings.
- Teach that relationships are gentle, loving, respectful of boundaries of others and never violent.
- Teach that males and females are equal in power and decision-making, and can problem solve without controlling and violent behaviours.
- Facilitate disclosure and sharing of experiences.
- Help the children understand that violence is always the complete responsibility of the perpetrator and never the responsibility of the victim or child.
- Teach ways of developing self-esteem and self-confidence.
- Help the children develop a personal safety plan without need to protect "mommy" it's not their job (Cohen, n.d., p. 7).

Osofsky (2003) asserts "It is important that we broaden our understanding of violence exposure from a primary focus on victims and perpetrators to recognize the important "ripple-effects" in terms of the psychological impact on children of exposure to violence" (p.168). She further states, "law enforcement officers, families, and others frequently overlook children when an incident of domestic violence occurs. Yet, the negative effects of exposure to domestic violence can be significant" (Osofsky, 2003, p.

168). With the knowledge of evidence-based practices child welfare workers can begin incorporating these interventions into their service plans, as well as identify changes in their role working with children that could compliment the intervention practices. But, where does practitioner knowledge and experience factor in as a social worker?

Credence Given to Intuitive-Inductive Approach in Social Work Practice

Amongst all of the strategic evidence-based practices, policies, procedures, and manuals that direct social work and child welfare there is something to be said about practitioner knowledge and experience that formulates intuitive processes, also known as practice wisdom. As far back as 1967, Feinstein discussed the role of clinical judgment in diagnosis and medical research breakthroughs. He argued that the research process could be seen in clinical practice itself and stated:

> A clinician performs an experiment every time he treats a patient… yet we had never been taught before to give our ordinary clinical treatment the scientific "respect" accorded to a laboratory experiment… We had been taught to call it "art," and to consign its intellectual aspects to some mystic realm of intuition that was "unworthy" of scientific attention because it was used for the practical everyday work of clinical care (p. 14).

Much to the dismay of scientific purists, an intuitive-inductive approach or acquiring practice wisdom is similar to the process of research theory development. Scott (1990) explains acquiring practice wisdom is like developing a theory based on, "lengthy exposure to similar situations through which unconscious associations are established between certain features of cases" (p. 565). Krueger (1997) concludes from his review of literature that there is an understanding among some qualitative researchers that, "awareness of one's experiences and feelings leads to a deeper understanding of the

meaning of what is occurring" hence, an intuitive process (p. 154). This process of deeper understanding is further explained by Bruner (1990) as allowing oneself to experience and look with intensity at the inter-relatedness of minor and significant events, and being open to seeking the reality created by the infusion of feelings and intuitive thought.

Ringel (2008) explains that although intuition has been researched in both social and cognitive psychology, it has not been extensively incorporated into social work practice literature. There is practical use for intuitive processes in social work especially in the early stages of assessment and information gathering. Rea (2000) speaks of the necessity to stop the mind, connect, and listen in order to practice a process of self-reflection and states that a clinician needs to, "stop struggling, quiet the mind, observe meticulously, and use self knowledge and creativity" (p. 9). Using an intuitive-inductive approach in child welfare assessment practices may enhance awareness and curiosity allowing oneself to be more open to the process of sharing narrative experiences, ultimately gaining a more elaborate picture of the events.

Stierlin (1983) asserts that clinical practice is a combination of both scientific evidence, and the art of human interaction. He negates the assumption that intuitive clinical practice does not produce empirical knowledge. It is said that at times a practitioner can benefit from abandoning familiar cognitive tools and rely more heavily on an intuitive-inductive approach as it allows practitioners to listen to clients more closely and acknowledge that clients hold expertise on their own experiences, values, and perceptions (Anderson & Goolishian, 1992; de Jong & Kim Berg, 2001). There is value in providing practice that is not one-dimensional and there is a place for the art of human interaction and non-structured assessment processes. There is also a need to show the

decision-making processes of your work, and use evidence-based practices; there can be barriers even to utilizing practices that are proven. That being said, what are the barriers faced by child welfare workers when following best practices?

Barriers to Following Best Practice

As can be seen, taking on an evidence-based practice approach is a process that not only involves individual child welfare workers but also the internal teams, and the child welfare system as a whole. Within the *Kauffman Best Practices Project,* barriers at all levels are identified regarding EBP implementation in child welfare settings and suggestions for overcoming these barriers were also provided in the report. These barriers and suggestions to evidence-based practice in the child welfare system include funding and reimbursement issues. These financial barriers were also identified by participants in this study when speaking of enhancing the response by the child welfare system in instances of domestic violence. The *Kauffman Best Practices Project* (2004) outlines that adopting new effective interventions are not without cost, especially when considering the training and consultation costs along with the lost productivity to train staff with new techniques. Yet, a participant in a supervisory/management level position in this study acknowledged that the majority of funding should be directed towards services regarding domestic violence, as it is a predominant area being addressed in child welfare. Even with this acknowledgement it is necessary for child welfare to gain understanding and increase value of EBP as the system is a major source of funding for domestic violence interventions. It is suggested in the *Kauffman Best Practices Project* (2004) that a change

in funding practices is required with a movement from output based funding to outcome focused that favour best practices that demonstrate competency.

A barrier within the barrier of finances is that child welfare organizations see frequent staff turnover making it difficult to implement new evidence-based practices "due to the constant need to orient and train new staff in a complex intervention" (Kauffman Best Practices Project, 2004, p. 24). Success in implementing best practices can be best achieved in an organized and supportive environment, the same is necessary for staff retention. Changes in the environment may lead to changes in staff retention, which then impact the need for greater financial resources for training.

The lack of training in child welfare specific to interventions for children was apparent from the interviews with participants in this study. It is stated in the *Kauffman Best Practices Project* (2004) that, "faithful adoption of these Best Practices requires in-depth training, and knowledgeable and skillful (and consistent) supervision" (p. 24). When reviewing the requirements in child welfare of high staff productivity, responsibility, and liability it is outlined in the *Kauffman Best Practices Project* (2004) that this is not compatible with the lack of training and supervision with evidence-based practices. It is said that, "many conferences and continuing education programs routinely offer training in unproven practices with unsupported claims of a research base". Professional societies and government agency training committees should be held responsible for ensuring education that is being offered meets EBP standards proving efficacy (Kauffman Best Practices Project, 2004, p. 31). Participants in this study expressed a desire for training specific to addressing domestic violence and working with children, yet it is not occurring to the degree they crave.

The *Kauffman Best Practices Project* (2004) identifies another barrier to following best practices in child welfare; "there are few advocates who are encouraging agencies to adopt best practices or influencing funding sources to provide proper reimbursement" (p. 23). The suggestion that arose from the project was to increase advocacy and social demand for the identified best practices (Trauma Focused-Cognitive Behavioral Therapy, Abuse Focused-Cognitive Behavioral Therapy, and Parent Child Interaction Therapy) by providing information to funding organizations, government and third-party payers, as well as professional organizations (Kauffman Best Practices Project, 2004). It further states, "if an organized body of advocates for abused children began to ask educated questions about the uses of the identified best practices to local service providers and those who fund such services, the effect would be significant" (Kauffman Best Practices Project, 2004, p. 31).

The absence of advocates encouraging best practices could also be a result of a third barrier identified in the *Kauffman Best Practices Project*, the lack of awareness and understanding of best practices. The project found that despite research findings, presentations, and project guidelines service providers working with children in the child welfare system are largely unaware of best practices (Kauffman Best Practices Project, 2004). The *Kauffman Best Practices Project* (2004) states that many social workers have a bias against manualized treatments, which includes that of evidence-based practices. It is believed that EBP are too structured and lack the spontaneity needed in the dynamic world of therapy and work with individuals and families. It is suggested that those with knowledge of evidence-based practices should provide education to counter misperceptions of evidence-based practice (Kauffman Best Practices Project, 2004).

The child welfare system is entrenched in a mentality of keeping the status quo and it lacks a tradition of adopting evidence-based practices or identifying implications of change for current practice (Kauffman Best Practices Project, 2004). It is said in the Kauffman Best Practices Project (2004) that there is a "complex mix of inertia associated with the natural tendency to maintain the status quo and concern that making a planned shift to a new intervention suggests that the provider has not been providing the best service in the past" (p. 23). The suggested resolution is that, "agency and program leaders must become acquainted with the best practices and develop plans for how to lead their organizations in a transformation to an evidence-based approach" (Kauffman Best Practices Project, 2004, p. 32). Included in this transformation should be the "creation of peer support networks or communities of practice that act as learning collaboratives where people with like preparation, implementing a similar innovation, are in consistent contact sharing their experiences and solutions to problems they encountered" (Kauffman Best Practices Project, 2004, p. 36).

Barriers within Domestic Violence Intervention

In May 2012, I attended *Intimate Partner Violence Training for Child Welfare Staff* along with a number of other child welfare workers. During that training a question was asked of the group, Why is it so hard to work with domestic violence cases? The following is a list of responses given by a group of child welfare workers in positions including Intake Workers, Long Term Care Workers, Children in Care Workers, Family Support Workers, and Supervisor/Managers:

- Complexity of the files, many issues not just domestic violence as a concern;

- Long histories with child welfare;
- Dangerous, our interventions may increase the risk to the children/parent;
- Violence is normalized;
- Societal view of blaming the victim;
- Domestic violence is cyclical;
- Challenge getting the parents to understand the impact of domestic violence on children;
- Limited training opportunities for new interventions or the use of child specific assessment tools;
- Lack of resources and services;
- Sometime the definition of domestic violence is not consistent between service providers/workers therefore reactions/responses are different;
- Professional partners are working with different values;
- Risk of harm for workers to intervene;
- Emotionally draining for workers, and exposed to secondary trauma.

Literature outlines that these same barriers are experienced by child welfare workers in different areas including other countries such as the United States (Button & Payne, 2009; Dane, 2000; Ferguson, 2009; and McGinn & van den Bosse, 2009).

Assessment

Edleson et al. (2007) explain that professionals working in child welfare settings have "little guidance and few tools to carefully assess exposed children so that they can target new policies and practices to best serve them" (p. 961). The lack of assessment tools specific for children is a commonly acknowledged barrier in addressing exposure to domestic violence. According to Edleson et al. (2007) there are currently no assessment tools that measure a child's exposure to adult domestic violence that have been subjected to rigorous psychometric testing. Any assessment tools that are currently being used have been adapted from adult versions to assess children's levels of exposure (Edleson et al.,

2007). Clearly there is a need for assessments that focus specifically on child exposure to domestic violence. This need was also expressed by participants in this study.

Training

A study conducted by Button and Payne (2009) revealed additional similarities to the challenges expressed by child welfare staff in the *Intimate Partner Violence Training for Child Welfare Staff*. They noted that their results revealed the following about training child protective service workers about domestic violence:

> Child protective services workers "knew more" about domestic violence than other social service workers, but they "knew less" than what they needed about a) communicating lethality, b) worker safety, c) coping with the frustrations that arise in these cases, d) intervening with offenders, and e) dealing with the critical mental health issues (p. 368).

Suggestions were made by Button and Payne (2009) regarding policy and practice implications to address these challenges, which included child welfare continuing efforts to broaden awareness about domestic violence including the best practice strategies used to intervene with children exposed to the violence. The importance of this suggestion is the recognition that common approaches in child welfare of isolated, victim-centered and victim-punitive responses lead to a child's needs in domestic violence cases being overlooked (Button & Payne, 2009). A second suggestion was made in response to the lack of knowledge or attention given about intervening with offenders; child welfare workers must become more familiar with batterer intervention techniques to truly address the source of violence (Button & Payne, 2009). The need for child welfare worker safety is clear when addressing children's exposure to domestic violence. Button and Payne

(2009) recognized a gap between what workers know about ensuring their own safety and what they need to know about it.

Secondary Trauma

It is suggested that worker safety training in child abuse and domestic violence cases be offered by child welfare and attended by staff to ensure both their physical and mental safety while working in this field (Button & Payne, 2009). A connection is made between a lack of clear policies and practice guidelines and knowledge of effective intervention in domestic violence. This asserts the need for mandates in the form of policy and practice guidelines specific to domestic violence (Button & Payne, 2009; Holt, 2003).

Carpenter, and Stacks (2009) identify the importance of reflective supervision to discuss vicarious/secondary traumas that professionals experience when working with families who have experienced their own traumas as a result of domestic violence. As a practitioner it is important to become familiar with the signs and symptoms of secondary trauma as it can greatly impact on a child welfare worker's mental and physical health as well as the quality of work provided to children and families (Hesse, 2002). Vicarious trauma is caused by the exposure to trauma material over time and can affect child welfare workers in the same areas that an individual experiences personal trauma (McCann & Pearlman, 1990). Participants' inability to provide descriptive and detailed accounts of their experiences working with children exposed to domestic violence may have been influenced by secondary trauma. McCann and Pearlman (1990) note that those who experience trauma experience an inability to speak of the traumatic events. Dane

(2000) developed a model to address secondary trauma in child welfare workers that included: providing knowledge on stress, burnout, countertransference, posttraumatic stress disorder, and vicarious trauma; followed by opportunities for self-evaluation, improved coping response, and development of self-care techniques to assist in reducing the effects of secondary trauma.

Safeguarding

Lastly, the topic of "safeguarding" in child welfare is one thoroughly discussed by Ferguson (2009) and one that impacts child welfare practices immensely. He states, "it is quite remarkable how little attention is given to practitioner's perspective and experience of doing work" in a climate of heightened safeguarding in child welfare (Ferguson, 2009, p. 472). According to Webster's New World Dictionary (1996), the word "safeguarding" is defined as something used as a form of protection, or defense mechanism to ensure safety. From my own experiences in the child welfare system, safeguarding comes in the form of new policies and procedures including guidelines around documentation, joint protocols with police, team-meeting requirements, and following standards of practice; all of which are necessary but at what point does it begin taking away from direct client service? Ferguson (2009) speaks of the change in climate from direct client-worker experiences to office-based practices. This perspective appears consistent with my finding that participants had difficulty describing experiences of working directly with children and their rationale for doing so was related to workload. Regardless of having an interview guide that was so focused on child welfare workers' experiences of working with children, 8 (80%) couldn't keep their answers child-focused.

This exploratory pilot study suggests that few child welfare workers have direct experiences of working with children. Children's needs are not being met and child welfare workers are experiencing burn out. Since the 1980's there has been a shift with an emphasis in child welfare on new procedures, audits, interdisciplinary sharing, inter-professional collaboration, and greater accountability as a way of managing client service risks (Ferguson, 2009). He asserts that this has led to child welfare workers increasingly being characterized as deskilled, as a result of needing to spend more time in the office maintaining documentation and less time with children and families utilizing services (Ferguson, 2009). Broadhurst et al (2010) found that social workers reported spending between 20% and 40% of their time outside of the office working with individuals and families. This seems counter-intuitive in a profession that is based upon social interaction, and the work of child welfare to protect children. Ferguson (2009) supports my thought as he states, "It is impossible for an effective child protection response not to involve human contact and relational work with children and families, including the use of good authority, and we need to place at the center of analysis and understanding what happens when social workers leave their desks and go on the move to enter the private lives and spaces, the home of service users" (p. 473).

Child welfare workers and the child welfare system as a whole need to raise consciousness to the barriers faced by child welfare workers that impede best practice service delivery to children. It is then and only then that solutions can be implemented to move in a direction of change. If barriers within domestic violence intervention are not addressed the children that child welfare workers are attempting to alleviate risk for today

may become the abusers or victims of tomorrow and they do not need to be (Bell, 1995; Jenkins & Bell, 1997; Osofsky, 2003; Shakoor & Chalmers 1991).

Connections were made throughout the literature review with the findings in this research study. Key connections were found with knowledge of the degree to which exposure to domestic violence affects children in that the effects can carry into adulthood and become an intergenerational cycle of violence, as well as there being a need in child welfare for in depth assessment of the effects of exposure to domestic violence. Participants in this study did not speak of the use of evidence-based practices when working with children exposed to domestic violence, and the common practices expressed by participants were not always consistent with best practices identified in the literature however, the barriers to following best practices identified by participants were the same barriers presented in the *Kauffman Best Practices Project* (2004). Literature outlining the effects of secondary trauma provided one possible explanation to what could have influenced participants' inability to provide descriptive and detailed accounts of their experiences working with children exposed to domestic violence. The connections made between the findings in this study and the literature review have provided a solid foundation on which to build recommendations for change in the area of working with children exposed to domestic violence.

CHAPTER 5

RECOMMENDATIONS

> As stated in his book, *Rules for Radicals* (1971) Alinsky asserts:
>
> Any revolutionary change must be preceded by a passive, affirmative, non-challenging attitude toward change among the mass of our people. They must feel so frustrated, so defeated, so lost, so futureless in the prevailing system that they are willing to let go of the past and chance the future (p. xix).

Through this research I learned that child welfare workers have a desire for change within the system when addressing the effects of children's exposure to domestic violence, and they have ideas about alternate ways for practice. However, they continue to work within the system in a very structured way and show ambivalence about the value of their knowledge and experience.

It is important that the thoughts and intuitive practice of skilled social workers are not lost in the child welfare system. From my own experience as well as from the experiences shared with me by colleagues, professors and friends, social workers come out of their education and training with a drive for social change, an ambition to value the self-determination of and to advocate for clients, and the energy to be a helping force for those struggling. All of those qualities can be quickly drained away by the demands of child welfare if value is not given to their thoughts.

I have a strong belief from both my education and practice that individual change can happen, leading to greater changes both within families and at times communities. However, there must be some discomfort to motivate actions for change. This is true for child welfare workers and the child welfare system as a whole. Intuition tells me that

ignorance is not bliss in child welfare. If child welfare workers open their eyes to truly see the needs of the children exposed to domestic violence, they may begin to experience enough discomfort with their new knowledge sufficient to change the way child welfare workers practice.

My recommendations out of this research would be for child welfare workers to increase awareness and dispose of the idea that it is better to be ignorant. I encourage them to open their eyes and see, spend time with the children they work with to observe their behaviours, personalities, strengths, and the effects of being exposed to domestic violence so they can address the effects to improve outcomes for children. I recommend that child welfare workers take the time to listen, and make what is unknown, known. This will require support by supervisors and management to encourage workers to spend time with the children and families they work with as well as advocate for manageable caseloads to allow for good quality work to be done.

Here is my opportunity to give child welfare workers a voice, to support and encourage their thoughts and intuition about change within the work they do as child welfare workers, and also to support their ideas of best practice. Participants shared recommendations for practice regarding working with children who have been exposed to domestic violence. They include the following. Participants spoke of the need for support to be provided to children by way of services. They recommended:

> If we provide extra supports for transportation and access workers if they don't have any family or friends available that definitely helps (Interview 001).
>
> I just think more services are probably needed for the kids (Interview 002).

> Definitely services for the children; I think there needs to be more for that. I think a lot of kids would benefit from more of a one to one thing to kind of process what they've gone through and that isn't always being offered to them (Interview 003).
>
> So what do you do with kids; most of our attention has not been there. Maybe better standards and assessments in assuring there are better resources for kids in child welfare (Interview 008).

Another recommendation suggested by participants was to be open to approaches and other forms of practice outside of common practices. They stated:

> I personally think that not with every situation we have to insist that the family separate and one of the parents has to leave. I think the best practice would be to assess the risk and then determine if there is a need for one parent to be removed from the home (Interview 001).
>
> I think we need to take more time and look at the full situation that happened instead of just jumping to conclusions and to approaches, really. I think that as child protection workers we need more education on it. I like to think that I know the general grasp that I can talk with clients about but it's something that needs to be covered a little more in depth and I think that in all areas of child welfare we need to be more open to our approaches and how we work with clients (Interview 003).
>
> I just feel that there needs to be more openness as to how we approach the situations. I feel that just doing the same thing for every client that we have isn't meeting what they need and isn't necessarily resolving the issues. Listening to what their needs are and not cookie cutter it to, "Oh, you gotta go do this program". Listen to what they say would work for them and trying to match that up with what services would be better for them. Instead of just automatically what we feel they should do (Interview 003).
>
> The family may be negatively affected if they are separated. Maybe if we were able to have more resources we could respond in a better way instead of responding in a child protection investigation way, we could respond in a family development way which would be that we could work with the family as opposed to bringing the children's act down on them like a ton of bricks (Interview 006).
>
> We should consider different ways to approach different families and specifically if the couple intends to reunite (Interview 010).

Participants presented a recommendation that falls in line with my recommendation to go against the idea that ignorance is bliss and begin to make what is unknown, known. They

recommended that child welfare workers spend time to experience the world of the children and families they are working with, and shared:

> Empathy helps (Interview 004).
>
> Definitely face-to-face meeting, I would say that is definitely a huge factor. Just listening, shutting up and just listening (Interview 004).
>
> Taking the least-intrusive measure and having the maximum effect for change. That's best practice, the hope, if we truly believe what's in the books at school and colleges then it's about trying to get families to change through their own actions. Self-determination, and agency to get families to the point where they make the change through the process of learning and behaviours so they can understand the situation and they can make changes. It's least - intrusive measure, which really means families, will stay together (Interview 006).
>
> There are people that are really just hungry for that education for a different way. There are people who are just dying to find a different way, if you can support people in that circumstance instead of the punitive aspect of making people feel bad about how they really messed up, things can change (Interview 009).
>
> To know where your own biases and reactions are so that when we are in that, we can be a little more open or forgiving or whatever is needed at that time. It's hard to help facilitate someone else in looking at themselves if you aren't able to look at your own. That's ongoing, that's life long, and I don't think that ever ends (Interview 009).
>
> You've got to have respect for people (Interview 009).
>
> Include the clients in the decision-making (Interview 010).
>
> The worker/client relationship is an important factor that benefits the work being done, and with a system that supports high caseloads you don't have the ability to build those relationships and therefor the outcome may be different for families (Interview 010).

Lastly, participants made the recommendation that there needs to be more advocacy in the child welfare system for domestic violence to be viewed as a priority. Participants expressed this when they said:

> We need to develop our child welfare system like the police have to identify domestic violence as a very important area of work. It's just about identifying it as

> a really important area. Child welfare needs to start identifying it as a really important area (Interview 006).
>
> I think we need more training in order to improve that best practice and we need to find a way to work with families as opposed to dictating to them what has to happen for lack of a better term, because if you can get the family invested in the change, the change is going to last longer. If they are not truly invested in making the changes then they are going to do it because they think they have to, not because they want to. We need to find a way to engage the families better in making changes for themselves (Interview 007).
>
> I think a specific tool that some of my social workers could do to help them find information about the child and getting an idea, because our legislation talks about repeated, Section 22 (2) i, although that's not really helpful. So if there was something that could help us measure the emotional harm of what's occurred already and the emotional harm of future exposure to violence I think that would be helpful. I think our risk assessment that we do like the matrix is probably not specific enough, if we had something that was family violence specific about a child's impact; a child's outcomes specifically would be helpful (Interview 008).

There was a consensus amongst all participants that in order to achieve the recommendations for best practice with children who have been exposed to domestic violence there needs to be changes within the system. It needs to be recognized that domestic violence issues are serious and one of the most prevalent issues being addressed in child welfare. Financial resources need to be put forth to help child welfare workers work with children and families to address the issue of domestic violence. This includes financial resources for training, services for children, services for families, adequate staffing, and preventative resources. Caseloads need to decrease to allow for competency by workers and good-quality practice to increase efficacy in the work with children and families. It needs to be recognized that not all cases are created equally and therefore two child welfare workers with the same number of cases may not have the same amount of work. The nature of the work that needs to be done needs to be considered when

determining caseloads. Using just a numerical value ignores the fact that some cases warrant more involvement on the part of the child welfare worker. Adequate staffing needs to be available to maintain a reasonable caseload. Value needs to be given to child welfare workers' knowledge, experiences, and ideas for best practice. Some flexibility needs to be given.

This research study focused on the child-focused responses of child welfare workers after domestic violence has been reported and a file opened. As outlined in the *Children and Family Services Act* (1990), child welfare workers have the authority to make decisions regarding the protection of a child. With this authority comes responsibility. Child welfare workers are responsible for providing services to alleviate risk to children when they have been exposed to domestic violence (*Children and Family Services Act*, 1990). This research suggests that workers often fall short of providing even minimal services to children. When their sight is set on following procedures they can lose sight of the children and their needs. When the child is invisible, the child welfare worker remains ignorant. As a closing statement I have taken an excerpt from one of the interviews:

> Participant: Your questions suck.
>
> Interviewer: Why, because they are hard?
>
> P: Yeah because we don't do anything, we don't do enough.
>
> I: Maybe this will lead to some changes (Interview 008).

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Appendix A

INTERVIEW GUIDE

A Qualitative Exploration of Child Welfare Workers' Understanding of Best Practice When Addressing the Effects of Children's Exposure to Domestic Violence

School of Social Work
Memorial University

INTERVIEW – Child Welfare Workers' Understanding of Best Practice When Addressing the Effects of Children's Exposure to Domestic Violence

BEFORE AUDIO RECORDING:

□ Explain the study (Purpose).
□ Specify the nature of participant involvement.
□ Explain confidentiality and the limitations of confidentiality.
□ Provide a clear statement of the reason for data collection and how it will be used.
□ Review Appendix C *Informed Consent Form* and ask the participant if they have questions.
□ Have the participant sign the *Informed Consent Form.*
□ Explain Appendix B *Demographic Information Sheet,* and allow 5 minutes for the participant to fill it out.
□ Discuss use of audio recording the interview, if the participant agrees, turn it on.

BEGIN AUDIO RECORDING:

□ Begin asking questions:

1. Describe for me your experiences working with children who have been exposed to domestic violence?
   Probe – What are some of the barriers?
   Probe – What are some of the factors that facilitate?

2. Can you tell me the knowledge you have about working with children who have been exposed to domestic violence?
   Probe – Where does that knowledge come from?

3. Can you share with me what your role(s) are when working with children who have been exposed to domestic violence?
   Probe – What services are provided?
   Probe – Benefits of service?
   Probe – Disadvantages of service?
   Probe – How are decisions made?

4. Can you share with me your knowledge of best practice when working with children who have been exposed to domestic violence?
   Probe – Where does that knowledge come from?

Probe – Assumptions?
Probe – Describe what you are doing.
Probe – System Structure?
Probe – Where does that break down?
Probe – What assists you?

5. Share with me any additional comments regarding your understanding of best practice when addressing the effects of children's exposure to domestic violence.

□ Turn the audio recording off.
□ Concluding comments, I will thank the participant for their involvement in the study.

Appendix B

DEMOGRAPHIC INFORMATION SHEET

A Qualitative Exploration of Child Welfare Workers' Understanding of Best Practice When Addressing the Effects of Children's Exposure to Domestic Violence

School of Social Work
Memorial University

1. Assigned Number Code:

2. Age:

3. Gender:

4. Cultural Background:

5. Do you identify with a cultural minority group (circle one)? Yes No

6. If Yes, please specify:

7. Marital Status:

8. Are you a parent (circle one)? Yes No

9. What best fits your job description (circle one)?

Family Support Worker Intake Worker Long Term Care Worker

Children in Care Worker Supervisor/Manager Other _____

10. How long have you been in this position (number of years)?

11. Have you had other positions in child welfare prior to your current position (circle one)? Yes No

12. If Yes, please specify:

13. Have you been employed as a social worker outside of child welfare (circle one)? Yes No

14. If Yes, please specify:

15. What is your education background (degree(s))?

16. How long have you been practicing with that degree (number of years)?

Appendix C
INFORMED CONSENT STATEMENT – INDIVIDUAL INTERVIEW

A Qualitative Exploration of Child Welfare Workers' Understanding of Best Practice When Addressing the Effects of Children's Exposure to Domestic Violence

School of Social Work
Memorial University

You are being asked to participate in a research study conducted by BriAnna Simons, a student from the School of Social Work at Memorial University, St. John's, Newfoundland. Results of this research project will be submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Social Work.
If you have any questions or concerns about this research project, please contact my research supervisor;

- Dr. Catherine de Boer
  (709) 864-2554
  cdeboer@mun.ca

PURPOSE OF THE STUDY
This study will explore child welfare workers' understanding of best practice when addressing the effects of children's exposure to domestic violence.
PROCEDURES

If you volunteer to participate in this study, I would ask you to do the following things:

Participate in a single interview that will last approximately one hour. This interview will be conducted solely by the researcher who will ask a series of questions related to your understanding as a child welfare worker, of best practice when addressing the effects of children's exposure to domestic violence. With your permission this interview will be taped and transcribed.

CONFIDENTIALITY

Any information obtained in connection with this study that can identify you will remain confidential and will be disclosed only with your permission or as required by law. Participants will not be named in this study. The names of the participants and the specific office of employment will not be identified in the study. The audio tapes will be secured in a locked environment within the researcher's home and will be retained for 5 years, after that time data will be destroyed. Data will only be accessed by the researcher, BriAnna Simons and the Faculty Supervisor, Dr. Catherine de Boer.

POTENTIAL RISKS AND DISCOMFORT

Your name, office and its specific location will not appear in any part of this study. Your confidentiality will be secured by omitting this information from the study. People may be identifiable in their office or community by the views they express. For this reason you can choose the level of your participation. You are not required to respond to anything you do not want to. You may decline to answer any questions you so choose. You can voluntarily withdraw from the study at any time without any repercussion. You may request not to be tape recorded during any part of the interview.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR SOCIETY

The potential benefits expected from the research are:

1. Participants may experience the opportunity to express their work experiences and have them valued as a beneficial contribution to their work in Child Welfare.
2. Participants' contributions to research may be used to advance social work knowledge and practice in the Child Welfare System and may serve as a basis for future studies and publications in the realm of domestic violence exposure.
3. Participants' contributions may also influence the revision of Child Welfare policy and development of programs and services that could be helpful to families who have experienced domestic violence.

PAYMENT FOR PARTICIPANTS

Participants in this research study will not receive any form of compensation.

PARTICIPATION AND WITHDRAWAL

You may choose whether to participate in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of having your data removed from the study. You may also refuse to answer any questions you do not want to answer and still remain in the study.

RIGHTS OF THE PARTICIPANT

You may withdraw you consent at any time and discontinue participation without reprisal. You are not waiving any legal claims, rights of remedies because of your participation in this research study.
The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at (709) 864-2861.
SIGNITURE OF THE RESEARCH PARTICIPANT

I understand that the information is provided solely for this study of "*A Qualitative Investigation of Common Practices in Child Welfare that Address the Effects of Exposure to Domestic Violence by Children, as Compared to Best Practice*" as described herein. My questions have been answered to my satisfaction, and I agree to participate in the study. I have been given a copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant Date

SIGNITURE OF THE INVESTIGATOR

In my judgment, the participant is voluntarily and knowingly giving informed consent and processes the legal capacity to give informed consent to participate in this research study.

_____ _____

Signature of Investigator Date

Appendix D

APPROVAL FOR PARTICIPATION

A Qualitative Exploration of Child Welfare Workers' Understanding of Best Practice When Addressing the Effects of Children's Exposure to Domestic Violence

School of Social Work
Memorial University

ICEHR Members,

This letter is to confirm that the attached proposal of study has been reviewed, and approval has been given to Ms. Simons to conduct the study with those in this office who agree to voluntarily participate. Workers within the child welfare office that I manage can participate if they wish to, and they will not be rewarded or penalized for their degree of participation. I am in a position to only provide consent for the office that I manage. Should this research proposal be approved by the ICEHR, I will contact other District Managers in the Province and share my knowledge of the study to assist in their decision making around participation in this study.

Sincerely,

Sean Marshall, B.S.W., R.S.W.
District Manager – Child Welfare

Appendix E

EMAIL RECRUITMENT SCRIPT

A Qualitative Exploration of Child Welfare Workers' Understanding of Best Practice When Addressing the Effects of Children's Exposure to Domestic Violence

School of Social Work
Memorial University

The administration worker will email this email recruitment script to child welfare staff and the Informed Consent Statement will be an attached document to the email.

Child Welfare Staff,

This email is being sent on the behalf of BriAnna Simons.

In partial fulfillment of the requirements of the Master of Social Work degree at Memorial University, St. John's, BriAnna Simons will be conducting a research study that will explore child welfare workers' understanding of best practice when addressing the effects of children's exposure to domestic violence.
She is looking for participants for this study; eligible participants must currently work for the Department of Community Services – Child Welfare in Nova Scotia, and have worked with a family where domestic violence was a presenting problem. Eligible participants can work in the following positions: Intake Worker, Long Term Care Worker, Family Support Worker, Children in Care Worker, or Supervisor/Manager.
If you volunteer to participate in this study you will be asked to participate in a single interview that will last approximately one hour. This interview will be conducted solely by the researcher (BriAnna Simons), who will ask a series of questions related to your understanding as a child welfare worker, of best practice when addressing the effects of children's exposure to domestic violence. With your permission this interview will be taped and transcribed for use in this research study.

For additional information on participation in this study see the attached document: Informed Consent Statement.

If you meet the above requirements and would like to voluntarily participate in this study please contact BriAnna Simons by email simonsbj@gov.ns.ca or phone (902) 306-0485 indicating your desire to participate and your preferred method of contact (email or phone). She will then contact you to arrange a time to conduct the interview. If you have any questions or concerns about this research project, please contact BriAnna's research supervisor;

- Dr. Catherine de Boer
  (709) 864-2554
  cdeboer@mun.ca

Appendix F

TABLE 1. EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN BY TYPE

Effects of Exposure	Those that are more easily seen by child welfare workers...	Those that can be missed by child welfare workers...
Mental	- Failure to thrive; - Delays in development.	- Being Traumatized; - Sleep disturbances and bad dreams; - PTSD Symptoms; - Learns that men are violent or male violence is normal; - Learns to disrespect women or that women get no respect; - Anxiety; - Psychological issues; - Difficulty concentrating; - Attachment issues; - Impact on in utero brain development; - Neuron degradation.
Physical	- Physical injury; - Death; - Delays in development; - Being colicky or sick; - Speech problems; - Verbalizes witnessing abuse; - Acting out violently; - Cruelty to animals; - Clinging to a parent; - Becomes pregnant; - Drop out of school; - Suicide;	- Eating problems (doesn't eat or overeating); - Feels tired often; - Has head and stomach aches; - Delayed toileting; - Running away; - School Problems; - Becomes an over-achiever; - Bed wetting; - Sexual activity; - Becomes caretaker of adults;

	- Oppositional; - Destructive of property; - Aggressive behaviours.	- Uses violence in his/her own relationship or accepts abuse; - Alcohol or drug problems; - Bullying; - High risk behaviours; - Perpetrators of violence as adults; - Victims of violence as adults.
Emotional/Social	- Fright; - Listlessness; - Crying a lot.	- Withdrawn; - Lack of affection with caregivers; - Problems relating to other children; - Being nervous, or jumpy; - Insecurity; - Low self-esteem; - Depression; - Early interest in alcohol or drugs; - Social problems; - Tendency to get serious in relationships; - Emotional distress; - Guilt or sense of responsibility for the violence; - Embarrassed about being male or female; - Family shame; - Relationship difficulties; - Fears being left alone; - Angers/upsets easily;

		- Difficulty trusting others; - Does negative things to get attention; - Overreacts to little things; - Has a don't care attitude; - Has trouble making/keeping friends; - Inability to express emotions.

Adapted from: Bridges (n.d.); Carpenter & Stacks (2009); Cohen (n.d.); Cunningham & Baker (2007); Holt, Buckley, & Whelan (2008); Meltzer, Doos, Vostanis, Ford, & Goodman (2009); Osofsky (2003)