

SOCIAL SUPPORT FOR CHILDREN WHO HAD A PARENT KILLED BY INTIMATE
PARTNER VIOLENCE: INTERVIEWS WITH MENTAL HEALTH WORKERS

by

ELAINE SPENCER-CARVER

B.S., Stephen F. Austin State University, 1970

M.S.W., University of Kansas, 1979

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2008

Abstract

Children experience catastrophic loss when they have a parent killed by intimate partner violence. Their lives are immediately changed by this event. They are often left orphaned and separated from natural support systems. This study looks at the social support that children and their families have had after the death of a parent from intimate partner violence. The support is reported as seen by mental health professionals who worked with the children and their caretakers after the death.

The study is a phenomenological study taken from interviews with six mental health professionals in three communities in three states. The themes found were described by at least five of the six interviewees and were also identified by a secondary rater. The themes outlined the existence of social support prior to the death as well as knowledge by the community that violence was present in the family before the murder. Stressors after the death of the parent were significant and required family re-organization. Families took steps to engage both existing and potential social supports but were often not able to utilize formal services at the time that they were offered. The importance of a consistent long-term attachment for the child was reinforced repeatedly. Grief response for both the child and the primary caretaker were complicated by the reality of the parent/son or daughter having been killed by their intimate partner. Finally, the difficulty of providing care and support for these children extracted a toll on the caretakers in their physical and mental health.

Several messages emerged beyond these themes. Caretakers needed to provide emotional as well as physical care. When the emotional support was available children were able to tell the story of their experience, which they needed to do over and over again. The most problematic situations that participants described were with children who had not discussed this life event since it occurred. These children did not explore their feelings about the death of their parent or share what the loss meant to them with others.

SOCIAL SUPPORT FOR CHILDREN WHO HAD A PARENT KILLED BY INTIMATE
PARTNER VIOLENCE: INTERVIEWS WITH MENTAL HEALTH WORKERS

by

ELAINE SPENCER-CARVER

B.S., Stephen F. Austin State University, 1970

M.S.W., University of Kansas, 1979

A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2008

Approved by:

Major Professor
William H. Meredith

Copyright

ELAINE SPENCER-CARVER

2008

Abstract

Children experience catastrophic loss when they have a parent killed by intimate partner violence. Their lives are immediately changed by this event. They are often left orphaned and separated from natural support systems. This study looks at the social support that children and their families have had after the death of a parent from intimate partner violence. The support is reported as seen by mental health professionals who worked with the children and their caretakers after the death.

The study is a phenomenological study taken from interviews with six mental health professionals in three communities in three states. The themes found were described by at least five of the six interviewees and were also identified by a secondary rater. The themes outlined the existence of social support prior to the death as well as knowledge by the community that violence was present in the family before the murder. Stressors after the death of the parent were significant and required family re-organization. Families took steps to engage both existing and potential social supports but were often not able to utilize formal services at the time that they were offered. The importance of a consistent long-term attachment for the child was reinforced repeatedly. Grief response for both the child and the primary caretaker were complicated by the reality of the parent/son or daughter having been killed by their intimate partner. Finally, the difficulty of providing care and support for these children extracted a toll on the caretakers in their physical and mental health.

Several messages emerged beyond these themes. Caretakers needed to provide emotional as well as physical care. When the emotional support was available children were able to tell the story of their experience, which they needed to do over and over again. The most problematic situations that participants described were with children who had not discussed this life event since it occurred. These children did not explore their feelings about the death of their parent or share what the loss meant to them with others.

Table of Contents

List of Tables	x
Acknowledgements.....	xi
CHAPTER 1 - Introduction	1
Intimate Partner Violence Murders.....	1
No Greater Loss	2
Statement of the Problem.....	3
Grief Takes its Toll	3
Purpose of the Study	4
Definition of Terms	4
Intimate Partner Violence	4
Murder.....	5
Children.....	5
Parent	5
Social Support System	5
Importance of This Study	6
Organization of the Dissertation.....	7
CHAPTER 2 - Literature Review.....	8
Historical Perspective of Intimate Partner Homicide	8
Theoretical Contributions	9
Feminist Theory	10
Human Ecological Theory	12
Resiliency Theory	12
Attachment and Mourning Theory.....	13
Social Support Theory	13
Help in Understanding the Importance of Social Support.....	15
The Effects of Children Witnessing Intimate Partner Violence	15
Children’s Response to the Death of a Parent.....	19
Children Who Have Had a Parent Die from Intimate Partner Violence.....	21

Age-Related Issues	23
Infants and Toddlers	23
School-Age Children	23
Adolescents	25
Role of Mental Health Professionals	26
CHAPTER 3 - Methodology	28
Phenomenological Research	29
Research Methods	30
Participants	30
Informed Consent and Confidentiality	31
Interview Agenda	31
Thematic Data Analysis	32
Researcher as an Instrument of Research	33
Clinical Social Worker Frame of Reference	33
Clinician as Researcher	34
Research and Family Life Education	34
Demographics of Participants	34
Referrals of Children to Participants	35
Interview Specifics	35
Efforts to Insure Accuracy	36
An Additional Reviewer was Incorporated	36
CHAPTER 4 - Findings	38
Social Support Existed Prior to the Homicide	39
The Intimate Partner Violence Was Known in the Community	39
Substance Abuse Was Often Present in These Families	41
Stressors on the Family Begin Immediately After the Homicide	42
Intimate Partner Homicide Created Immediate Need for a Caregiver for the Children	42
Caregiving Was Complicated by Grief and Pre-Existing Issues but Needed To Be Consolidated	43
There Were Financial Burdens	44
Sources of Social Support	44

Day Care and Schools	45
Children’s Services or Child Welfare Agencies	46
Courts and Police	46
Faith-Based Communities.....	47
Engaging in Social Support after the Homicide	48
Hesitant Connections on Both Sides.....	48
Providers of Support Had To Learn What Would Work	48
Sometimes Families Were Not Ready for Interventions	49
Sometimes the Children Were Not Ready To Use the Help.....	50
When the Children Were Ready They Could Be Resilient.....	51
Socials Support Sources Were More Available to Older Children.....	51
Not All Social Supports Were Positive.....	53
Support Was Sometimes Found in the Perpetrator’s Family.....	54
Long-term Attachments Are a Critical Component of Social Support.....	54
The Child Needs Consolidated Care.....	55
Children Need More Than Physical Support	56
Children Are Able To Maintain Attachments and Develop New Ones.....	58
The Ability to Process Grief and Recover Was Often Impaired	59
Impact of Substance Abuse.....	59
Processing Grief in a Violent Environment	60
Isolation for Survivors of Intimate Partner Violence Murder.....	61
The Strain of Care-Giving	62
Mental Health Professionals Also Needed Social Support.....	64
CHAPTER 5 - Discussion	67
Response to Research Questions	67
Who are the people mental health providers identify as providing children with positive support.....	67
What critical supports serve to decrease the severity of the trauma?	68
What supportive services are identified by mental health professionals as critical to the child’s well-being after the loss?	68
What is the experience of mental health professionals who work with these children?.....	69

Several New Perspectives	70
The Existence of Social Support Did Not Prevent the Homicide	70
Social Support Could Be Elusive and Unpredictable	70
Social Support Was Critical for Caregivers.....	71
Intimate Partner Homicide May Be One Layer of Trauma	71
Resilience Was Evident Even in the Midst of Complex Trauma	72
The Ever-Present Connection between Intimate Partner Violence and Chemical Dependency	72
The Importance of Service Coordination.....	73
Social Support Services Need To Be Tenacious.....	73
Need for Training of Mental Health Workers.....	74
Need for Supervision	74
Families Need Ongoing Contact.....	75
References.....	77
Appendix A - Institutional Review Board Approval	87
Appendix B - Informed Consent Documentation	89

List of Tables

Table 3.1 Reviewer II thematic chart of social support for children who had a parent killed by intimate partner violence.....	37
Table 4.1 Thematic chart of social support for children who have had a parent killed by intimate partner violence.....	39
Table 4.2 Participants' education and experience.	66

Acknowledgements

This research project would not have been possible without the generous contributions of the six mental health professionals who volunteered their time to be interviewed. The on-going empathy and concern that they had for their clients was evident throughout their participation. Three of the participants were recovering from the impact of the hurricane Katrina and even though their lives were in disarray they chose to spend time sharing the stories of their work. I am grateful to them for making these stories of helping come alive in through the interview process.

Dr. William Meredith and Dr. Candyce Russell were continuously supportive to both the research and me personally as I journeyed through the doctoral process. Both have taught me a great deal about families and moreover about leadership in an academic setting. They have both been models and mentors to me. Thanks also to Annalese Zawodny-Benlon, MSW, for the assistance and encouragement that she provided.

In 1939 Robert E. Spencer and Cornelia Chancellor married and created a family that provided a safe haven where my sister Gayle, my brother Rob and I could grow to our potential. We were protected from violence at home and in our community. I am grateful for this early foundation of love and encouragement and for the undying support that they provided. It is my hope that more children will have the opportunity to grow up in such a loving and safe environment.

More recently, I have been blessed with a blended family that has offered me both support and acceptance. My husband Larry Carver provided loving care while we were separated by many miles as I committed to my doctoral studies. His on-going support made it possible for me to dedicate my time and energy to my education. Our children, Mitch, Diana and Debbie are an inspiration to me as they juggle their busy professional and family lives. The other person who gives enormous support and steadfastness is Susan Scott my friend, mentor and fellow sojourner.

CHAPTER 1 - Introduction

Richard, a beautiful Asian American boy, presented at the child psychiatric clinic at the age of five years, four months. He was accompanied to the clinic by his maternal aunt and her husband, his guardians. Richard's school had required that he be evaluated because of his erratic, aggressive, and at times bizarre behaviors. The school's principal was concerned because Richard's behavior at times endangered both the boy and his peers. When not acting out, Richard reportedly performed academic tasks quite well. He was able to read at a second grade level and could converse maturely with his teachers, when calm. Problems at home included tantrums that seemed out of context, encopresis, night terrors and intermittent defiant behaviors. Most of the time, at home, he was reportedly compliant and pleasant. His aunt reported that she was confused by his behavior especially when he would stare, not speak and not move for two to three minutes at a time. Richard had been examined by a pediatric neurologist, including extensive neurological tests. A seizure disorder had been ruled out. Richard appeared to have bonded with his aunt and uncle. He had lived with them for the previous two years. From the age of two years until that time he lived with his maternal grandmother.

When Richard was two years old his mother had been shot at point blank range and killed by her lover. She was holding Richard at the time of the shooting. When she was shot, she fell on Richard. He was trapped under her body until they were discovered by a neighbor, hours later.

Disguised actual case study

Intimate Partner Violence Murders

In 1994 state and county prosecutor records were surveyed by the U.S. Department of Justice in order to study the murders occurring in 75 of the nation's largest cities. The survey found that 6.5% of murders reported were committed by the victim's intimate partner (Dawson & Langan, 1994). In 1999 the Violence Policy Center (n.d.) wrote a report entitled, When Men

Murder Women. This report analyzed the Supplementary Homicide Report data submitted to the Federal Bureau of Investigation (FBI) by local communities. Findings included that 60% of female homicide victims were wives or intimate acquaintances of their killers, and “317 women were shot and killed by either their husband or intimate acquaintance during the course of an argument – nearly one woman a day” (The Violence Policy Center, n.d., p. 2).

Studies have indicated that the majority of households experiencing intimate partner violence include at least one child (Fantuzzo & Mohr, 1999). The FBI Supplementary Homicide Reports list 512 men and 1,317 women killed by intimate partners in 1998 in the United States (Rennison & Welchans, 2000). Total figures for the 10-year period from 1988 to 1998 include 7,542 men and 15,636 women killed by intimate partner violence (Rennison & Welchans, 2000). If one used an average of only 1.5 children per family the number of children could be as high as 34,767.

No Greater Loss

The profound loss that a child experiences with the death of a parent has been studied extensively through formal research and historically through popular literature. Worden (1996) describes the loss in this way: When a parent dies, life as the child knows it is disrupted and irrevocably changed (p.18). Depending on the relationship that the child had with the deceased parent, the loss often is a defining experience for her or his childhood years. More recently the FBI Uniformed Crime Statistics (2005) reports that 1055 women and 287 men were killed by intimate partners in 2005. If the factor of 1.5 children is used, the number impacted would be 2013 or higher for 2005 alone. However, there is limited information written on the impact that the death of a parent by intimate partner violence has on the surviving children. A number of case studies have documented the experience that some families have had and the treatment that the children have received (Burman & Allen-Meares, 1994; Malmquist, 1986; Osofsky, Cohen, & Drell, 1995). Harris-Hendriks, D. Black and Kaplan (1993) studied over 100 children whose mothers had been killed by their fathers in the United Kingdom. These studies and others will be discussed in later chapters.

There are some commonalities that have been observed in case studies and clinical observations of children who have had a parent die from partner violence. When the intimate partner violence occurs in the child’s biological family, that child is often orphaned immediately

(Websdale, 1999). One parent is killed. The other parent is arrested and imprisoned, disappears, or commits suicide; the child loses both parents. These children often are found on the scene of the murder, by the police, friends or family members (Bevin, 2002; D. Black, 1998; D. Black & Kaplan, 1988; Harris-Hendriks et al., 1993). The police will attempt to find extended family to care for the children or will depend on the local child welfare agency to provide the necessary care (Harris-Hendriks et al., 1993). Generally this means an immediate uprooting of the children from the family home. Foster care may be used if there are no family members available or if the family is too overwhelmed by the death. Harris-Hendriks et al. also noted if there were several children in the family the siblings may be separated immediately after the murder. Thus they lose not only their familiar surrounding, but also immediate access to all remaining first degree family members (D. Black & Kaplan, 1988). Even when extended family is available there may be severe antagonism between the families of the murder victim and the perpetrator (Harris-Hendriks et al., 1993). Additionally, families feeling stigmatized by the occurrence of a murder in their midst may ignore the importance of talking openly about the event, thus not allowing the children the essential step of processing their grief (Websdale, 1999). The child's relationship to the parents' families also may be complicated by a conflict of loyalties that the child may experience (Harris-Hendriks et al., 1993). All of these factors contribute to a lack of support available to the child faced with trying to recover from the death of a parent by intimate partner violence.

The research in this area has been somewhat limited in its scope. Historically researchers have limited their study of intimate partner violence to heterosexual, married couples (Renzetti, 1997). This is not always the case. Intimate partner violence also occurs in same sex couples. For example, Richard's mother's lover was a woman. Current research indicates that intimate partner violence occurs in all forms of intimate partnerships (Centers for Disease Control [CDC], n.d.). Therefore, all forms of relationships need to be included to adequately reflect the nature and prevalence of this problem.

Statement of the Problem

Grief Takes its Toll

While there has been limited study of the children impacted by domestic murder there is a growing body of knowledge regarding the impact of growing up in families where intimate

partner violence is present. The critical nature of this problem was emphasized when the David and Lucille Packard Foundation devoted its winter 1999 issue of *The Future of Children* to domestic violence and children (Carter, Weithorn, & Behrman, 1999). Carter et al. reported in their analysis that research suggests that between 3.3 million and 10 million children in the United States are exposed to domestic violence each year. And more than a decade of empirical studies indicate that this exposure can have significant negative effects on children's behavioral, emotional, social and cognitive development (p. 5). They are referring to children whose parents have survived the violence. How can we calculate the further complication of parental death? If the difficulties could be quantified in a mathematical way surely the children surviving the death of a parent by intimate partner violence would be considered to be at greatest risk for problem behaviors as children and adults. Not only do these children grow up in environments where violence is the common problem-solving technique modeled for them, but also they may be the victims of physical, emotional and sexual abuse. Edelson (1999) documented that children who live in families where intimate partner violence exists have a 30% to 60% greater chance of experiencing child maltreatment. For all practical purposes the cards are stacked against these children for growing into healthy, contributing citizens.

Purpose of the Study

The purpose of this study is to document the social support a child needs in order to recover from the death of a parent by intimate partner violence. Through extensive interviews with mental health professionals, I have gained knowledge of the histories of the families who were seen by these mental health providers, both positive and negative. This knowledge of what factors may be essential for positive adjustment to occur. In addition, there will be an opportunity in a small population to ascertain whether current policies are adequate for providing the necessary support for these children at the time of the loss of their parent.

Definition of Terms

Intimate Partner Violence

Intimate partner violence has begun to replace the term domestic violence because it is more inclusive. Intimate partner violence includes heterosexual and homosexual relationships and does not require an established marriage or publicly recognized union. The term has been

recommended by the CDC (n.d.) to describe violence - physical, sexual or emotional - that occurs between two people who are intimately involved.

Murder

The U.S. Department of Justice defines murder to include:

Intentionally causing the death of another person without extreme provocation or legal justification, causing the death of another while committing or attempting to commit another crime, and non-negligent or voluntary manslaughter. Murder excludes negligent or involuntary manslaughter as well as attempted murder. (cited by Dawson & Langan, 1994, p. 2)

In order to be consistent with statistics gathered by the Justice Department, this definition will be used throughout this study.

Children

For the purpose of this study, children will be defined as anyone under the age of 18 years at the time that the murder occurred. The child may or may not have been living in the home at the time of the murder. Also included in this population can be children who are within the designated age bracket but are living with a relative or friend outside of the home as an unemancipated minor. Children in foster care are to be included.

Parent

Parent as a victim of perpetration will include any biological father or mother. In addition, any step-parent or step-parent figure will be included in this study. Also if a grandparent has been the primary caregiver of the child, he or she will be included whether or not there is a legal custody agreement.

Social Support System

Any person or system currently or in the past that has been important to the child can contribute to the support system of the child. These persons may be friends, relatives, professionals or laypersons the child identifies as important to him/her. When social support is positive, these persons provide the child with acceptance, warmth and give him/her an opportunity to process the death of his/her parent verbally or nonverbally.

Importance of This Study

J.C. Campbell (personal communication October 4, 2007) has attempted to establish the prevalence of intimate partner homicide and the number of children affected. Websdale (1999) also describes this difficulty because of lack of documentation and conviction of perpetrators. Most of the studies of the impact of intimate partner violence on children have focused on the consequences that the child experiences from living in a violent home (Carter et al., 1999; Fantuzzo & Mohr, 1999; Groves, Zuckerman, Marans, & Cohen, 1993). A limited number have addressed the ultimate violent outcome of death (Azarian, Miller, Palumbo, & Skriptchenko-Gregorian, 1997; D. Black & Kaplan, 1988; Lewandowski, McFarlane, Campbell, Gray, & Barenski, 2004; Burman & Allen-Meares, 1994; Osofsky et al., 1995).

My interest in this population developed from my work with two clients - a boy who was under two at the time of his mother's murder and a boy who was 15 at the time of his father's death. Both children had been adversely affected by this experience and had sustained considerable trauma as observed in their behavior and through their verbal descriptions. The younger child was more adversely affected. It is not clear whether this was because he was more directly involved by being in his mother's arms when she was shot. He suffered greater trauma and was more primarily affected emotionally and developmentally even though he had family support in the form of his grandmother and aunt. The older boy was supported by his school and especially by the school's counselor. He was in another room when he heard his parents fighting and reported feeling guilt that he had not interrupted the fight and prevented his father's death.

These clinical experiences led to the development of the following hypothesis and research questions.

Assumption: Children who have a positive social support system have a more positive adjustment to the death of a parent by intimate partner violence.

Research Questions:

1. Who are the people mental health providers identify as providing children with positive support?
2. What critical social supports serve to decrease the severity of the trauma?
3. What supportive services are identified by mental health professionals as critical to the child's well-being after this loss?

4. What is the experience of mental health professionals who work with these individuals?

The ultimate importance of this study is to gain information that can lead to a better understanding of what children need to survive this life-changing experience with as little trauma as possible. With a reduction of the severity of trauma, the children may experience less disruption of their childhood development and be able to better meet the challenges of growing to a functional maturity. If children who have experienced this ultimate loss are not effectively helped to adjust to their loss and learn to trust in new loving relationships, they are surely doomed to lives torn by grief and possible continued violence.

Organization of the Dissertation

The order of this dissertation has begun in Chapter 1 with an introduction including a discussion of the purpose and importance of the study and the definitions of specific terms. In order to familiarize the reader with necessary background information, Chapter 2 includes a review of recent literature describing characteristics of intimate partner violence that directly influence the development of children who experience this in their families. This chapter also includes review studies that have narrowed their population to those children who have had a parent killed through intimate partner violence. Chapter 3 describes the phenomenological methodology used in this study and justifies the use of this approach. Chapter 4 outlines the findings derived from the interviews and the thematic analysis. Chapter 5 utilizes the information gained to make recommendations for intervention and education efforts that will assist families and professionals to better support these children.

CHAPTER 2 - Literature Review

Beyond the initial trauma of a domestic homicide there is a complexity of dynamics that not only impact the immediate social support for the child and their family, but also begin structuring their futures. This complexity of dynamics – the loss of a parent/family member to homicide, the relationship to the perpetrator, the accompanying confused loyalties and limited options for caring for often orphaned children - creates overwhelming challenges. This literature review attempts to address this complexity.

Historical Perspective of Intimate Partner Homicide

The passion of intimate partners and families has been a human fascination since the beginning of the written word. Greek mythology and Shakespearian plays have depicted intimate partner murder through verse. Hamlet's mother killed his father amid the incantations of witches and the betrayal of friends (Shakespeare, 1969). Humans have long been aware of the incredible strength of both negative and positive feelings in relation to families and intimate partnerships. These historical writings reflect the devotion, betrayal, loss and devastation also experienced by real families as they struggle with these emotionally laden relationships.

Perhaps we can consider these stories as the first attempts at understanding the complexities of families and the violence that can erupt in their life cycles. Even though these stories cannot be considered research, they do reflect the understanding of the time - that relationships that combine passion, jealousy, power and control can become deadly.

Intimate partner violence research is a relatively young area of investigation. Tjaden and Thoennes (2000) noted that the first studies referring to "domestic violence" in the late 1960s to early 1970s were primarily quantitative and were focused on violence in the home, (e.g. the quantity, severity and frequency). However, Tjaden and Thoennes also point out that research became controversial when the formal studies did not reflect statistics that were similar to the numbers that domestic violence advocates were experiencing in the growing community of battered women's shelters. The research most often referenced the use of the Conflict Tactics Scale written by Straus and his subsequent research (Straus & Gelles, 1986). Quantitative studies

often supported a continued minimization of the severity of the problem making it difficult for battered women's shelters to find adequate funding prior to the Violence Against Women Act in 1994 (Violence Against Women Act, 1994).

As statistical records became more available at a national level through the Bureau of Justice and the CDC, more accurate statistics were used to offset the earlier quantitative studies (Tjaden & Thoennes, 1998). Feminist researchers encouraged their colleagues to utilize feminist principles in their research endeavors. Reinharz (1992) argued that feminist research is not bound by limitation of definition but moreover is an inclusive process that includes recognition of gender bias and the importance of not only identifying oppressed voices but insuring that these voices are included in publications. Fonow and Cook (1991) emphasized the importance of consciousness raising as a part of the research process. Naples (2003) described feminist research as an opportunity for increased self awareness and transformation.

In an example of feminist research, Davis and Srinivasan (1995) studied a group of women, survivors of intimate partner violence, who had utilized battered women's shelters. She employed a focus group format to learn about the depth and severity of the abuse that these women had experienced and the difficulties that they had encountered in finding the support needed to help them leave their abusive relationships. As the stories of women's survival began to emerge, qualitative studies were used more often than quantitative studies in research about violent families. Today there is a great deal of qualitative and quantitative research in intimate partner violence (Tjaden & Thoennes, 1998). Dobash and Dobash (1998), in fact, called for a greater diversity of research and inclusion of a range of disciplines to contribute to research on domestic violence.

Theoretical Contributions

Five theoretical perspectives have been critical to a better understanding of the complex problem of intimate partner homicide and its impact on children: Feminist theory, Human Ecological theory, Grief/Bereavement theory, Attachment/Mourning theory, and Social Support theory. In the following section each theory is discussed briefly, and its importance to the concept of surviving parental death by intimate partner violence is outlined.

Feminist Theory

Every woman in the United States owes a debt of gratitude to the Feminist Movement for creating a system to serve women who are abused in their intimate relationships (Jenkins & Davidson, 2001). Without the political and logistical work of these feminist women, there would not be a battered women's shelter movement as we know it today (P. Jenkins, personal communication, June 2002). Historically women who reported being brutalized by their partners were not believed or the offenses perpetrated on them were minimized or condoned by law (Pence, 2001). In the early 1970s advocates who were grassroots feminists operating on a local level began to systematically confront legal and social systems in order to protect women (Schechter, 1982). This movement would eventually put enough pressure on governmental leaders that the Violence Against Women Act would be passed in our nation's capitol in 1994 (Valente, Hart, Zeya, & Malefyt, 2001).

It is important for the reader to know that feminist theorists, researchers, clinicians and advocates have fought and sacrificed a great deal to better protect the safety of women and children because feminist theorists have defined many of the key issues of intimate partner violence. This defining began with the question, "Why do men batter their wives?" which defied the paternalistic traditional question of "Why do women stay in abusive relationships?" (Ptacek, 1997).

The important rewording of this question is the foundation of the feminist theoretical view of violence against women (P. Jenkins, personal communication, June 2002). In the past, women had been blamed for their partners' behavior. Men were not held responsible. Ptacek (1988), in his study of 18 male clients in a batterer's group, found that the most common way that batterers justify their behavior is claiming a loss of control, sometimes due to the influence of chemicals. The men also denied their responsibility for their behavior by blaming their partners. However, in the final analysis of Ptacek's findings, it became clear that men batter their partners because society accepts their excuses and tolerates the violence (1999). "Men continue to abuse women because they can" (P. Jenkins, personal communication, June 2002).

Websdale (1999) stated two critical points must be made when discussing deaths by intimate partner violence: 1) The majority of individual murders are perpetrated by men, and 2) Men kill for different reasons than women. In his study of domestic homicide, men committed 80.3% of the murders, and 79% of the family homicides. "Men usually kill their intimate female

partners after violently abusing them, often for long periods” (p. 205). “Women who killed intimate partners were profoundly trapped in their relationships” and were often “separated or estranged from their abusive partners” (p. 212).

Rennison and Welchans (2000) reported that the number of men killed by women decreased by 4% between 1976 and 1998. During this same period the number of female victims fell by 1%. The authors speculated that the greater decrease in the number of male victims mirrors the increase of services to battered women offering them a greater range of options (Justice Department, Bureau of Statistics, 2002). This having been said, it is important to study all types of parental death. Currently, the vast majority of the literature about these deaths is focused on the deaths of mothers (Harris-Hendriks et al., 1993; D. Black & Kaplan, 1988; Lewandowski et al., 2004; Websdale, 1999). The murders described in these studies were perpetrated by men, however, current records show that deaths also occur in gay and lesbian relationships, and that women also kill men as well (Renzetti, 1997; Russell & Harnes, 2001; Radford & Russell, 1992; Websdale, 1999).

Feminists introduced the critical analysis of two key factors in intimate partner violence: gender and the combination of power and the need to control (Pence, 2001). Perhaps it is time to consider that power and control are not gender-specific aspects of relationships, but operate in all intimate relationships. bell hooks (2000) pointed out in her primer on feminist theory, “The fact that women may not commit violent acts as often as men does not negate the reality of female violence. We must see both men and women in society as groups who support the use of violence if we are to eliminate it” (p. 63).

This issue of power and control is linked with the historical patriarchal structure of our society. Men have been able to abuse women because women were subordinate to men and did not have the same access to power that men had (Pence, 2001). In his study on domestic homicide, Websdale (1999) described the increase of risk that occurs when a woman tries to change this imbalance of power by leaving the relationship or filing for divorce. The majority of domestic murders occur at this time of attempted change.

There are three aspects of feminist theory and research that are critical to this study. The first is viewing people in context. The second is the inclusion of multiculturalism. And the third is validating women’s/children’s experience by giving voice to research participants (Davis &

Srinivasan, 1995). This study will explore the experience of children who have survived parental murder by intimate partner violence by utilizing these concepts.

Human Ecological Theory

Clarke (1973) gave credit for the early development of Human Ecological Theory to Ellen Swallow Richards. Bronfenbrenner (1974) later described individuals as interdependent biological beings who are part of a larger social and physical environment. When a tragic death of a parent occurs in a child's life, his environment is not only thrown into crisis, it is often redefined and restructured. In this theory, the individual microsystem interacts with other microsystems to form a mesosystem which serve as each individual's connection to their environment. For some children, the relationship that they have with their parent may be their only mesosystem involvement prior to the parent's death. This theory helps to illustrate the overwhelming loss that children experience and the importance of a sustaining support system following the death. Possible policy changes to encourage adequate services and social support would be responsibility of the child's macrosystem.

Resiliency Theory

Understanding the survival and coping of children who were born into chaotic and stressful lives motivated researchers in the fields of psychiatry and psychology to develop this relatively new theory. Leadbeater, Dodgen, and Solarz (2000) pointed out that "a central goal of resilience research is to increase knowledge not only about strengths or competencies but also the conditions or contexts that are necessary to maintain, promote or enhance strengths and competent functioning in the face of adversity" (p. 47). Masten and Powell (2003) noted the importance of studying the links among competence, adversity and protective factors. They went on to say that the competence level in the face of adversity can be increased through resources like "better parenting, intellectual skills or social support" (p 10).

Werner (2000) described the movement of this theoretical approach away from a pathological-based retrospective approach to begin to look at a "complex chain of protective factors linked across time" (p. 3), to describe how men and women in the 40-year study of residents of Kawai survived and thrived after adversity. In looking at the lives of children after they have survived the death of a parent by intimate partner violence, this theory will give greater understanding to the strengths and vulnerabilities they exhibit.

Attachment and Mourning Theory

Bowlby's (1961a, 1961b, 1963, 1980) work in the area of child attachment helped to illuminate the significance of the loss that a child experiences when she/he is separated from the "mother figure" and placed with strangers. He stated:

First, once the child has formed a tie to a mother-figure, which has ordinarily occurred by the middle of the first year, its rupture leads to separation anxiety and grief and sets in train processes of mourning, secondly that in the early years of life these mourning processes not infrequently take a course unfavorable to future personality development and thereby predispose to psychiatric illness. (1963, p. 500)

Later writing by Worden (1996) identified tasks that children must complete and move through to process the pain involved in grieving and develop the ability to redevelop trust in relationships. Christ's (2000) research on children's responses to the death of a parent clarified the development of differences in a child's grief response. It is apparent in Bowlby's later writings that he focused less on the pathological aspects of their behavior and began to see children's responses to grief as normative (Bowlby, 1980).

Social Support Theory

Social support theory builds on attachment theory to explain how individuals develop social networks of family, friends, co-workers and acquaintances, then utilize those networks to provide themselves with social connectedness (Vaux, 1988). Vaux's view of social support is that "rather than being a static personal characteristic or environmental condition, [social support] involves a dynamic process of transaction ...between the person and his/her support network that takes place in an ecological context" (p. 59).

Social networks have features that can affect the potentiality of the system to be helpful to the recipient (Vaux, 1988). Network size, the sheer number of supportive resources that the person has; density, the interconnectedness of the network; complexity, the diversity of talents of the network and reciprocity of the network all can influence its effectiveness. This social connection then provides the individual with a variety of need satisfaction. Several authors describe a variety of ways that social support systems can provide need satisfaction including both concrete and emotional assistance. Caplan (1974) described social support as providing promotion of mastery, offering guidance and validating identity. Barrera and Ainlay (1983, as

cited in Vaux, 1988) described social support as providing: “material aid... behavioral assistance... intimate interaction... guidance... feedback... and positive social interaction” (p. 20). Vaux outlined five “modes of support” in his Social Support Resources Assessment: These are “emotional, socializing, practical, financial and advice/guidance” (p. 40).

Social support, both physical and emotional, provides the individual with a buffer against the stress of her/his environment. Social support studies have been utilized to better understand how individuals survive stressful environments or traumatic events (Fleming, Baum, Gisriel, & Gatchel, 1982; King, Taft, King, Hammond, & Stone, 2006; Marwit & Carusa, 1998). Hirsch’s (1980) work on the interaction of social support and the ecology of human development has looked at the relationship between social support and mental health. The concept of the connection between emotional well-being and social support is helpful in understanding the importance of social support for children who have lost a parent, especially for those children who have been raised in socially isolated, violent homes.

Bevin (2002) wrote about the benefits of social support in her depiction of her therapeutic work with “Marty.” Marty was two years old when his mother was shot by his father. His father killed himself immediately after killing his wife. Marty was present and trying to comfort his mother when he was found by neighbors. The horror of this experience led this child to regressive behavior and excruciating grief. However, Marty was fortunate to have maternal grandparents who were very close to him before the death of his mother. In spite of their own crippling grief, they were able to provide Marty with a warm, loving home where his emotional struggles could be tolerated. In addition to their support, they followed through with professional support to help Marty work through his grief tasks. The grandparents also supported Marty in connecting with his paternal extended family. As he grew closer to his father’s family he extended his social network, which gave him an expanded sense of identity.

Vaux (1988) supported the importance of family influence on social support development as illustrated in the above example. “A person’s family of origin lays the groundwork for how the network will be developed and maintained” (p. 80.) This is especially true for young children who are dependent on adults to open the doors to systems outside of the immediate familial caretakers. As a child ages their options for social support has the opportunity to expand outside of the family as she/he enters educational environments and develop independent social

contacts. As adolescents increase separation from their family of origin they further expand their options for social networking (Christ, 2000).

Help in Understanding the Importance of Social Support

Children who survive the death of a parent by intimate partner violence experience concomitant losses: the loss of a parent by death, the loss of a parent or parent figure by incarceration, death or disappearance, and the loss of their family (D. Black & Kaplan, 1988; Harris-Hendriks et al., 1993; Malmquist, 1986). To understand this complexity, the reader must have exposure to three areas of research. The first area is focused on the impact of children witnessing intimate partner violence. Included is basic information about intimate partner violence as a social phenomenon. The second area describes the response that children have to the death of a parent. The final area is that which deals specifically with the impact of intimate partner murder on the children who survive. This literature review will include these three areas of study in hopes of giving the reader a comprehensive understanding of the problems that these children must endure and the importance of social support to their survival.

The literature devoted to those children who have experienced the death of a parent has been described as limited by several researchers (Bevin, 2002, Burman & Allen-Meares, 1994; Harris-Hendricks, 2001); however, a few significant studies have recognized a number of common experiences that children have reported (D. Black & Kaplan, 1988; Malmquist, 1986; Osofsky et al., 1995). These experiences are helpful in understanding the importance of social support. Including the additional literature areas serve to compensate for the limitations of this body of work.

The Effects of Children Witnessing Intimate Partner Violence

The effects of witnessing intimate partner violence have been documented in children of all ages (Carter et al., 1999; Groves et al., 1993; Groves, 1999). Children do not have to visually see the abuse to experience its negative impact. They may hear, feel the tension surrounding the violence, or see the aftermath of observable injuries (Jaffe, Wolfe, & Wilson, 1990). The effects can actually begin before birth when a child is in utero (Perry, 1997). The family created by the birth of the child develops in an atmosphere of violence. In his 1976 study, Gelles hypothesized “that the fewer resources a wife has in a marriage, the fewer alternatives she has to her marriage, the more entrapped she is in the marriage, the more reluctant she will be to seek outside

intervention” (p. 664). The CDC (n.d.) reported that “at least 4-8% of women report violence during pregnancy. Using this conservative range of prevalence, of the 4 million women who delivered live-born infants in 1998 between 152,000 and 334,000 would have experienced violence during pregnancy.” This information was also supported through the work of Gazmararian, Lazorick, Spitz, Ballard, Saltzman, and Marks (1996). McFarlane, Parker and Soeken (1995) studied the frequency, severity and risk factors of homicide for pregnant women. They reported that “physical abuse during pregnancy is common, easily detected... and associated with higher... risk factors for homicide” (p. 288). What does this mean for the unborn child?

One risk to the unborn child is miscarriage (CDC, n.d.). However, there are more common risks that can have lifelong consequences. How does a woman who becomes a victim of intimate partner violence while pregnant effectively bond with her newborn? Does she experience depression because of her situation? Does a preoccupation with safety impair her ability to bond? Osofsky (1999) pointed out that when parents are exposed to violence as victims they may “become depressed and unable to provide for their young child’s needs” (p. 41). When considering the impact of violence on infants and children below the age of three, other than direct physical abuse for the child, violence in the family is the most significant risk (Zeanah & Scheeringa, 1997). One must consider that the mother is often the only social and physical support that an infant or toddler knows. Her impairment can significantly impact the child’s understanding and response to his or her social and physical world.

Fantuzzo and Mohr (1999) reported that children under the age of five were represented in higher numbers than expected in homes where intimate violence takes place. These young children can become vulnerable because they do not have the ability to cope with the negative emotionality that is characteristic of intimate partner violence. Scerbo and Kolko (1995) reported that the emotional regulation that is needed for children to cope with negative emotionality is initially learned in early childhood. Emotional regulation modifies an individual’s response to negative stimuli; the establishment of these basic coping skills begins in the first two years of life. “By late preschool failure to learn to modulate strong negative emotions may have taken its toll on the child’s social relationships and on self-image” (Karr-Morse & Wiley, 1997, p. 201).

As children enter an academic setting in kindergarten, their social support systems expand to include teachers; with this expansion comes increased expectation of the child's academic performance (Silvern, Karyl, & Landis, 1995). Cognitive and social development becomes the focus of those expectations. Children, who are witnesses to intimate partner violence, may exhibit impaired cognitive skills leading to poor academic performance, impaired problem-solving skills, compromised self-esteem and limited empathy. Other problems documented and observed are behavioral problems including increased aggression, sleeping difficulties and depression (Jouriles, Norwood, & McDonald, 1996).

Young children may live for years with fear and anger about the violence in their homes (Groves et al., 1999). However, their options are limited and their choices are controlled by the violent adults with whom they live. Adolescence brings new recognition of the possibilities of being independent. Children at this age are painfully aware of the secrets in their lives; developmentally they want to be like their peers. "Adolescents want desperately to be normal" (Bilides, 1992, p. 141). This developmental process makes them aware and able to recognize that not all families are violent like theirs. C. Black (1981) described spending evenings walking around her hometown during her adolescent years looking in neighbor's windows trying to figure out what "normal" families did when they were together. Somehow she knew that life with her violent, alcoholic father was not the way she wanted to live.

Adolescents may confront their mothers with their growing awareness that the violence in their home is wrong. Even though some youth confront their mothers and urge them to leave the perpetrating partner, others choose to focus primarily on their friendships and do not want a move that will complicate their access to age cohorts (Jaffe et al., 1990). I have observed through clinical experiences that adolescents may act out their anger about the violence through self-destructive behaviors such as abusing alcohol and drugs, promiscuous sexual acting out and violence. Both boys and girls may cope through acting-out behaviors, though males tend to act out more externally and females tend to internalize their anger and pain (Groves, 2002).

Gelles (1997) pointed out that growing up in a violent home where the adult male partner is abusive of the female partner may model for a male child that the females are "appropriate" victims of abuse. "There are abundant historical and cross-cultural data to support the claim that women are the 'appropriate' victims of domestic violence" (p. 71).

Male adolescents also can follow in their fathers' footsteps and vent their anger at their mothers carrying on the tradition of male power and control, even if the mother is able to leave the perpetrator (Zink, Elder, & Jacobson, 2003). This learning process contributes to a generational cycle of violence as adolescents become involved in their own intimate relationships (Gelles, 1997; Lichter & McCloskey, 2004; McCloskey & Walker, 2000; Wolfe & Jaffe, 1999). Growing up in a home where the adults are violent can teach males that violent behavior toward their partners is an acceptable solution to conflict. Likewise, females may be more at risk for choosing violent relationships (Lichter & McCloskey, 2004).

In 1998, Graham-Bermann and Levendosky studied 64 children utilizing the Achenbach Child Behavior Checklist. Violence in their homes was assessed by utilizing the Strauss Conflict Tactics Scale and the Marshall Violence Against Women Scale. The outcome of the study showed that only 8 of the 64 children showed adequate symptomology to support a posttraumatic stress disorder (PTSD) diagnosis, however 52% reported intrusive re-experiencing of the trauma, 19% indicated avoidance of the trauma, and 42% reported increased hyperarousal. Even though the outcome indicates great concern, the following quote from the authors describes the confounding circumstances that these children experience. "Children in families of domestic violence may be further damaged and harmed by the lack of available support and an abundance of negative role models — that is, the available models are for the very relationships that children may wish to reject but are often doomed to repeat" (p. 111). Moreover, perhaps the most worrisome factor is that children begin to see violence as the norm (Kelly, 2003).

Like adults, children can develop PTSD when exposed to an overwhelming traumatic event, like the death of a parent by intimate partner violence. PTSD is characterized by three symptom categories: 1) intrusive thoughts and disruptive re-experiencing of the trauma, 2) a reluctance to revisit the trauma and 3) increased hyperarousal and reactivity (McCloskey & Walker, 2000). McClosky and Walker studied 337 school-age children and found that the loss of a person who is close to the child, family violence, and violent crime were the leading causes of PTSD in the children studied. The children who lost a parent by intimate partner violence have experienced all three of these causal factors.

Richard Famularo (1997) in his article in the Harvard Mental Health Letter pointed out that children with PTSD often are misdiagnosed because of the symptom variability. These children may be diagnosed as hyperactive, depressed, bipolar and overanxious. He explained

that traumatized children may need remedial support in school and may be a greater risk for suspension. PTSD, if not treated, can inhibit a child's emotional growth and social development.

When working with children living in abusive homes, I have observed parallels to the experiences described by Cermak (1988) in his research on children raised in alcoholic homes. Children are trained by living in a violent home. These lessons reinforce that trust cannot be assumed and that much of life takes place shrouded in secrecy. Intimate partner violence often increases in severity and frequency over time, increasing the exposure as the child ages. Because they are bystanders in this drama, children often assume guilt for the pain that their parent experiences, and expect that they should be able to do something to stop the violence and secure peace for their family.

Fortunately protective factors can be present to aid the child who witnesses intimate partner violence. Social supports are one of the most important sources of strength and resiliency for children (Masten & Powell, 2003). Osofsky and Fenichel (1994) pointed out that the most powerful protective factor is a strong relationship with an adult characterized by warmth and acceptance providing the child with needed social support.

Children's Response to the Death of a Parent

The reactions to the loss of a parent by death differ with the developmental level of the child including age, cognitive development and emotional maturity. How the child understands the loss and the reason for the loss will vary radically from age to age. However, the very youngest child is aware that his or her world has changed (Zeanah, 1993). The murder as the cause of the loss further complicates the death. If the child has watched his parent decline through a long debilitating illness, the child may have had a chance to say good bye to the parent and feel some relief that the illness is over. In contrast, those who lose a parent by an accident, violence or suicide must come to terms with the unexpected nature of the death. Violence and suicide can further complicate the loss because of the attributions of judgment given by religious, cultural, and social expectations (Bluestone, 1999; Cain, 2002; Wolfelt, 1996).

Parental death in childhood is the focus of a considerable body of research. Researchers have looked at a child's loss of a parent from many different perspectives during varying developmental periods. During infancy and toddlerhood, children are the most dependent on their parents for sustenance and survival, having neither the capabilities nor skills to survive

without constant care. In addition, attachment as described by Bowlby (1961b) is critical to the child's positive development. It is during these early years that children are the most vulnerable to devastation by the loss of a parent, especially if that parent is the focus of their primary attachment. "Loss of the attachment figure for an infant or toddler is so devastating that it is qualitatively different from loss at another point in the life cycle" (Zeanah, 2000, p. 363). The loss may be even more difficult if the infant has a strong attachment with the murdered parent, or if there are not others with whom the child has bonded prior to the loss (Gaensbauer, Chatoor, Drell, Siegel, & Zeanah, 1995).

Preschoolers have an expanded world that may include a variety of people in their lives. However, their dependency needs are very high and attachment to the parent is still primary in their lives. Children who have lost a parent and are in day care have been observed to have become withdrawn, to have shown regression in social skills, and to have increased behavioral problems, especially if they do not have adequate verbal skill to express their anger and fear (Groves, 2002).

Worden and Silverman (1996) compared the adjustment of bereaved children and non-bereaved children who were all of school-age. The authors found that bereaved children as a group showed greater emotional and behavioral problems than did their peers who had not lost a parent to death. This is especially true if the parent was a source of love, warmth and security for the child. As Bluestone (1999) described, "the death of such a loved one leaves a bereft child with a world that may never again be as secure and safe a place" (p.225). In her article about working with two elementary age children who had both lost parents, Bluestone described their struggles to come to terms with their loss and rebuild their lives through their experience in peer therapy.

Ellis and Granger (2002) studied African Americans who had lost parents during their adolescence. They found that there were higher rates of delinquency in males than in females following the death of a parent. When children experienced prolonged grief that lasted for more than a year they often experienced multiple problems - both behavioral and interpersonal. With the death of a parent, the separation and individuation process may be interrupted or prolonged due to the adolescents' need to focus on the surviving family instead of using their energies to separate (Wolfelt, 1996). Marwit and Carusa (1998) pointed out that when a parental loss occurs during adolescence it may coincide with a time of rebellion or a struggle with the deceased

parent for individuation. This element of timing may affect to whom the adolescent will feel comfortable going for support.

Support is critically important to the child or adolescent who loses a parent. An interesting finding by Ellis and Granger (2002) was that most of the children they studied did not receive professional assistance. The children depended on their informal support system for emotional sustenance. Children and adolescents are helped if family, friends, neighbors and teachers take on some of the functions of the lost parent (Marwit & Carusa, 1998). This support, whether systematic or intermittent, may serve as a protective factor for children so that they can grieve and continue to grow without symptom development.

Worden (1996) described four tasks of mourning for children following a parent's death. The tasks are:

- 1) To accept the reality of the loss, 2) To experience the pain or emotional aspects of the loss, 3) To adjust to the environment in which the deceased is missing, 4) To find ways to relocate the dead person within one's life and find ways to memorialize the person.
- (pp.13-15).

With the loss of the parent the child must transfer the parent from being an emotional support that is present in their lives to one whose past support is remembered and cherished in the present. A child's support system often is the key to working through these tasks. For some children, this support is adequate, and they are able to move on in their developmental strides (Worden, 1996).

Children whose development is interrupted or arrested by their parent's death may show a variety of symptoms and problem behaviors which may develop. Depression, anxiety, school behavioral problems, inattention, low self-esteem, and fears of death are only a few of those discussed (Ellis & Granger, 2002; Ziller & Stewart-Dowdell, 1991). When the parent has died due to violence or to suicide, the symptoms increase and are more protracted (Bluestone, 1999; Cain, 2002).

Children Who Have Had a Parent Die from Intimate Partner Violence

It is hard to imagine a loss greater than to have one parent killed by another parent. Burman and Allen-Meares (1994) described the loss as "simultaneously numbing and debilitating, creating scars of far-reaching proportions" (p.28). There are very few records kept

documenting the number of children who have sustained this loss. Even though statistics are kept on the number of intimate partner deaths, there is no record of the number of children in the home or their ages. However, the studies that are available have contributed to the understanding of their experience.

In a British study of 28 children whose fathers had killed their mothers, D. Black and Kaplan (1988) described these children as “experiencing both the death of a mother as a horrifying violence and being the child of a murderer at the same time” (p 624). This double bind for children is the origin of many of the struggles they face as they attempt to recover from this convoluted loss. They further reported that children often are stigmatized by being seen as the child of a murderer and may hesitate to recount their memories of the event. Not being able to openly share their memories may further complicate their grief reaction.

Other factors that contribute to the response of the child are his or her proximity to the murder, and whether the child sees the mutilated remains of the parent (D. Black & Kaplan, 1988). Both of these factors can increase the risk of the child developing PTSD. These authors speculated that children who are not present at the time of the lethal violence are somewhat protected by not having the visual images and audio memories of the event.

Another complicating factor is the isolated nature of many violent families. It is my belief that this isolation may cause the surviving children to be cut off from extended family members who could be a natural source of support after the death. This isolation may influence the choice of emergency or long-term placement for the child after the event and lead to greater distance from previous social supports.

Children often are relocated immediately after the death because of the immediate incarceration, suicide, or disappearance of the perpetrating parent (D. Black & Kaplan, 1988). Active mourning may be postponed by these disruptions in the children’s lives or because the natural supports in their life are overwhelmed by the horror of the events. Children may sense that the people in their support system are too overwhelmed by their own grief to listen to the child recount the event.

Because his or her story is painful to listen to, provoking in the listener intense feelings of horror, rage, sadness, and shame, the child may feel compelled to remain silent. This suppression further increases the likelihood of a pathological grief reaction occurring. (p. 626)

The impact of dislocation and a series of relocations may further complicate the child's life with a sense of "profound rootlessness" (D. Black and Kaplan, 1988, p. 629). Of the 28 children in the D. Black and Kaplan study, the location of six of the children immediately after the murder was unknown. Of the remaining 22, six were in foster care, six were in the care of a paternal relative, four children remained in their home, three were with neighbors, two were with maternal relatives, and one was in a foster home at the time of the parent's death. This breakdown relates two of the complicating factors - dislocation and the complication of finding a listener who is interested and unbiased.

Age-Related Issues

Infants and Toddlers

Gaensbauer et al. (1995) discussed the experience of a child who was one year old at the time that her mother was killed by her mother's boyfriend. The child was immediately placed in foster care for one week, then in another foster home for five weeks before being placed permanently with a maternal aunt and uncle. Within this six week period, the child had lost acquired language skills, had developed feeding problems and had become detached from caregivers.

Gaensbauer et al. (1995) speculated that the regressive behaviors and her flat affect had been enhanced by: the impact of the horror of her mother's tragic death creating PTSD, the loss of her primary attachment, and the lack of initial stability of placement. Even though her effective bond with her mother was a protective factor, her inability to consciously remember the details of her mother's death kept her from effectively grieving the loss of that attachment. Not being able to grieve about her mother's death and understand the unconscious memories of the horrors of that death caused her development to be compromised both physically and emotionally.

School-Age Children

Even when the murder is considered to be justifiable homicide, the child's ability to understand and evaluate her/his circumstances may be impaired by the crushing nature of her/his loss. Norton (1994) illustrated how a child whose mother is acquitted of killing her father is torn by her attachment to two loving parents who were locked in a deadly, violent relationship. She

had followed this family as part of a research project for six years and had observed the child's attachments through personal interviews and videotaped interviews. She had observed the child's joyful reciprocated love of both parents in spite of her father's chronic drug abuse, and the near constant chaos caused by his abuse of her mother. "Although Jade could not trust her parents with each other she could trust them with herself" (p. 19). In spite of this devastating loss, this child was successful in her academic achievements at the age of seven. Perhaps her ability to continue in her developmental strides was because she had this loving foundation in the beginning of her life. Would the outcome of this tragedy have been different if her mother had been the one who had been killed?

Burman and Allen-Meares (1994) emphasized the importance of early intervention with children who have experienced the death of a parent by intimate partner violence. These "children and their families are in urgent need of immediate and intensive care" (p. 28). Likewise Pynoos and Eth (1985) pointed out that crisis intervention is critical to the child because it gives the child a chance to share their emotions and the visual images that were seen. This early intervention gives the child a chance to share these feelings and images before they are less accessible to the child because of the pain that she/he is experiencing.

Burman and Allen-Meares (1994) described two brothers who were referred two years after their father shot and killed their mother in their presence. Following the event the children were fortunate to be placed with their maternal aunt with whom they had lived before and had a close relationship. This became their permanent home. The authors pointed out the importance of this accessible support system for the children, but they emphasized that how the aunt handled her grief created problems for the boys. The aunt did not talk about their mother's death or encourage the boys to do so. The aunt was fearful of other children teasing the boys about their family problems, so she did not allow them to play with children outside the family. Eventually, both boys became symptomatic at school with behavioral and academic problems and were referred to treatment. The authors found that even though they had been surrounded by love, they had not been able to successfully grieve their mother's death, nor had they been able to develop supportive friendships with age cohorts. Through individual, family and group therapy the children were encouraged to grieve, learn new social skills and renegotiate their relationship and trust with their aunt allowing them to form a closer attachment to her.

Malmquist (1986) described a child witnessing the murder of a parent as a “rare event” (p. 320), and reiterated other authors’ observations that it is surprising that only a very few of these children are seen by mental health clinicians at the time of the trauma. One can speculate that the reason that the child is not initially referred to a professional is that the caretakers do not know the child well and are not aware of behavioral changes. If the child has been moved to a new neighborhood or town, then she/he will be attending a new school and behavioral changes may go unrecognized. Often classroom teachers are the first to recognize behavior and emotional problems in children because of the constant contact with the child in context. Malmquist looked at six children who had witnessed parental murder and evaluated them for symptoms of PTSD. He found that all of the children met the DSM III diagnostic criteria for post traumatic stress disorder.

These children were described as having intrusive thoughts of the trauma when they were trying to concentrate at school, often at inopportune moments (Malmquist, 1986). This often made the children appear spacey to peers and was cause for ridicule. In addition, teachers thought the children were daydreaming or not paying attention. Most of the children reported having nightmares and a variety of fears. Even though these children were depressed, their behavior and affect looked very different from a similar depressed adult population. They exhibited “anxiety, restlessness, hyper alertness, vigilance, and difficulty concentrating” (p. 322). However, Malmquist found hope in the fact that the children were able to stay intact and not become psychotic.

Despite the presence of diverse symptom pictures, indicating distressing signs of anxiety, they did not collapse into psychotic states. Perhaps the key lies in the strength of their antecedent object relations and self-esteem which allows them to handle such a traumatic event and loss without a massive abandonment of ego functioning...beyond the clinical picture that they presented. (p. 325)

He hypothesized that the children who eventually are able to cope with such horror and disappointment in their lives are those who can still “affirm their own value and worth” (p. 325).

Adolescents

Most of the case research, in the survival of the death of a parent by intimate partner violence, whether single case or larger subject groups, has been focused on very young or school

age children. Out of D. Black and Kaplan's (1988) subject pool, only 7 of the 28 subjects were 12 or older. As mentioned earlier, the record of the number of children and their ages has not been incorporated into the statistics currently maintained on domestic murder therefore information is limited.

One possible reason for the lack of information is that the behavior, whether internalized as depression or externalized as "acting out," is brought to society's attention rather than the loss that was the antecedent of the behavior. Unfortunately, if the background of having grown up in a violent household is part of the child's experience, the adolescent's survival may be marred by attempts at suicide or conflicts with the legal system (D. Black, 1998).

In view of the fact that most of the literature focuses on a clinical population, the more hopeful for encouragement may be that increased verbal abilities occurring in adolescence assist the older child in their adjustment (D. Black, 1998). The increased independence of adolescence also creates an opportunity for the older child to have a larger, more diverse social support system to assist her/him in her/his adjustment thus explaining their absence from the research populations.

Role of Mental Health Professionals

A child who has had a parent killed by intimate partner violence may never receive mental health services. It is impossible to know what proportions are seen by clinicians; very limited records are kept regarding the children. However, Harris-Hendriks et al. (1993) have recommended that all children who have had this experience should be seen by a professional within 24 hours of the event. There is limited indication that this recommendation has been incorporated in current services. If this recommendation were taken and utilized by communities for each child it could help insure that there would be more monitoring of the child's needs both for immediate social support and long time services.

Mental health professionals can provide immediate social support, encouraging the child to talk about her or his experience and if the child is old enough consult with her or him about future care (Harris-Hendriks et al., 1993). Mental health professionals may be able to provide some consistency when a child's future is undefined. Harris-Hendriks et al. describe therapeutic relationships children have had with their mental health professionals that have been consistent

through a number of different placements for the child. This type of stability is critical when a child has lost a parent.

The literature review gives insight into the importance of attachment and the critical nature of children processing their grief. The impact of intimate partner violence on the lives of children whose parents are caught in these destructive cycles is well documented. However, little has been written about the children and their families' lives after the murder. How do families find the support to care for the children after the death? How do children find the support needed to restructure their emotional lives?

Exploring the social support systems available to the children and their families is a logical next step. Understanding the formal and informal support systems as observed by and reported to mental health professionals adds to the body of knowledge about these children and their families and will help answer the research questions presented in Chapter 1.

CHAPTER 3 - Methodology

. The majority of studies published about the experience that children have when a parent is killed by an intimate partner have been in the case study form of qualitative research. Burman and Allen-Meares (1994) have described the response of two brothers whose father killed their mother. The study by Azarian et al. (1997) described a five-year-old boy's anniversary reactions to his father's attempt to murder his mother and the father's subsequent suicide. Bevin (2002) has written a case study of a toddler whose mother was killed by her father. Likewise Gaensbauer et al. (1995) described a toddler who witnessed her mother being murdered by her father. Osofsky et al. (1995) provided a case study of two brothers whose mother was killed. All of these case studies were of clinical cases. Originally I wanted to interview adults who had experienced the loss of a parent by intimate partner violence as a child. However, after trying to recruit those adults through mental health professionals (a requirement of the Kansas State University Institutional Review Board) I was unable to identify any participants for whom the time was right for them to participate in the study. Therefore a new proposal was submitted to interview mental health professionals regarding their observations of and experiences with social support in the lives of these children.

The choice of utilizing a phenomenological approach for this study to examine the work of mental health professionals is an appropriate next step for further exploration of this phenomenon for three reasons. It offers the possibility of learning about the social supports that were reported or observed, examining services that have been utilized. In addition, it offers the opportunity to examine needed services that were not available. In the process mental health professionals describe their experience in working with individuals who have had a parent killed by intimate partner violence. Phenomenological research is naturalistic, inductive and requires direct personal contact (Patton, 2002). The naturalistic quality is seen in the lack of manipulation of the research subjects. The fact that the individual's experience is used rather than a limited interpretation by the researcher makes it inductive. The use of personal contact gives the researcher a chance to report the voice of the participant without layers of interpretation (Patton, 1990).

Phenomenological Research

Creswell (1998) described a phenomenological study as one that studies several individuals' experiences or concepts of a phenomenon, whereas a case study examines an individual's experience. Edmund Husserl is credited with being the father of phenomenological research (cited by Patton, 1990). Phenomenology was based on Husserl's basic belief that "we can only know what we experience" (p. 69). His assumption was that humans recognize phenomena through our senses then make interpretation about those sensory experiences. "Phenomenologists focus on how we put together the phenomena we experience in such a way as to make sense of the world and in doing so, develop a world view" (p.69). This study explores how mental health professionals experience working with individuals who have had a parent killed by a loved one. The mental health professionals interviewed not only talk about their experience of this work, but also give some assessment of the availability of social support to these individuals.

Husserl's philosophical influence is seen in four themes of phenomenological studies that Creswell (1998) described as, "1) A return to the traditional tasks of philosophy, 2) A philosophy without presuppositions, 3) The intentionality of consciousness, and 4) The refusal of the subject/object dichotomy" (pp.52-53.).

Moustakas (1994) described Husserl's contribution of intentionality and ideation in phenomenological research. Intentionality is the idea that an object is perceived through the meaning that the object has for the person who is judging it (Creswell, 2007, pp. 235-236). An example of intentionality could be seen in this author's perception of "family" that was developed through my own experience of growing up in an intact family of five during the 1950s and 1960s. What I saw around me were other intact families of traditional structure. Moustakas (1994) stated that knowledge of intentionality requires "that we recognize that self and world are inseparable components of meaning" (p. 28). Ideation refers to the "object that appears in consciousness mingles with the object in nature so that a meaning is created and knowledge is extended" (p. 27). The ideation of family now is very different for me because within my own family system, and within the family systems of my friends, we have a wide variety of family structures.

Moustakas's (1994) interest in phenomenological research is of particular importance to this study because of his expertise in child play therapy and his renowned work with troubled

children. This bridge between his interest in children and this particular form of qualitative research reinforces the validity of using this approach. My experience in completing the review of the literature for this study also contributed to my interest in pursuing a phenomenological approach. No studies were found that reported the voices of the children; most were the voices of clinicians. Though it is again clinicians who have participated in this study, they have often quoted the children. It was not my first choice to interview mental health professionals as participants for this study. Because I was not successful in recruiting adults who had experienced this loss as children, for the most part, the voices of the children continue to be missing.

The implications of utilizing a phenomenological qualitative method are that the study encompasses the words of the participants rather than interpretations of their words. Patton's (1990) description of the advantages of using direct quotes from participants applies well to this study. "Direct quotations are a basic source of raw data in qualitative inquiry, revealing respondents' depth of emotion, the ways they have organized their world, their thoughts about what is happening, their experiences and their basic perceptions" (p. 24). In phenomenological studies the words are documented, recorded and analyzed to determine thematic similarities. When the choice was made to interview mental health professionals, I knew that I would be analyzing their words; however, I never expected their words to be as powerful as they proved to be. The reader will find that through the analysis of the themes, interpretations can be made regarding the impact of death of the parent on the participant and the social support that they have received, which may, in fact, change the reader's perception of this experience.

Research Methods

Participants

Six mental health workers who worked with children who had a parent killed by intimate partner violence were recruited for the study. These mental health workers worked with these children individually, in families and in groups to enhance their emotional health. All participants were voluntary participants who were instructed that they could withdraw participation at any time. I chose to interview mental health professionals because through their clinical or case-management roles they were in a position to learn about the social support available and needed by these children at the time of their engagement with the children. While

working with these children they learned about their client's life experiences both positively and negatively related to the loss of their parent. These professionals observed the social supports that helped or hindered the grief process. In addition, these professionals were able to assess the services that were needed and not available to the children in their communities. The mental health workers interviewed were in an excellent position to make recommendations to enhance services to these children.

I recruited the mental health professionals by making personal contacts with agencies and researchers who are currently working with or studying intimate partner violence with letters describing the study and requesting subject referrals. While there was a small snowball effect most of the participants were recruited individually. Five of the participants represented were social workers, and one was an art therapist. The participants were from three states and a number of different communities. One community was noted for having high levels of community violence, and therefore, that community had specialized services available.

Informed Consent and Confidentiality

Great care was given to insure the safety and well being of participants. Approval was granted by the Kansas State Institutional Review Board to proceed with the study (Appendix A). Each participant was required to sign an informed consent form (Appendix B). I included a caveat in the informed consent that the participants could terminate their participation at any point in the research whether during the interview or after the interview took place without any negative consequences.

Because the participants were mental health professionals, I made an effort to insure that all HIPAA regulations were followed. I reminded the mental health workers at the time of the interview to disguise all the information they shared to insure that they did not share identifying information about their clients. Any names that appear in the findings were fictionalized.

Interview Agenda

“The purpose of interviewing is to find out what is in and on someone else's mind” (Patton, 1990, p.278). I conducted a detailed face-to-face interview with the participants that utilized a consistent format and outline. This form of interview insured continuity while allowing for flexibility. Five of these “standardized open-ended” interviews (Patton, 1990, p. 287) lasted approximately one hour; one lasted for almost three hours. Interviews took place

after the informed consent was agreed to and signed by the participants. They occurred in a variety of locations convenient to the participants, while allowing for confidentiality. My 25 years of experience in clinical interviewing helped insure that I had the skills to provide the participants with a warm and supportive experience. This was important in encouraging the participant to give a “comprehensive disclosure of the experience” (Moustakas, 1994, p. 123). I did not expect the interviews would be emotionally difficult for the mental health providers. However, there was evidence of emotional involvement as I observed tears from more than one participant. The participants also seemed to feel a sense of accomplishment in contributing to the body of knowledge about children who have had a parent killed by intimate partner violence.

I tape recorded interviews; permission for this was included in the informed consent. Problems occurred during interview 1 so it was repeated and re-recorded. I designed the interview questionnaire to include only open-ended questions that incorporated the participants’ experiences and their knowledge of the social support of their clients. However, most of the interviews built naturally on the knowledge and experience of the participants and went beyond the limitations of the anticipated questions and beyond my intentions.

Thematic Data Analysis

After the choice was made to concentrate on social support as the primary way of approaching the research questions tape recorded interviews were transcribed. The themes identified centered around the social support experienced by the child and her/his family. I completed five transcripts, and a colleague, who had been trained in qualitative research and had completed University of Missouri Kansas City Social Science Institutional Review Board compliance requirements, transcribed one of them. These themes, which emerged from the interview data, were analyzed utilizing the modification of the Van Kaam method of analysis of phenomenological data as described by Moustakas (1994) using the following steps:

1. A list was made of all relevant expressions that were a part of the experience; Moustakas referred to this process as “horizontalization” (p. 120).
2. Each expression was tested utilizing two criteria: a) “Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?
b) “Is it possible to abstract and label it? If so, it is a horizon of the experience.

Expressions that do not meet these requirements are eliminated.... The horizons that remain are invariant constituents of the experience” (p.121).

3. Invariant constituents were clustered in relation to thematic labels.
4. The invariant constituents and their related themes were compared to the transcript to insure that they were true to the verbalizations of the participant.
5. An “Individual Textural Description” was constructed and included quotes from the transcript (p.121).
6. Each participant was given a “Textural-Structural Description of the meanings and essences of the experience” (p.121).

I compiled findings by combining the individual textural descriptions of each participant that captured the “meaning and essence of the experience of the group as a whole” (p.121).

One foundation of feminist research is the inclusion of participants as collaborators in research projects (Fonow & Cook, 1991). Sharing the outcomes of the research is one way of insuring that collaboration takes place. The findings of this study will be shared in summary form with each participant. In the final viewing of the findings of this study, the participants should have a validation of their experience and feel as though they have contributed to a better understanding of the experience that a person has when they have a parent killed by an intimate partner. Participants in this study also were able to review transcripts of their interviews, which insured the accuracy of the researcher’s view increasing the validity of the study.

Researcher as an Instrument of Research

Validity in qualitative research is dependent on the “skill, competence and rigor” of the researcher (Patton, 1990, p. 14). The credibility of the researcher is essential to the credibility of the study. In order to inform the reader of my relevant qualifications and values the next section outlines pertinent information that illustrates my credibility and my fit with this research method.

Clinical Social Worker Frame of Reference

I received my Master’s Degree in Social Welfare (MSW) from the University of Kansas in 1979 and began working with children, adults and families focusing on a variety of issues many having to do with grief and loss. During the subsequent 24 years as I worked with children, I became aware of their strengths and resiliency. Working from a strengths perspective, I believe that each individual has the potential to find the answers to her/his

dilemmas in her/his understanding of her/his experiences. This is especially true of issues of loss that must be explored in order to resolve the accompanying grief (Kubler-Ross, 1983; Worden, 2002). When grief is expressed it is my belief that a synergy occurs that allows the individual or family to reinvest in life.

Clinician as Researcher

My experiences as a clinician working with children led me to the role of researcher. Initially I had been rather suspect of research, however, my attitude changed after I had the opportunity to work with Joy Osofsky, PhD. Osofsky (1997) is well known for her research into the impact of violence both domestic and community on children (Osofsky, 1997). She was able to convince me of the importance of research. Though Osofsky's research tended to be quantitative in its methodology, I needed to hear the voices of the people I studied. Perhaps this need grew out of having been a clinician first. I had listened to the voices of clients describe their pain; I needed to know more.

Research and Family Life Education

While working with children I realized that in order to be truly helpful I would need to learn more about families. This realization led to PhD studies in Family Life Education and Consultation; this research is the culmination of that effort. I believe that in order for children to have better lives, free of trauma and chaos, there must be less violence. I also believe that families are faced with unprecedented stressors including a rapidly changing world that is unstable politically and economically. The expansion of a global perspective in communications means that families are constantly bombarded with stories of violence from around the world. In order for families to develop free of trauma and chaos they must understand that peace must begin at home. This research will be used to help nurture our understanding of peace in families and how social support can help mend families torn by violence.

Demographics of Participants

Six participants were recruited through a variety of sources, word of mouth contacts and networks, coalitions and the domestic violence shelter system. All of the six participants were women; one of the six was African American. Four had Master's of Social Work degrees, and one had a PhD in Social Work; the sixth participant had a Master's in Art Therapy. Two of the

six had post-master's fellowships in infant psychiatry. One participant had participated in a post-master's family therapy training program. Out of six participants, five had master's degrees before they worked with children who had a parent killed by intimate partner violence. One participant had not yet received her master's training, but she had a Bachelor's in Social Work at the time that she saw the children that she described.

The participants lived and worked in three states and were residents of medium-sized cities in the South and in the Midwest. They worked for non-profit private and public agencies, medical schools, and private for-profit helping service staffing agencies at the time that they worked with the children who were seen. Referrals were made by a variety of public and private agencies. School districts and day care centers initiated many of the referrals to the agencies where participants were employed in response to the child's problem behaviors.

Referrals of Children to Participants

School districts initiated many of the referrals, however, parents or caretakers also initiated referrals because of behavioral problems at home. These referrals were not necessarily made at the time of the death of the parent but could be months to years afterwards.

I think that it was 18 months or a full two years because the children had initially done okay so there was really not a concern. Again they did not seek treatment because of the children's exposure to the events leading to the loss of both of their parents (Interviewee 2, p.4, para. 1).

One of the participants was actively working with the child at the time that the parent was murdered. Another participant had recently been introduced to the family and child before the parent was killed.

Interview Specifics

I interviewed the participants at locations they requested. Three were held at the participants' offices. Two were held at a children's mental health foundation, and one was held at the participant's residence. Most of the interviews lasted for one and a half to two hours. One participant had worked with several children; her interview lasted for three hours.

Efforts to Insure Accuracy

I shared transcripts with the participants to insure that they had been well represented and that the transcripts were accurate. I emailed or sent them through standard mail. I also sent participants a letter of appreciation and a small booklet entitled, *A Child's View of Grief: A Guide for Parents, Teachers and Counselors* by Alan Wolfelt, PhD.

An Additional Reviewer was Incorporated

In an effort to insure that there was a secondary evaluation of the thematic analysis, I utilized a second reviewer. Table 3.1 identifies the themes described by the second reviewer. There was one theme found by the reviewer that is not reflected in this document. That theme was one of Social Support through Play and Social Contacts. I utilized themes that were represented by at least five of the six participants and only three participants referenced this theme. Otherwise all other themes identified by the second reviewer were identified by the researcher and were included in the findings and discussion sections. This was a helpful process in reinforcing the thematic analysis. The second reviewer was a trained researcher and was familiar with the study.

Table 3.1 Reviewer II thematic chart of social support for children who had a parent killed by intimate partner violence.

Extended Family Involvement	Interviewees: 1,2,3,5
Need for Primary Caregiver/Support of the Caregiver	Interviewees: 1,2,3,5
Stability vs. Emotional Support	Interviewees: 1,2,3,5,6
Systems and Agencies – As Positive Social Support vs. Hindrance to the Healing Process; referral, linkage, assessment and interference	Interviewees: 1,2,3,5,6
Play and Community Connections as Support	Interviewees: 1,2,3,4,6,
Importance of Supervision, Training and Peer Support for Workers as Social Supports	Interviewees: 2,3,4,5,6

CHAPTER 4 - Findings

Chapter 4 reflects themes indicated by the majority of participants. These themes are illustrated by participants' quotes. The theme clusters are the participants' recollections of the experiences of children and their families as they attempted to heal from a horrendous loss. Descriptions of participants' knowledge and awareness of the social supports of the families that they served included:

1. Specific social supports acknowledged before and after the homicide occurred.
2. Stressors experienced by the families immediately following the event.
3. Steps that were taken by families to engage in both existing and potential sources of social support after the homicide occurred.
4. The importance of long-term attachment figures for children who had a parent killed by intimate partner violence.
5. Coping efforts and grief recovery explored specifically in light of the complications created by homicide involving intimate partners.
6. Finally the chapter will explore:
7. The difficulties of providing long-term care and support for these children and the personal costs those caregivers may experience.

These thematic elements are outlined in Table 4.1 with the number of participants contributing to each theme noted.

Table 4.1 Thematic chart of social support for children who have had a parent killed by intimate partner violence.

Social Supports Prior to the Homicide	Interviewees: 2, 3, 4, 5, 6
Stressors on the family Began Immediately after the Homicide	Interviewees: 1, 2, 3, 4, 5, 6
Social Support After the Homicide	Interviewees: 1, 2, 3, 4, 5, 6
Efforts to Engage Social Support after the Homicide	Interviewees: 1, 2, 3, 4, 5, 6
The Importance of Long Term Attachments for the Children after the Homicide	Interviewees: 1, 2, 3, 5, 6
Coping Efforts and Grief Recovery	Interviewees: 1, 2, 3, 4, 5, 6,

Social Support Existed Prior to the Homicide

Though not all participants worked with the children prior to the death of their parent, all had some knowledge of the levels of social support the families experienced prior to the event. This information was gleaned from social histories or from reports given after the homicide by caregivers in the process of their work with the mental health care providers.

The Intimate Partner Violence Was Known in the Community

It was not unusual for there to be evidence that knowledge about the violence in the home existed before that violence escalated to homicide. However, this involvement with social support and even prevention/treatment agencies did not prevent the homicide from occurring.

Everyone was aware that this family has substance abuse issues and that the parents were...even though they were divorced they were constantly in chaos and in crisis...the parents would sometimes make attempts to reconcile and it would end disastrously...and actually both of the parents had therapy here as well. Her mother was a member for quite some time of the women's support group and the father was for a very short [time] in our batterer's group. (Interviewee 5, p. 5, para. 2)

In response to a question about the level of social support that a family received at the time that the mother killed the abusive father, Interviewee 4 speculated that the community knew that domestic violence was a problem for this family:

I think that it [the incarceration] was extremely limited if at all...obviously she went through this court thing but then that was dismissed fairly soon...I don't believe that she was jailed. I think that the community knew what was going on to some extent or maybe to a large extent and it was pretty much self defense. (Interviewee 4, p. 6, para. 1)

There were indicators that neighbors would even try to assist victims of abuse as Interviewee 6 mentioned:

She was called at her the job by a neighbor who said dad was tearing the house up. It was about the time for the child to get off the bus from school and go to a neighbor's house. Well, if he saw dad's truck, mom was afraid that he [the child] would go directly home. She goes home. The child *had* [italics added] come home. Dad was actually assaulting the child at the time. He [the dad] was taking things from the house. The child was screaming and crying. He had taken the television, the child's game...It was like a play station...Mom comes in and sees the child with red marks on his face and starts yelling at dad. Dad chokes mother to death...The neighbors called [the police] as soon as they saw the mom drive up...by the time the police got there she had been assaulted and was unconscious. By the time that the ambulance got there she was deceased. (Interviewee 6, p. 2, para. 2-3)

In addition, social service agencies (specifically child welfare service agencies) were sometimes involved prior to the death of the parent.

Because of the violence in the home... well there had been [child welfare] involvement...the guardianship was granted to the grandparents because actually the mother at the time...actually both parents were dealing with substance abuse issues and

were just not able to supply a safe place for Sarah or her sisters. (Interviewee 5, p. 1, para. 3)

Another participant had worked with a child who had been referred to a family preservation unit of the state child welfare agency. “They were in the purview of the family preservation because in one of the assaults of mom by dad the child was injured. So they were put into the system of ... child protection” (Interviewee 6, p.1 para. 1).

Another child was in a family preservation program; the same participant points out that the domestic violence had not been assessed prior to the homicide.

She had been removed from the family another time and been reunited. And then a year or two later was in imminent danger of being moved again, hence her involvement in family preservation...The little girl was there [in the home]. Dad was molesting the little girl; Mom came home...was not supposed to be there. Dad killed mom...almost kills the little girl... This family was in care *before* [italics added]; domestic violence had never been assessed. (Interviewee 6, p. 18, para. 3 & p. 20, para. 1)

Substance Abuse Was Often Present in These Families

Substance abuse appeared in the interviews as contributing to the lethality of these situations. Interviewee 4 described the father of the child as both a perpetrator and victim.

At the age of two his dad had been an alcoholic and horribly abusive to the mother. It had been going on for some time that he was threatening her and drinking heavily and about a week before this incident happened he forced her to go with him while he taught her how to use this rifle, these guns. She did not want to handle them [the guns] but by that time she knew the consequences if she did not do whatever he said. And so she did and she had the feeling...she just had a negative feeling of why he wanted her to know how to use these guns. At any case on the day that she ended up shooting him...It was night time, he had been gone all day drinking and he came home. The boys were asleep in their bedroom and he came in and she had turned out of the lights out in the house so that he could not see her...of course she was fearful of what he would do. He came in yelling and threatening her and then said that he was going for the boys...she knew the boys lives were in danger then she did pick up the gun off of the dining room table and shot in the dark and killed him. (Interviewee 4, p.2, para. 1)

Interviewee 5 reported that the child that she worked with lived in a home where the chaos was inspired by both violence and substance use in both parents. In addition, this mental health professional described both problems having a multigenerational history. “The grandfather had a domestic violence history as well and a substance abuse issue. He was an alcoholic. He was clean now so she [the child] was somewhat comfortable there...Actually she was really kind of connected with her grandfather.” (p.2, para. 1). Interviewee 6 described the family of origin and the extended family of one of the children as having long histories of drug addiction and criminal behavior. “Chemical abuse...criminal activity...in and out of jail...both mom and dad had been in and out of jail a couple of times... and the family system...mirrored...that” (p. 25, para. 2).

Stressors on the Family Begin Immediately After the Homicide

Intimate Partner Homicide Created Immediate Need for a Caregiver for the Children

Most children required a caretaker immediately because of the death of one parent and the suicide or the incarceration of the other. Both mothers and fathers were victims of intimate partner homicide in the families described by participants. Sometimes a child’s care would be in limbo while appropriate caretakers were located. Interviewee 6 described the situation of a child whose father killed his mother.

He had not seen his grandparents for a long time and had not even spoken to them in so long that he didn’t know how to tell anyone how to get hold of them...It was a Friday late afternoon...the detectives came and were investigating and didn’t contact us ...they didn’t contact Family Preservation Unit or the state about any of this until Monday...he had been in foster home emergency care over the weekend...we had him by the next day placed with his grandparents from out of state which was really tricky...because of inter-state compacts... [can] take weeks if not months...But they agreed to come here...They came ...and stayed in a hotel for a week until all of the stuff was done, but he was able to stay with them. (Interviewee 6, p. 4, para. 2 - p. 7, para. 4)

Caregiving Was Complicated by Grief and Pre-Existing Issues but Needed To Be Consolidated

Caregivers were often grandparents or aunts and uncles who were directly impacted by the loss of a daughter, son, brother or sister. Sometimes a number of family members took on the care-giving function. Interviewee 1 described the importance of one person taking and owning the role of primary caregiver.

Dr. Charlie Zeanah was our consultant. He would say, “Someone has to step up to the plate to be the mother of this child” ... For the child’s needs to be met we had to say “Who is going to be the primary mother, the primary parent?” and have someone really identify that they were going to do that. (p.2, para. 5 – p. 3, para. 1)

The demands of caring for children who had a parent killed by intimate partner violence were not easy. Interviewee 3 discussed the experience:

I think that caregivers started out with varying degrees of stability before taking on the care-giving role. Caregivers might have histories of mental illness themselves; they might have been completely undermined by earlier grief and trauma and violence exposure that then get layered on with this recent trauma. Caregivers are struggling with health issues, financial issues, having enough room in their house, negotiating the systems of support to be able to physically care for children. There is the grief for the person who died and the trauma of that, but there is also the grief for their stage of life. They had moved on past the caring for young children. (Interviewee 3, p.7, para. 3)

Beyond the grief for such a traumatic loss, member families experienced many other stressors. Caregivers had to manage their own grief in order to effectively provide care for the children.

They had their own grief and mixed into that grief was their own anger about what had happened and then [they were] caught up in the court system. Focused on...is there going to be a trial and when is there going to be a trial. “Is there enough evidence?” (Interviewee 1, p.1, para. 5)

There Were Financial Burdens

Participants reported that there were usually pressing financial needs that the families of these children experienced immediately after the death. Sometimes these pressing needs were long term.

Crime Victim's funding could dependably be called upon to help with funeral costs. I know it was really hard to get loss of support funding. A lot of time people's work histories were sporadic so demonstrating a previous history of support was difficult...not all work is on the books and some of these parents are very young; they did not have much time to establish a work history. A lot of these women were in their early to mid-20s. So they had not necessarily worked long enough to be eligible for survivor's benefits through Social Security...that is helpful to understand... especially with infants you would expect the mothers to be young...Kinship care benefits are often applicable; they are time limited. [The expectation was that] Families need to move toward adoption. But I think that is a strong source of support...Food stamps are often something that can be available to families...it is not necessarily going to meet the needs of the children. Especially when you think of your housing needs...the amount of space that you need...every time you go on an outing...it is not just feeding children. It is including them in your life. (Interviewee 3 p. 11, para. 2)

Caregivers would be called away from their jobs to respond to problems that children were having at school or daycare.

A lot of people...because they took care of young children that needed to be cared for at home or...older children ...they were always getting called to school for...It is not just taking on any children it is taking on children in the midst of their grief and trauma who are really quite challenging to care for. (Interviewee 3, p. 8, para. 1)

Sources of Social Support

Resources for social support were available and present in the lives of the children described by participants but were not always sources of positive support. Even positive support was sometimes accompanied by stress and complications. Social support also was available through unexpected avenues.

Day Care and Schools

Schools referred many of the children to the participants' agencies. "Schools help hook families with resources. So families that know that they have problems might not know where to go" (Interviewee 3, p. 4, para. 1). The support could be both positive and negative as Interviewee 3 points out.

For the most, part teachers were relieved to know that the child was being seen...Somebody was going to help this child..."What can I do about their behavior in class?" We would start working together...teachers could be a support and could also be a hindrance. Sometimes teachers just got really tired of it...the child could be very problematic in class and they were getting very frustrated with them then they would respond to the child in a way that the child did not need them to. (Interviewee 1, p. 5, para. 4 – p. 6, para. 1)

Sometimes the schools helped diminish the child's behavior problems. Interviewee 2 describes how the caregiver's choice of a new school helped her grandson's behavioral problems.

She found a religious private school for this little boy to go to and as I said his behavior...just flattened right out. He was just a great little kid. He was able to say, "You know, they have rules here and they enforce the rules and everybody has to do the same thing. If somebody hits me I don't have to hit them back." (Interviewee 2, p. 8, para. 2)

Day care serves a similar purpose for young children and is perhaps a more critical support.

The people who are really key in the lives of young children are day care providers and parents and extended family...it is a painful thing to think about very young children hurting so badly and they have a much more narrow range of ways to express that hurt. So for people who have a hard time thinking about that hurt it is easier to look the other way...we are more likely to hear that this is a bad child...It is harder to distinguish the cause and effect here...One of the things that we look for with trauma reactions is after the trauma things change for a child; we want that pre and post. We want to see not that the child is aggressive but that the child is more aggressive after the trauma or not that the child is a clingy child but is more clingy. (Interviewee 3, p. 3, para. 1)

Children's Services or Child Welfare Agencies

Children's services and child welfare agencies were involved in several of the families before the murders took place. They often were in a critical position of support. Interviewee 5 described a young woman she worked with who had been in the child welfare agency because of previous sexual abuse that led to a teen pregnancy. The agency, along with the child's mental health professional, coordinated services to help insure safety and stability in the child's life after the murder of her mother. Her client did not necessarily appreciate the support from the child welfare agency. "Well in some ways she resented their involvement. She would have preferred to have more of a choice in where she was going to live" (Interviewee 5, p. 4, para. 3). This collaboration eventually led to the two agencies working together to get the girl placed with her child at her paternal aunt's home. The aunt was her primary social support prior to her placement with the grandmother and prior to her mother's death.

Courts and Police

Courts and police personnel were often in positions to be helpful to families but could also be a source of frustration.

If they had a child or we had a child that was testifying they were really good about contacting us. The assistant district attorneys were also good about saying, "help me ...Help me with language. Help me understand how to get through to this child." Once they realized that we were not going to get in the way and that we were going to help them have a better witness they would work with us. On the adult side there was a lot of frustration though "I called the ADA and I can't get information." From the families' side, motion hearings would take place and the family would not know about it.

(Interviewee 1, p. 6, para 4)

There were times when families and neighbors in their frustration provided information to the police in hopes that perpetrators would be apprehended.

The father allegedly killed the mother. The grandmother would call and she would have neighbors call, too. Again the supports...the neighbors really kept up with the case...well they saw that one night a case was in a news story about cold cases and [realized] what that means. "They say on the news that this case had been dropped." To not be informed of that and they [the neighbors] would hear sightings of where he was.

So we were able to arrange a meeting with the cold case division...the family and a lot of the extended family came to the meeting and they were listened to; I think at least they felt heard. (Interviewee 1, p.7, para. 1)

Faith-Based Communities

Faith-Based communities also were described as sources of social support.

For many families churches would play a very significant role and some of the times the family would turn to the pastor for guidance. With a particular family...and this occurred many times...they would turn to the pastor and ask, "What should I tell these children?" (Interviewee 1, p. 8 para. 5)

One participant described the church as the only resource for one family that she worked with.

She [the mom] did not want to be living in the community that they were living when she shot him [the abusive father]. So, I think that she left fairly soon after that. I am really fuzzy about what happened immediately after that in terms of where she went...I don't recall that there was much talk at all about family members being present to help her. It was just her and the church. (Interviewee 4, p. 5, para. 2)

Church families sometimes added to the social support network that in turn increased the availability of the caregiver. "When a caregiver had a lot of supports; when she was connected to her church; when she had people to lean on then she had more to give to the children" (Interviewee 3, p. 8, para. 3).

In one situation the mother's church involvement may have limited the support available to the child.

By the time they came here, other than the church there was very little else. And she was so invested in the church that I think it turned her son away; in some ways from being able to use that support because she was using it so heavily that it almost took her away from him. And I think that there was some resentment of her not being as present for him as he wanted. (Interviewee 4, p. 2, para. 3)

Engaging in Social Support after the Homicide

Hesitant Connections on Both Sides

After the child's parent had been killed, the need for social support for these families increased, yet it was often difficult for children and their caregivers to reach out for the needed support. Sometimes the support was not sought until years later when the child's behavior was out of control. That was the situation described by one participant working in a residential facility. The child's abusive father had been killed by the child's mother, but it was never discussed. It was the family secret. The participant said: "This was a red flag that defined this family, and more so because she chose to isolate herself for so long and not open up her world to other relationships - even good girlfriends" (Interviewee 4, p. 9, para. 1). Her isolation insured the isolation of her son.

Earlier in the interview the participant had discussed her work with the mother and the son as she tried to understand the killing of the son's father and how this death had impacted the son. Her son was now 13 years old; his father was killed when the child was two.

I think that this kid going through his whole life cycle as he did with no more support... that had made it difficult for him to open up at the age of 13. It was pretty late I think for him. (Interviewee 4, p. 8, para. 2)

Providers of Support Had To Learn What Would Work

Two participants worked for an agency that had a support group for adult survivors of homicide. Interviewee 3 shared:

In the families that I worked with the caregivers rarely followed through with attending those groups...I did on one occasion have a woman who was a co-facilitator of that support group come out with me to meet the grandmother who was caring for the children... Actually she joined us when we made a trip to the cemetery. It was the grandmother's first trip. The kids were asking to go so she and I made a trip out there first so that she could get her initial ...to become acclimated to being there before she took the children out there...My hope was that we would form a connection and then she would feel, "Oh, this is good support for me." (p. 11, para. 1)

Interviewee 1 who worked for the same agency described the evolution of the support group.

We tried a support group for adults, a community-wide support group...for 10 to 15 years the murder rate consistently stayed high. Hundreds of people have been murdered in a very small community. We said from a mental health perspective we are going to offer this support group and we would maybe have 10 people show up out of hundreds who needed to be there. At a certain point it even got lower than that...we said, "What else can we do?" What we did is that we hired a woman that had been coming for a year and a half who herself was a survivor. This was not from intimate violence but from community violence...but people who would attend this support group had loved ones who had been killed from intimate partner violence. It seemed to be okay for the adults to be in a group together whether it was community or intimate partner violence. We hired a woman and the model was that you had a survivor and a mental health professional working together. The key to this was that we changed what we offered too. So we did not offer a support group we rotated it. We did once a month educational events...We would have different topics. Every year the group would make up the topics: revenge, dealing with guilt, dealing with the criminal justice system, how we can help our children, or what about forgiveness...and the other thing that we found was that people in the groups did not want to talk, and they did not sometimes want to hear other people's stories. It was too much.

They would come to these educational events to get information. And then we would make it feel more like community. We would have full suppers...full suppers plus door prizes. We were building a network community for people so that they did not feel isolated but they did not have to face their horror and listen to other people's horror in a verbal way. They could be there just to support each other, eat with each other and talk with each other. Phone numbers started to be exchanged. We started [to gain] a momentum. (Interviewee 1, p. 9, para. 2 - p. 10, para. 1)

Sometimes Families Were Not Ready for Interventions

Participants found that families were not always ready to utilize supportive services at the time of the death.

We would try to do outreach so we could see the family as soon as possible. And some would want that and some would not. I think that needed to be respected. I feel strongly about that. I know that there is some literature that says that immediate psychiatric or psychological services are needed...But I think that allowing some of the family's strengths and resources to be there for that child too are important. (Interviewee 1, p. 8, para. 3)

Sometimes the Children Were Not Ready To Use the Help

For some children their journey had been so traumatic that the utilization of social support was not recognized until years later. Interviewee 6 described life after homicide for the young child whose mother was murdered as she interrupted the child being sexually abused by her father, as a series of foster homes, residential treatment centers, substance abuse treatment centers and incarceration.

This little girl could have experienced something totally different had her interventions, specialists and professionals been able to work together. She's a success today in many ways. She came out of some addictions and is clean and sober to my knowledge today. I had contact with current systems that she is in now in the last six months. She ...does some speaking in schools...She finished a RN degree which she was also told that she could not do... because she had committed some crimes and had gotten into some trouble during her addiction...If you were one of those positive people that had been in her life, at any point; [she] is still thanking people that helped her. (Interviewee 6, p. 23, para. 2 – p. 24, para. 1)

This same child had no family support.

She had no family social support...Like I said, this family...the siblings, parents, relatives of both of these folks...they had drug addictions and criminal history background, low education, low income...One person in one of those families had pulled themselves out of that environment and culture and had actually gone to school and was actually a case manager in one of the social service agencies. The relative was asked if she could care for this child after the murder. She said "I can't do it. She is still my niece but I can't put myself back into that family of origin." Today she [the child as an adult] has a relationship with that person [the aunt]. (Interviewee 6, p. 26, para. 1 and 2)

When the Children Were Ready They Could Be Resilient

This description reflects the resiliency of this child and her ability to utilize a limited social support network that could be short-lived:

A janitor at school that she had connected with at some time. She was removed from that school because the foster home placement changed after she became violent. She did connect; it was never identified at the time ... The Family Preservation worker in working with her on her life book... she remembered this...it was somebody who pushed the bucket around and mopped the floors and smiled at her and didn't believe she was bad. She identified that there were people that she always had in her "heart"... Someone out there knew that it was as bad as she knew it... and there was a window somewhere and where she got that she couldn't identify...Who gave that to her, who had that faith out there she couldn't identify. (Interviewee 6, p. 29, para. 1, p. 27, para. 2)

Socials Support Sources Were More Available to Older Children

Participants pointed out that the age of the child at the time of the murder had a significant impact on their ability to secure social support. Young children have limited ways of expressing their grief. Interviewee 1 was reminded of this when she described how sometimes the youngest children in a family were overlooked as professionals were trying to help families cope with the trauma of the murder.

I say that he is our landmark child. I say that because when you have a lot of children, siblings...he was the youngest at almost two. In case consultation Dr. Charlie Zeanah had all of these kids' names written on the board. He said, "What about the two-year-old?" I said, "What about him?"...I had no idea...I did not know how to assess. I said "Well he does not talk very much"...I said, "Oh, he is wetting himself" I had not paid attention to him which I think happens a lot with the young children. That is why we started the infant mental health program [in our agency]. (Interviewee 1, p. 11, para. 2)

In talking about another family Interviewee 1 described the different grief responses of the siblings.

The boy was 11 when I saw him...he was so angry...He was getting into fights all of the time. We wrote a letter to the judge because he wanted to know from the judge; why did his mom have to go to jail? I think that in working with children if they can do impact

statements or be involved in some way...it was very powerful for him to be able to write to the judge and give his letter to the judge. Then he had a voice...The younger two were the ones that were having still the most difficult time...which might speak to the age of when the murder happened. The children were experiencing this when they were most vulnerable...the loss...I had a 2-year-old to a 16-year-old in this family and they were all siblings. Really the older two were doing quite well, the younger two were having all kinds of difficulties. (p. 12, para. 2-3)

Older children had more ways to process the grief either by describing their memories or by sharing their feeling verbally or through writing or art.

In the process of taking the history she [the grandmother] told me that the mother and father had died in a fire. I think that she told me that the fire had been set by the husband and both had perished. The child subsequently told me in greater detail and it turned out that the child that had been brought in for services was the younger of the two boys. Both of the boys were in the home at the time that this happened. The parents went into the bathroom, the boys heard the father making threatening comments to the mother and shortly thereafter the house caught on fire. The boys thank goodness were able to make it out but neither of their parents made it out of the fire. Shortly thereafter the boys came to live with the maternal grandmother...He was able to talk about it once, in one session. He described what happened. But he would never go back to it. He was able to communicate that much but he was never able to go back to it. (Interviewee 2, p.3, para. 3 & p. 6, para. 1)

Interviewee 5, an art therapist described how the child that she worked with had use creating a memory book to process grief issues.

She did, I think, grieve her mother's death through her art work and through memory books...She would share and reminisce about memories that she had about her mom in sessions. I think that she may have adequately grieved Mom but may not have dealt with Dad's heinous act. I hope that she will return to someone someday and reprocess that. I think that she felt like she couldn't completely do that because she had to stay strong for her younger sisters. She did not want to appear weak though I tried to indicate to her that crying was not a weakness. In general as far as tearfulness probably only once or twice did she even get watery eyes through all of that. (Interviewee 5, p. 5, para. 3-p. 6, para. 1)

When asked if this child was more angry than sad she responded:

No it was more avoidance. She is not an angry kid. She has never really ever gone through a period of aggressively acting out or even teen drinking or drug use. So she is just very closed off. Her outlets are pretty closed...minimal. She is at the age that I can't figure out really how she has dealt with such a traumatic history and still is pleasant...

(Interviewee 5, p. 6, para. 2)

One participant described the experience of the two siblings who had lost both of their parents when the father set their house on fire.

It [social support] varied for the two children. My sense was that the older of the two who at this time was a college student had more support. He was involved in his college life he was not living in the home with the grandmother at that point and seemed really to have made a life for himself. The younger child seemed much more bereft of support.

(Interviewee 2, p. 4, para. 2)

Not All Social Supports Were Positive

The same participant went on to describe the younger child as developing a persona that reflected gang culture after his behavior got him kicked off the basketball team.

He came to the session wearing completely different clothing...he was wearing a bandana; he was wearing an oversized white t-shirt. He was for lack of a better definition dressed more in keeping with what I understood to be "thug culture" or the "acting out young gang culture." He had actually gone to a photography studio to have his photograph taken wearing the bandana and wearing a very challenging expression on his face. The grandmother reported to me later that he had gotten into fairly serious difficulty with this group of boys. It appeared that he was really seeking acceptance and found acceptance. (Interviewee 2, p.4, para. 2)

In retrospect, the reporting participant was wishing his school could have been more flexible in their relationship with this child.

I did not think that they (the school) were supportive of him. They were more punitive in their reaction than supportive...I think we were just too late (deep sigh). Partially he found his own solutions, but I think at the beginning of treatment he really made a couple of efforts. I saw the basketball team as an effort to find a more socially acceptable peer

group to belong to and when it failed is when he sought the less acceptable peer group. (Interviewee 2, p. 5, para. 1)

Support Was Sometimes Found in the Perpetrator's Family

This same participant worked with another child that seemed to have a highly effective familial support system.

Talk about social supports! This was a family that seemed much more connected. It was a larger family. One had a sense that it was a permeable family; people came and went in a very...positive way. So this young boy had interactions with aunts and uncles. I think that it was remarkable that this grandmother even before coming into treatment had allowed this child to have some contact with the father's family... (Interviewee 2, p. 9, para. 2)

Earlier in the interview this participant had shared a story about this child and his grandmother's growth in her reconciliation.

You know how parents will say: Can I have a couple of minutes with you...I think she actually said, "He wants to see his father [the man who killed his mother, her daughter and was in prison]". I said, "Well, that must be kind of challenging to you." And she said: "It is, but it is his father...I am not going to take him, but if he can figure out a way to see his father that would be okay with me. But I can't be a part of making it happen and I don't want to see his father." I started exploring with the child about seeing his dad and exploring with him ways that it might happen either through his father's family...I called the prison because the child had to be put on the father's visiting list. There were quite a few complications to making this happen. I think that the father had corresponded with him...for a couple of years prior to the child coming into treatment (Interviewee 2, p. 10, para. 1).

This child continued his attachment to his father's family and in reaching out to his father was finding a better understanding of self.

Long-term Attachments Are a Critical Component of Social Support

Participants repeatedly talked about the importance of attachment. As discussed earlier in the literature review, a child's attachment can be compromised when that child's primary caregiver is a victim of intimate partner violence. Participants described children who had a

strong attachment to both mothers and fathers and to other family members who served as primary parent figures even prior to the homicide.

Interviewee 3, who worked primarily with infants and toddlers, described with passion the essential nature of attachment for these children as they recovered from loss.

The most key issue is; who is going to be the attachment figure for these children? And really looking at; did they have an attachment before this death? What was the quality of the care-giver before this death and how can we continue to move toward quality care-giving in their present? I think that one of the risks is with...all of the children who were survivors of fatal domestic violence lost their mother. I did not have any fathers murdered by intimate partner violence. Largely that mother had been in a primary care-giving role for the children. Not always exclusively, not always attentively, but perhaps in tandem with a grandmother or perhaps not to the standard of care that I would have even hoped for the children. We know that domestic violence undermines a women's ability to mother. We know that there are many aspects of domestic violence that directly interfere with taking on that care-giving role and performing it well. Some of the children had attentive caring parents before and then they lost that parent, others had varying degrees of unstable parenting before, but still lost that parent. All of the children that I can think of lost a primary attachment figure when their father killed their mother or their stepfather killed their mother. And young children need someone who will be responsible for their care; who will make sure they are safe; who will be sure that they have all of their needs taken care of; who they can rely on to be responsive to their needs; their basic physical needs and their emotional needs. (Interviewee 3, p. 7, para. 1).

The Child Needs Consolidated Care

As mentioned earlier in this chapter, it is critical that the child have a new attachment figure after the death of her or his parent. Participant 1 described an experience that illustrated the need for clarity in the child's relationships.

I met with this little boy after his mother died and it was some six years later so this child was now six or seven. I asked him to draw a picture of what was on his mind. He drew a picture and then we would write a story about it. The story was, it was a confusing picture to me but his story made sense the story said: "I love my maw, I love my

grandmaw,” and then he named his aunt who he loved and then he said “Will you be my maw?” Because his grandmother was being his mother, his aunt was being his mother; he was between two homes. And he wanted to know now that his mother had died who is going to be my mother? It was so clear... While they were both taking care of him... when I brought this up in a session to both of them and it was put out there between the two of them; they both said. “Yeah one of us needs to decide” because they realized that both of them were doing it kind of half in. (Interviewee 1, p. 3, para. 4)

Interviewee 3 had her own views of the fragmentation of attachment that children experienced after the murder.

I think that when they lose the person that everyone held responsible for that care... a lot of times the person who takes on their care only takes on a segment of that care. A person takes on the physical care of that child but...sometimes people did not want that role sometimes people are so undermined by their own grief that they don't step up to the plate in all of the aspects of that role. Sometimes people just weren't in a good place to start out...Never out of maliciousness. (p. 7, para. 2)

It was clear to participants that emotional support and closeness was essential for the children.

Children Need More Than Physical Support

Attachment was an issue that came up in the majority of the interviews as participants remembered the experience of working with these children. There was indication that, even though most caregivers would give physical support that they were not always able to give emotional support, leaving the child without an attachment figure. Interviewee 2 described her experience with one child's grandmother. Both of the parents of this child had been killed. The Interviewee was asked whether the grandmother had been able to process her grief issues in their sessions.

No, she came to the first few sessions...she came for the assessment...but once we got through that phase, it was the responsibility of the young man to make it to treatment by himself. And the ...communication that I had with her was over the phone. It was *very* [italics added] difficult to re-engage her...I think that she was a functional caretaker, but I don't think that she was a nurturing caretaker. I think quite frankly that she saw this boy

as a burden and though she cared about him, she did not seem to have much to give him...I did not get the sense that there was much warmth or joy in the family's life together. It seems pretty barren. (Interviewee 2, p. 5, para. 4)

This same child shared some happy memories of life with his mother and father.

The father was in the military and the murder/suicide happened on base. It seemed to follow that pattern of containment and rigidity. Although he did describe...at some point earlier when he was a younger child... having fun with his family...having fun with his mother and father. (Interviewee 2, p. 7, para. 1)

One can hope that he had experienced attachment in his family of origin that helped him find connectedness in future relationships.

Attachment to the Perpetrator Contributed to Ambivalence for the Children

Children also indicated to participants that they maintained attachment to the perpetrators. Participant 1 shared that this connection sometimes made it difficult for the children to testify in court.

There was a whole lot of preparing for the young girl...she was ten...to go to court...so she did not end up going [because he pled guilty]...The preparing and the anxiety about it was tremendous... a lot of ambivalent feelings ...One child said "I want him to be punished, but I don't want him to be in jail" Children have a sense of fairness. It was fair to be punished, but he did not want the loss... *Did not want the loss* [italics added]. For him it was a loss; he had lost his mother and now he was losing his father to jail. I think that his statement that, "he needs to be punished, but I don't want him to go to jail," really summed up how a lot of children feel. That he did it; it was wrong and it was bad but I do not want to lose my father too. (Interviewee 1, p. 7, para. 2)

Interviewee 5 described her client's need to maintain a relationship with her father.

She had built such a strong wall around herself that I think that she was afraid to really tear down that wall...completely vulnerable after all of the years of hurt at what her father had done. Even when Dad was sentenced and in prison she was still writing letters to him. In a letter she had forgiven him, I am not sure that she was ready to forgive him. She also wanted her father to still have some role in her child's life. She wanted her child to have a grandfather. (Interviewee 5, p. 5, para. 3)

Sometimes the child is unable to confront the perpetrator or the victim. In the situation where the mother killed the abusive father, the child was left with a violent history and no way to understand his violent legacy.

He was two and his little brother was about six months old...then as he grew up there was this identity that he took on as the dad. It was this loss to him...He was Mr. Tough Guy and he began to be abusive towards his mother...He had to act out a lot to try to prove his self worth and power. That power and control so much of which was lost through all of that whole experience; not only did he lose his dad who in reality was never there for him anyway but he also lost his mother in many ways... (Interviewee 4, p. 2, para. 2 & p.3, para. 1)

There were times when caregivers were able to put aside their anger with the perpetrator to allow the child to move on in her/his own development.

The father had corresponded with him [the child] for a couple of years prior to the child coming to treatment. The father would occasionally send a letter [from prison]. But what was really remarkable was that at one point the father had made a leather cover that could be put on a Bible and sent it to the grandmother. The grandmother had been able to open it but she had not been able to do anything more than that. She opened it and put it away. And it may have been in the very last session or it may not have been that dramatic...But I remember that I almost cried when she came in and said to me. "You know, do you remember that leather cover that I told you about?" She said, "I finally put it on the Bible." She said, "I did it for my grandson. I realized how important that it was for him for me to be able to accept just this small thing from his father. So I am doing it for my grandson. Sometimes it is easier than it is at other times, but I know it is important to him." (Interviewee 2, p.9, para. 3 - p.10, para. 1)

Children Are Able To Maintain Attachments and Develop New Ones

Participants described some children as having strong connections with their siblings. Interviewee 4 discussed that while the child with whom she worked seemed minimally connected to his mother he was connected to his brother. "He connected with his brother and the loyalty of the boys was really strong" (p. 7, para.1). The child seen by Interviewee 5 was described as having assumed a great deal of responsibility in her family growing up with both

parents having substance abuse problems and there being violence in the home. “She was a very ‘parentified’ child and...mothered her own younger sisters. She was/is very mature for her age so we were working a lot on those issues” (p.1, para. 3).

Interviewee 5 described this child who had become a mother through a sexually abusive relationship with a friend of her father as being able to attach with her own child. “[We] have done some ‘Theraplay’ activities together and she is very engaged with her child, very nurturing; [she] provides appropriate structure; she is really amazing” (p. 6, para. 3). This ability to attach existed in spite of the vulnerability of her relationship with her mother.

There were positive moments that they share[d] with each other, but in general this mom was emotionally unavailable to her daughters most of their lives because of her own substance abuse and the domestic violence. Her parents were constantly in chaos; so there was not a healthy attachment. I guess I would say that Sarah would say that she was more connected to her dad, even though he was the abuser. And she was even the victim sometimes of physical abuse by him. (Interviewee 5, p. 6, para. 6)

This child seemed to be able to find the hope of attachment in another relative who became her role model in a very complex family system.

The person that Sarah is most connected to in her entire family system is her father’s sister, her aunt. This aunt is married to the brother of her abuser. So currently Sarah lives with this aunt and the brother of her abuser. The abuser [sexual abuse] is in jail and of course so is the father for the double murder [of Sarah’s mother and her lover]. (Interviewee 5, p.2, para. 4)

The Ability to Process Grief and Recover Was Often Impaired

Families were not prepared for the complicated grief and recovery needed to deal with intimate partner homicide. Their progress was impaired by pre-existing problems and the sheer overwhelming nature of the loss. Some of the most commonly mentioned problems were substance abuse, reoccurring violence, and isolation.

Impact of Substance Abuse

The child in the family that Interviewee 6 described in the paragraph above eventually developed problems with addictions that created serious difficulties for her as she negotiated her way through foster care and residential homes. “She came out of some addictions is clean and

sober to my knowledge today...She got into some pretty serious things...had committed some crimes, had gotten into some trouble during her addiction” (p. 24, para. 1).

Caregivers caring for children after the murder were also vulnerable to chemical dependency as discussed by Interviewee 1.

What comes to mind is one child where there was a murder/suicide and it actually was a female who killed her husband then killed herself and left the child. The grandmother ended up taking over the care of the child, the maternal grandmother, the mother of the perpetrator. That young girl...I was in and out of her life and at a certain point other social workers that I was supervising were in and out of her life. She struggled her entire life and so did the maternal grandmother with severe depression. I think that this is...I don't know if it is a secret or not but it needs to be talked about...Substance abuse...I got a letter from her one day in the mail, from the grandmother that said that she had been drinking a lot. The grandmother had been self-medicating. I think we finally made that a protocol that we would, not in a judgmental way... but just talk about it in an educational way... that a lot of people may turn to using substances in different ways to try to get through this. (Interviewee 1, p. 7, para. 4 - p. 8, para. 1)

Processing Grief in a Violent Environment

Participants pointed out that the impact of violence often permeates the grief response of survivors especially in communities that have high rates of violence. Interviewee 3 worked in a city with extremely high levels of community and domestic violence.

When I am meeting with families if you look back through the history within their extended family... within their social connections there are so many violent deaths or violent injuries...I think that the violence gets layered upon itself. Some families are carrying so much more of the burden of the violent deaths in our community than others. It is not equally spaced out and so as a result in one of the families that I have worked with there were two very close deaths, one by community violence and one by domestic violence. But the level of threat and the potential for violence in other segments of their relationships...people that they knew [was high]. An auntie who was currently in a domestic violent relationship...the potential for more violence was high. (Interviewee 3, p. 5, para. 2)

The example described by Interviewee 3 shows the interrelatedness of community violence and intimate partner death.

One family that sticks out in my head, the children did move schools and did move from their home. But their home was not safe. Their father stalked and murdered their mother. In the time before her death there was a tremendous level of threat of violence and actual violence that they had been exposed to. They were living in a neighborhood with a lot of community violence. When their mother was murdered and they moved with their grandmother they were in a safe neighborhood with room to play without active domestic violence in their direct home... each with their own bed. (p. 9, para. 1)

Though some aspects of the children's lives could improve as illustrated above, many were challenged by living with a sense of isolation.

Isolation for Survivors of Intimate Partner Violence Murder

One of the most profound concerns expressed by participants was the level of isolation that survivors experienced in the days, months and years after a murder of a parent by intimate partner violence. Interviewee 5 described two communities where her child client grew up; one community was the one where she had lived with her parents, and the other was where her grandparents lived.

She felt that both of these towns were her own...she had spent a lot of time in both.

There were adults in each town that she had connected with, but in general she reported that after the murder she felt even more isolated; that people did not know how to respond to such a traumatic event...She felt uncomfortable with the attention that it gave her, but also it seemed to distance people from her. People just felt so uncomfortable. (p. 4, para. 1)

One Interviewee, who worked for many years in a residential treatment center for children, expressed the impact of this isolation:

Almost always where there is murder or attempted murder there is almost not greater loss. Children who have been horribly abused...they struggle...The kids who have experienced murder of some sort...the social stigma of that is so different...The walls of defense seem higher than the kids who have been abused...The kids who have been molested and abused have been victimized. They go through their lives imaging themselves as victims. The kids who have had murder in their family; it is a secret that

they have guarded so that the walls are up and the rage is a whole different category for them. We have insurance that covers catastrophic illness but not that covers catastrophic trauma. (Interviewee 4, p. 10, para. 1)

The weight of that “catastrophic trauma” falls on the shoulders of the caregivers who choose to care for these children and do so with little community support.

The Strain of Care-Giving

Taking on the care of any child in an emergency is stressful and will put a strain on any caretaker and/or family system. The complexities of intimate partner homicide include grief responses of guilt, anger, sadness, split loyalties and fear. Often these emotional stresses are apparent in the child and in the caregiver.

Taking on the care of a young child means that you have 18 years ahead of you. Some of these people were tired and that wasn't what they had envisioned. Even people who had been a primary caretaker [before the murder] for these children had been living with the illusion that the mother would step up to the plate and take this job over. There is the loss of that vision for their future. And then there is the grief and loss for the actual person who was ripped from their life. There is guilt, I think that there might be more guilt with domestic violence deaths than community violence deaths. Because, “I should have seen this coming I should have taken more protection. She called me for help...What could I have done differently?” At the same time there is anger: “She left me. Why didn't she get out? She left me with this burden, this responsibility that I don't want or don't feel ready for”...Even the people who really did want to care for these children even the devoted, connected caregivers weren't always happy that this was what they were doing with their life right now. (Interviewee 3, p.7, para. 3 – p. 8, para.1)

Interviewee 3's description of the reality for many caregivers was reflected in many of the interviews. She went on to elaborate on the fragility of the health of some of the caregivers who would often put their own healthcare after the child's and lose the social support and affirmation of working outside of the home.

There is a lot of face value to the idea that there is stress in caring. What I absolutely saw is that it is very time consuming to take care of the needs of children and something has to get put on the back burner. I would see follow through for self care continually get put

on the back burner. You would know that the caregiver needed to go to the doctor and you would follow up; did she go to the doctor? “Well, no, I did not go to the doctor, but I took the kids to the doctor.” Which was very good!...I think that those health care things continue to get put off...People took longer to respond to their own needs...The longer you let things go the worse they get...I think that people are very busy, preoccupied...Part of that is due to the recent trauma and part is that they have a lot of new responsibilities and might not be taking time to observe how their body is doing...We attribute a lot to the grief which might be true...Their fatigue and headaches fit what they are going through now but may also mask things that also need help. (Interviewee 3, p. 13, para. 2)

Often caregivers especially those who needed to care for young children would not be able to keep their jobs.

People who found a lot of validation in their work who then had their ability to work or their ability to do their job well undermined by this process; they definitely lost part of themselves in that. Work is not always a burden; work can be something that can be a real core aspect of self. The [caregiver's] ability to maintain a job is absolutely undermined by taking on this care. (Interviewee 3, p. 13, para. 2)

Interviewees described how hard it could be for the caregivers to process their grief and the grief of the children.

A lot of times in the family the silencing that would go on with the caregiver not wanting to upset the child so they did not talk about the person who died or what happened...Then the child was doing the same thing...not wanting to upset the caregiver...not wanting to see the grandmother upset or crying. So there was a lot of silence going on creating a lot of isolation. (Interviewee 1, p. 2, para. 1)

Interviewee 3 discussed how the caregiver's grief could interfere with her emotional availability.

The trauma was devastating and the effect of that murder on the family...The grandmother was a caregiver who would have been more prepared to take on this job if she hadn't had to do it in this way. She was absolutely grief and trauma stricken to the core at this time and was less emotionally available to them than I think that she would have been if she had taken on their care in another way. (p. 9, para. 1)

There were situations where the caregiver was also dealing with her own emotional health before the murder occurred.

One of my clients went to live with a grandmother who struggled with her own mental health issues. She was very giving and in many ways did provide for all of his basic care and needs, but her emotional responsiveness to him could never be on target. She did not have the skills in place to read those cues and be responsive to those cues. But there was no abuse in the home...He had possibly witnessed the death of his mom but [was] living with the family of the father who did murder her...I think that his basic care was safer after the death... (Interviewee 3, p. 9, para. 2)

Interviewee 2 described how one grandmother was able to use the child's treatment as an opportunity to help her grandson and resolve some of her own grief.

This was many, many years later...she had done what she needed to do immediately after the murder to make sure that her daughter was buried properly; then she just got on with the business of life and raising her grandson...There was only one child ...There were no pictures of his mother in the home. There wasn't a lot of talk about his mother in the home. As one would guess, this little boy had a lot of curiosity about his mother. To her credit this grandmother would allow this little boy to interact with the family of the father...I was able to talk to the grandmother by herself and ...talk about opening up the wound and finding some pictures and being able to talk to her grandson about his mother. Who his mother was; what she was like...stories... She cried and she said "I don't want to cry in front of him. I can't do that; that is not good for him." I said, "I understand why you would think that way but in reality for your grandson it would be good if you guys could cry together." We talked and talked about it... and they came back to the next session and they had found this tiny photograph...of this child's mother when she was pregnant with him. This child was just radiant! (Interviewee 2, p. 8, para. 1 and 2)

Mental Health Professionals Also Needed Social Support

There was one of the findings that focused outside of the children and their families. The mental health professionals interviewed were each at different stages of their professional training and experiencing different levels of supervision. The chart in Table 4.2 describes their level of training at the time of their work with these families and their current level of training.

Those with less formal training with less supervision appeared to be more emotionally impacted in a negative way than were those with more graduate and post-graduate training. Though most of the descriptions of supervision were anecdotal, the essential need for supervision with these cases was critical for workers no matter what level of training they had attained.

I was considered one of the senior staff, but I think that I could have benefited from supervision on that case. I think it might have been helpful to strategize with someone how to better engage this young man...There were supports built in around the big traumas, but not necessarily around ongoing work. (Interviewee 2, p.6, para. 4 – p.7, para. 1)

One of the participants who had the least amount of formal training noted that she was working as a contract worker for a system that did not provide her the necessary support. Instead she got her support from the contracting agency and other workers. “So the support that I got that I should have gotten from the systems supervisor and so forth; I got from the other supervisors and from the workers”(Interviewee 6, p. 11, para. 1).

Several of the participants had continued their training and saw themselves as a resource for the child but not her/his lifelong social support.

It is most important to me to feel that I am doing something that I know is going to be helpful. I get that through the models that are out there that blessedly someone else is researching, because that is not my area of strength...I don't have to take on the responsibility of that child's emotional support forever. I might be a temporary repository for it, but I will hand that responsibility over to someone else. (Interviewee 3, p.16, para.1)

The fact that these and other mental health professionals are available to meet the challenge of working with these children and their families helps pave the way for their futures. Not only did the participants work with the children to help them better understand their losses and be able to express their feelings about their losses, but also the participants helped the families, specifically the caregivers, learn to become the children's lifelong social supports that the children desperately needed.

Table 4.2 Participants' education and experience.

Interviewee	Education at time of Service	Current Education
1	M.S.W., Licensure	Ph.D.
2	M.S.W. , Licensure Family Therapy Fellow Infant Mental Health Fellow	Same
3	M.S.W. , Licensure Infant Mental Health Fellow	Same
4	M.S.W., Licensure	Same
5	M.S. Art Therapy	Same

CHAPTER 5 - Discussion

The assumption that children who have a positive social support system have a more positive adjustment to the death of a parent by intimate partner violence - was partially supported by this research project. In retrospect, the assumption seems limited; social supports, both positive and negative, have a great impact on the child. There are, however, a myriad of factors supporting or compromising the child's adjustment. The complexity of the relationship between social support and the trauma of a child losing a parent through intimate partner violence was clearly illustrated in the study. Social support, in and of itself, is a complex phenomenon that is difficult to research. Vaux (1988) pointed out in his work that social support continues to be elusive to researchers as a topic because of the variations for perspectives and foci.

Response to Research Questions

Who are the people mental health providers identify as providing children with positive support?

Long-term attachments were emphasized by all participants as a critical component of the child's social support system. All participants identified the importance of the caregivers who took on the care of these children after the homicide. Even though the children were not necessarily close to the caretakers before the event, their relationships became essential afterwards. The support reported was both positive and negative. In addition, participants described the importance of one identified person who would be the primary caretaker for the child. The participants stressed that this person was someone who needed to be able to provide positive emotional support as well as physical support.

For some children the families of the perpetrators provided positive support over the years, even when the perpetrator was imprisoned. This support was not always comfortably received by caretakers or extended family of the victim. The children discussed by the participants, however, showed an interest in staying connected to the perpetrating parents and that side of their families.

What critical supports serve to decrease the severity of the trauma?

There was one resounding message in this research was the importance of the children having support in their grieving. They needed to talk about their loss and the experience over and over again. Any supportive person or program that offered the opportunity to process the grief helped the child develop an understanding of how this trauma fit within the context of their lives. Understanding the loss in context helped the children move ahead in their development.

The participants explained that formal social supports were documented as being present before the homicide, but these did not serve to prevent the homicide. The consistency of the support after the homicide was helpful, especially if the support presented an opportunity for the children and the children's caretakers to process their loss and grief. The participants recounted situations where the agency and/or family members did not allow the children to tell their story or process the loss the support. They participants described that this could be detrimental to the children's adjustment.

The formal support systems available before the homicide were: day care centers, schools, child welfare services, domestic violence shelters and services, and faith-based communities. After the event the police and the court systems became involved. Again, not all support systems were positive in their support; the opportunity to grieve was the critical factor delineating the positive from the negative support.

What supportive services are identified by mental health professionals as critical to the child's well-being after the loss?

The most stabilizing support for the children was a healthy primary caregiver who was able to give the children both positive emotional support and adequate physical support. The participants explained that this was not easy because of the emotional and financial strain that many caretakers experienced after the homicide. These caretakers in turn needed ongoing supportive services to attain needed financial aide and emotional support. Formal support for the child and her/his family was by far the most consistently identified urgent need. The caretakers' ability to provide long-term support to the children was often dependent on the availability of these formal systems, especially as the caretakers continued to age and their health became more vulnerable.

Connecting to and utilizing available services was a challenge to these families who were grieving and experiencing enormous change. Services needed to be offered to families repeatedly sometimes over a period of years. Due to the extreme nature of the loss, there was high risk of these families becoming isolated from more extended family, friends and formal services in the midst of their grief experiences.

The developmental stage of the children contributed to the availability of social supports and the ways they were able to access services. The inability to verbalize their grief for very young children who lost a parent presented a unique problem for both formal and familial support as described by participants. As the children aged, their world opened up to them through school, work and social experiences to allow them supportive relationships, which had not been available to them at a younger age.

What is the experience of mental health professionals who work with these children?

Providing services required participants to persevere with families as they struggled with the chaos in their lives. Families were sometimes unable to utilize services at the time they were first offered. The mental health providers had to offer services repeatedly to see positive results for these families. In addition these professional often had to find continued connections for the family in their own agencies and to advocate for them with other systems in order to get their needs met.

Workers exhibited ongoing concern and attachment for these families even after not having seen them for years. One participant shared a story on which she had been looking for one of the families after Hurricane Katrina to give them a funeral program. She knew this family's home had been destroyed during the storm, and they would have lost this memento. Participants appeared to be highly vested in the outcomes of these families and enjoyed observing their successes. One participant had the opportunity to see her child-client grow into a successful professional woman who was giving workshops on intimate partner violence prevention.

Several New Perspectives

The Existence of Social Support Did Not Prevent the Homicide

Participants in this study were both observers and providers of social support in the lives of the children for whom they served. Intimate partner violence can isolate families and create distance between them and potential providers of social support. The mental health professionals interviewed for this study, however, reported the existence of social support in the lives of children prior to the death of the intimate partner, even though there were great variations in the support described. Families and children were, at times, involved with community social service agencies prior to the murder of the parent.

Participants reported that there was some knowledge of the presence of intimate partner violence in the home before the murders took place. Sometimes this information was known by friends, but also it was sometimes known by authorities and domestic violence shelters. Neighbors reportedly tried to aid victims of abuse and help insure their safety. However, there was also evidence that community services like family preservation were involved, but these agencies never identified the presence of violence in the home after months and/or years of services provided to the family. Critical assessments of violence were not completed in all situations before families spiraled out of control, eventually leading to the death of one of the parents.

With the awareness of the pre-existing social support available prior to the murder in mind, the view of social support in the hypothesis of this paper seems at once naïve and presumptuous. Even though social support was important in the lives of these children, social support, alone, cannot insure the positive adjustment of a child who has undergone this level of trauma - a “catastrophic trauma” as coined by one participant. Social support, however, can contribute to either the positive well-being or the negative emotional disillusionment of the child. At the same time, the data support that the resilience of children continues to help them overcome incredible difficulties.

Social Support Could Be Elusive and Unpredictable

A child who had extremely limited social support at the time of her mother’s death managed to survive poorly coordinated services to become a professional educating others on the

risks of domestic violence. Whereas some children with more readily available social supports were not able to benefit from that support; other children rejected efforts by others to be supportive to them. The ability of the child to utilize available social support may have been related directly to the social support available to the primary caregiver. This was even more pronounced when the children involved were very young.

Social Support Was Critical for Caregivers

Caregivers were described as a vulnerable group trying to provide adequate care to children who were traumatized and not easily cared for either physically or emotionally. Caregivers were affected by their own grief and loss, struggling to provide for these children while experiencing the isolation of being survivors of homicide. Hardesty, Campbell, McFarlane and Lewandowski (2008) found in their study of caregivers and children that support for both was essential to the healing process. Amour (2002) found that survivors of homicide were, as a whole, a very socially isolated group, but when the perpetrator was a family member there was an even higher level of isolation. Her findings appeared to be supported in this study. The need for ongoing support of caregivers was also supported by this study. Caregivers and children must be a priority to supportive social service providers after a homicide or death due to intimate partner violence. Even deaths that were in self-defense caused apparent trauma to the survivors, and social support by families, friends and the community was needed. An example of this is the story describing the child who grew up never discussing his father being killed by his mother after the father had threatened to hurt him and his brother.

Caregivers were not necessarily able to ask for help or accept support when it was offered. Multiple attempts to offer social support were needed over extended periods of time rather than a one-time offer of assistance. This was well-described by the participants who struggled to create effective support groups for these families. Support also was needed as children went through different developmental stages or experienced other losses in their lives.

Intimate Partner Homicide May Be One Layer of Trauma

Participants discussed that individuals living in neighborhoods with high levels of community violence experienced these personal losses as layers of loss adding trauma on top of trauma. These families were especially vulnerable when they had other family members currently involved with intimate partner violence. Rose and McClain (1990) explored the

layering of loss and trauma in their work with African American neighborhoods that had high levels of crime. Moser (2004) addressed layering of violence in her discussions of urban violence in Latin America. Cook, Blaustein, Spinazzola and van der Kolk (2003) in a White Paper for the Complex Trauma in Children and Adolescents, National Child Traumatic Stress Network Complex Trauma Task Force, described this layering as complex trauma.

Complex traumatic exposure refers to children's experiences of multiple traumatic events that occur within the caregiving system – the social system that is suppose to be the source of safety and stability in a child's life. Typically, complex trauma exposure refers to the simultaneous or sequential occurrences of child maltreatment-including emotional abuse and neglect, sexual abuse, physical abuse, and witnessing domestic violence- that are chronic and begin in early childhood. (p. 5)

It is imperative that mental health professionals screen for multiple traumas when assessments are made with children and adults regardless of what the presenting problem may be.

Resilience Was Evident Even in the Midst of Complex Trauma

Masten and Powell (2003) describe the study of resilience as “a search for the processes that protect development from the ravages of hazardous growing conditions” (p.9). Initially theorists believed that only certain children with exceptional coping skills were able to be resilient in the face of high risk life experiences. However, Masten (2001) described resilience as a more universal capability available to many children if they are provided with social supports, have adequate cognitive skills and community connection. Participants in this study gave testimony to the resilient strengths of children and reinforced the importance of providing a nurturing community of supportive individuals and services to insure that theses children of trauma had a fertile environment in which their resilience could bloom.

The Ever-Present Connection between Intimate Partner Violence and Chemical Dependency

Another area that needed to be addressed in mental health assessments and evaluation was the juxtaposition of intimate partner violence and chemical dependency in homes. Even though there was not adequate information presented in this study to understand the relationship of the chemical use and the escalation of violence, the presence of both problems was

documented. This factor was in keeping with research findings of Campbell et al. (2003), who studied factors that existed in the lives of victims before these individuals were killed by violent intimate partners. She found that there were a number of key factors that were evident in a significant number of intimate partner deaths. Chemical abuse was one of those factors. The accurate and detailed assessment of both chemical dependency and violence is critically important in all mental health assessments.

Efforts have been made to routinely train mental health providers in the accurate assessment of chemical abuse and intimate partner abuse. A number of initiatives have existed at a national level to emphasize the importance of the identification of these two problems to help decrease the abuse of intimate partners and their children. One such effort is the SAMSHA series written by Fazzino, Holton, and Reed (2000). In recent years communities throughout the United States have brought together key social services to insure that professional teachers, child welfare workers, drug and alcohol abuse counselors, police, judges, attorneys and domestic violence workers were trained to identify both intimate partner violence and chemical abuse.

The Importance of Service Coordination

One of the difficulties in protecting both intimate partners and their children is that often social service agencies, police, courts, hospitals and faith-based communities do not work together or communicate well with each other. Even though efforts have been encouraged, there continues to be difficulty in preventing the escalation of violence that can lead to intimate partner murder. Cross-training of professionals at all levels must continue. When violence is present in the home, individuals must have the danger clearly outlined to them. There needs to be continuous public education on the lethal combination presented when intimate violence and chemical abuse exist in a family. The “Greenbook Initiative” that was initially co-authored by Schechter and Edelson (1999) was a national proposal to train a wide range of professionals in communities throughout the country about the risk that domestic violence also presents for children. The collaborations created by the efforts of these initiatives would be excellent repositories for this educational process.

Social Support Services Need To Be Tenacious

After the death of a parent, the children that were seen by the interviewees were exposed to a variety of social supports, as were their families. The participants described six common

sources of social support. Caregivers were the most critical components of the support system and could include extended family members. Schools and day care centers had contact with the children on a day-to-day basis and were often a referral source for community services. Social service agencies, such as child welfare agencies, often were automatically involved because the child became orphaned by the death and subsequent incarceration or death of the perpetrator. Because of the nature of the crime, police and the courts also were potential supportive systems and finally faith-based communities offered support to some families. However, because of isolation and stigma, caregivers did not always elicit the support needed. Social support services need to be offered repeatedly and ideally throughout the child's life.

Need for Training of Mental Health Workers

Participants recommended professionals be trained in working with these families. They discussed that mental health professionals need training in how to assess domestic violence in all ages and situations. They pointed out that it is important that professionals understand the stages of grief and that these stages are not always clear-cut or chronological and may be especially complicated by the presence of previous trauma. The impact of grief on very young children was also an area that participants identified as often overlooked by professionals.

The coordination of service providers was identified as a training need. Often communications were interrupted, or nonexistent, between professionals. This was a concern that was especially difficult for families. Families need to be informed of the status of legal cases and the coordination of services for the best possible outcomes. Families are a source of knowledge that could have helped both police and judges in their work. Families needed to be involved with future trainings in order to ensure that the needs they identify are addressed by service providers.

Need for Supervision

Participants discussed the difficulty of working with these families, especially those mental health providers who had worked with several different families. Consistent and ongoing supervision and consultation were considered essential by all of the participants, even for seasoned practitioners with a great deal of experience and previous training. Participants found that they had a high level of memory about these cases even though they had utilized "selective

forgetting” as a coping mechanism. All described feeling that the experience of working with these families was a significant opportunity for learning in their work history.

Five of the six professionals interviewed had completed their master’s level training before they worked with these families. One participant was a bachelor’s level social worker at the time that she was involved with three families. Her interview was significantly longer than the other five and included a sizable portion of time devoted to the difficulty of the experiences both in regard to the families and the agencies that were involved with those families. The small size of the sample cannot allow for generalizations, but it seemed to emphasize the importance of higher levels of training in working with families exposed to trauma. Unfortunately, many front-line workers, especially in child welfare agencies, will have only bachelor’s degree-level training. These mental health and social service workers will need even more intense supportive supervision to help them cope with the risk of secondary traumatization (Cunningham, 2004). Secondary traumatization, also called vicarious traumatization, is described by Stamm (1997), Figley (1995), and Saakvitne and Pearlman (1996) as creating a risk for clinical workers especially those working with traumatized persons. These workers may not be aware of the negative impact that hearing about violent victimization can have on them personally and professionally.

Families Need Ongoing Contact

Participants pointed out gaps in services that may occur through the life of these children and their caregivers. One gap was the limitation of insurance, which made it difficult for children to receive the mental health treatment that they needed either at the time of the parent’s death or years later. Health care for caregivers was another gap that may have contributed to the caregivers letting their own health care slide as was described in an earlier chapter. Moreover, families needed to know that someone was concerned about them. At the time of the tragic death of their family member, the family may have been too disorganized and chaotic to have been able to utilize professional services. These services were needed for years as the child developed and struggled with the reality of their trauma. A two-year-old child who saw a parent killed by another parent figure was not able to thoroughly process this loss until many years later.

A number of states, including the state of Kansas, have initiated the development of death investigation boards that explore domestic violence deaths to help communities learn from these

losses. The boards or committees investigate the problems that led to the death, the services that have been utilized by the victim and perpetrator and possible breaks in service delivery that may have contributed to the loss. These boards are in the perfect position to identify the children who are most affected by the deaths and insure that they receive needed services. They could maintain contact with the family until the child has reached age 18. This would not need to be intrusive, but it could be a contact that could create a conduit for services if those services were needed. The Victims Reparation Act provides a possible funding source that could be administered by the board to supply supportive services for the child. Perhaps this could include respite care for children so that caregivers could have time off and focus on their own needs. Participant 2 described what she thought would be ideal.

I think it would have been so good if there had been some outreach to that grandmother as she went through the process of grieving the loss of her daughter... as she went through the judicial process that resulted in her son-in-law's incarceration for life... as she mobilized herself to begin the process of raising her infant grandson. Ideally it would have been wonderful if we could have provided some support at that juncture then periodically have been able to check in with her as she went about the never ending process of adjusting to her loss. (Interviewee 2, p. 11, para. 4)

Having a parent killed by intimate partner violence is a tragedy that immediately changes the lives of three generations of a family: the child, the parent and the grandparent. Addressing the needs of these families can help insure that their future generations will be able to live in less violent environments with hope for peace and safety in their future.

References

Amour, M. (2002). Journey of family members of homicide victims: A qualitative study of study of their post-homicide experience. *American Journal of Orthopsychiatry*, 72, 372 – 383.

Azarian, A., Miller, T., Palumbo, A., & Skriptchenko-Gregorian, V. (1997). Anniversary reactions in a five-year-old boy. In A. J. Solnit, P. B. Neubauer, S. Abrams, & A. S. Dowling (Eds.), *The psychoanalytic study of the child* (pp. 214-226). New Haven, CT: Yale University Press.

Barrera, M., Ainlay, S.L. (1983). The structure of social support: A conceptual and empirical analysis. *Journal of Community Psychology*, 11, 133-143.

Bevin, T. (2002). Violent deaths of both parents. In N. B. Webb (Ed.), *Helping bereaved children: A handbook for practitioners* (2nd ed.) (pp. 149-166). New York: Guildford Press.

Bilides, D.G. (1992). Reaching inner city children: a group work program model for a public middle school. In J. Garland (Ed.), *Group work reaching out: People, places and power* (pp. 129-144). New York: The Haworth Press Inc.

Black, C. (1981). *It will never happen to me*. Denver, CO.: M.A.C. Printing and Publications Division. ACT.

Black, D., & Kaplan, T. (1988). Father kills mother. *British Journal of Psychiatry* 153, 624- 630.

Black, D. (1998). Witnessing adults' violence: The effects on children and adolescents. *Advances in Psychiatric Treatment*, 4, 202-210.

Bluestone, J. (1999). School-based peer therapy to facilitate mourning in latency-age children following sudden parental death: Cases of Joan, age 10 1/2, and Roberta age 9 1/2, with follow-up 8 years later. In N.B. Webb (Ed.), *Play therapy with children in crisis: Individual, group, and family treatment* (pp. 225-251). New York: Guilford Press.

Bowlby, J. (1961a). Processes of moving. *International Journal of Psycho-Analysis*, 42, 317-340.

Bowlby, J. (1961b). Childhood mourning and its implications for psychiatry. *American Journal of Psychiatry*, 118, 481-498.

- Bowlby, J. (1963). Pathological mourning and childhood mourning. *Journal of the American Psychoanalytic Association, 11*, 500-541.
- Bowlby, J. (1980). *Loss, Sadness and Depression*. New York: Basic Books.
- Bronfenbrenner, U. (1974). *The ecology of human development experiments by nature and design*. Cambridge, MA: Harvard University Press.
- Burman, S., & Allen-Meares, P. (1994). Neglected victims of murder: Children's witness to parental homicide. *Social Work, 39*, 28-34.
- Cain, A.C. (2002). Children of suicide: The telling and the knowing. *Psychiatry, 65* (2), 124-236. Retrieved October 15, 2002, from <http://80newfirstsearch.oclc.org.er.lib.ksu.edu/WebZ/FSPage?pagename=ftascii:pagetyp>
- Campbell, J.C., Koziol-McClain, J., Bloce, C.R., Campbell, D., Curry, M.A., Gary, F., Sachs, C., Sharps, P.W., Webster, D., Wilt, S., Manganello, J. (2003). Assessing risk factors for intimate partner homicide. *NIJ Journal, 250*, 14-19.
- Caplan, G. (1974). *Support systems and community mental health: Lectures on concept development*. New York: Behavioral Publications.
- Carter, L., Weithorn, L., & Behrman, R. (1999). Domestic violence and children: Analysis and recommendations. *The Future of Children, 9* (3), 4-20.
- Centers for Disease Control. (n.d.). *Dating violence*. Retrieved January 17, 2002, from National Center for Injury Prevention and Control: <http://www.cdc.gov/ncipc/factsheets/datviol.htm>
- Centers for Disease Control. (n.d.). *Fact Book for the year 2000: Working to prevent and control injury in the United States*. Retrieved January 28, 2002, from National Center for Injury Prevention and Control: <http://www.cdc.gov/ncipc/pub-res/FactBook/partner.htm>
- Centers for Disease Control. (n.d.). *Intimate partner violence fact sheet*. Retrieved January 16, 2002, from National Center for Injury Prevention and Control: <http://www.cdc.gov/ncipc/factsheets/ipvfacts.htm>
- Centers for Disease Control. (n.d.) *Intimate partner violence during pregnancy: A guide for clinicians*. Retrieved November 25, 2007, from <http://www.cdc.gov/reproductivehealth/violence/IntimatePartnerViolence/sld011.htm>
- Cermak, T.L. (1988). *A time to heal: The road to recovery for adult children of alcoholics*. Los Angeles: J.P. Tarcher.

Christ, G.H. (2000). Impact of development on children's mourning. *Cancer Practice*, 8 (2), 72-81.

Clarke, R. (1973). *Ellen Swallow*. Chicago: Follett.

Cook, A., Blaustein, M. Spinazzola, J. & van der Kolk, B. (Eds.). (2003). *Complex trauma in children and adolescents* [White Paper]. Retrieved February 2, 2008, from the National Child Traumatic Stress Network Complex Trauma Task Force www.nctsnet.org/nctsn_assets/pdfs/edu_materials/ComplexTrauma_All.pdf

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Cunningham, M. (2004). Avoiding Vicarious Traumatization. In N. B. Webb (Ed.), *Mass trauma and violence* (pp. 327-346). New York: Guilford Press.

Davis, L.V., & Srinivasan, M. (1995). Listening to the voices of battered women: What helps them escape violence?. *Affilia*, 10, 49-69.

Dawson, J.M. & Langan, P.A. (1994). *Bureau of Justice Statistics special report: Murder in families*. [Electronic version]. Washington, DC: U.S. Department of Justice. Available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mf.pdf>

Dobash, R.E., & Dobash, R.P. (Eds.). (1998). *Rethinking violence against women*. Thousand Oaks, CA: Sage Publications.

Dobash, R.E., & Dobash, R.P. (1998). Violent men and violent contexts. In R.E. Dobash, & R.P. Dobash (Eds.), *Rethinking violence against women* (pp. 141-168). Thousand Oaks, CA: Sage Publications.

Edelson, J.L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, 5 (2), 134-154.

Ellis, R.T., & Granger, J.M. (2002). African American adults' perceptions of the effects of parental loss during adolescence. *Child and Adolescent Social Work Journal*, 19 (4), 271-284.

Famularo, R. (1997). What are the symptoms, causes and treatments of childhood post traumatic stress disorder?. *The Harvard Mental Health Letter*, 13 (7), 8.

Fantuzzo, J.W., & Mohr, W.K. (1999). Prevalence and effects of child exposure to domestic violence. *The Future of Children*, 9 (3), 21-32.

Fazzone, P.A., Holton, J.K., Reed, B.G., (2000) *Substance abuse treatment and domestic violence treatment improvement protocol series 25*. Rockville, MD: U.S. Department of Health and Human Services.

Federal Bureau of Investigation. (2005). Expanded homicide data table 9. Retrieved January 15, 2008, from http://www.fbi.gov/ucr/05cius/offenses/expanded_information/data/shrtable_09.html

Figley, C.R. (Ed.). (1995). *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.

Fleming, R. Baum, A., Gisriel, M., & Gatchel, J. (1982). Mediating influences of social support on stress at Three Mile Island. *Journal of Human Stress*, 8, 14-22.

Fonow, M.M., & Cook, J.A. (Eds.). (1991). *Beyond methodology: Feminist scholarship as lived research*. Bloomington, IN: Indiana University Press.

Gaensbauer, T., Chatoor, I., Drell, M., Siegel, D., & Zeanah, C. (1995). Traumatic loss in a one-year-old girl. *Journal of American Child Adolescent Psychiatry*, 34, 520-528.

Gazmararian, J., Lazorick, S., Spitz, A.M., Ballard, T., Saltzman, L.E., & Marks, J.S. (1996). Prevalence of violence against pregnant women. *Journal of the American Medical Association*, 275, 1915-1920. Retrieved January 8, 2002, from Ovid database.

Gelles, R. J. (1976). Abused wives why do they stay? *Journal of Marriage and the Family*, 38, 659-668.

Gelles, R. J. (1997). *Intimate violence in families*. (3rd ed.). Thousand Oaks, CA: Sage Publications.

Graham-Bermann, S.A., & Levendosky, A.A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence*, 13, 111-129. Retrieved October 7, 2002, from Health Reference Center-Academic database.

Groves, B.M. (1999). Mental health services for children who witness domestic violence. *The Future of Children*, 9 (3), 122-132.

Groves, B.M. (2002). *Children who see too much: Lessons from the child witness to violence project*. Boston: Beacon Press.

Groves, B.M., Zuckerman, B., Marans, S., & Cohen, D. (1993). Silent victims: Children who witness violence. *Journal of the American Medical Association*, 13, 262-264.

Hardesty, J.L., Campbell, J.C., McFarlane, J.M., & Lewandowski, L.A. (2008). How children and their caregivers adjust after intimate partner femicide. *Journal of Family Issues*, (29) 1, 100-124.

Harris-Hendriks, J., Black, D. and Kaplan, T. (1993). *When father kills mother: Guiding children through trauma and grief*. London: Routledge.

Hirsch, B.J. (1980). Natural support systems and coping with major life changes. *American Journal of Community Psychology*, 8 (2), 159-172.

Hooks, B. (2000). *Feminism is for everybody: Passionate politics*. New York: South End Press.

Jaffe, P.G., Wolfe, D.A., & Wilson, S.L. (1990). *Children of battered women*. Newbury Park, CA: Sage Publications.

Jenkins, P., & Davidson, B. (2001). *Stopping domestic violence: How a community can prevent spousal abuse*. New York: Plenum Publishers.

Jouriles, E.N., Norwood, W.D., McDonald, Vincent, J.P., & Mahoney, A. (1996). Physical violence and other forms of marital aggression: Links with children's behavior problems. *Journal of Family Psychology*, 10, 223-234.

Kelly, K.A. (2003). *Domestic violence and the politics of privacy*. Ithaca, NY: Cornell University Press.

King, D.W., Taft, C., King, L.A., Hammond, C., & Stone, E.R. (2006). Directionality of the association between social support and post-traumatic stress disorder: A longitudinal investigation. *Social Psychology*, 36 (12), 2980-2992.

Kubler-Ross, E. (1983). *On children and death*. New York: Simon & Schuster.

Lavoie, F., Robitaville, L., & Herbert, M. (2000). Teen dating relationships and aggression: An exploratory study. *Violence Against Women*, 6, 6-36.

Leadbeater, B, Dodgen, D., & Solarz, A. (2000). The resilience revolution: A paradigm shift for research and policy?. In R. DeV. Peters, B. Leadbeater, & R.J. McMahon (Eds.), *Resilience in children, families and communities: Linking context to practice and policy* (pp. 47-64). New York: Kluwer Academic/ Plenum Publishers.

Lewandowski, L., McFarlane, J. Campbell, J.C., Gary, F., & Barenski, C. (2004). "He killed my mommy!" Murder or attempted murder of a child's mother. *Journal of Family Violence*, 19 (4), 201-210.

Lichter, E. L. & McCloskey, L.A. (2004). The effects of childhood exposure to marital violence on adolescent gender-role beliefs and dating violence. *Psychology of Women Quarterly* 28 (4), 344-357.

Malmquist, C. (1986). Children who witness parental murder: Posttraumatic aspects. *Journal of the American Academy of Child Psychiatry*, 25, 320-325.

Marwit, S.J., & Carusa, S.S. (1998). Communicated support following loss: Examining the experiences of parental death and parental divorce in adolescence. *Death Studies*, 22, 237-255.

Masten, A.S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56, 227-238.

Masten, A.S., & Powell, J.L. (2003). A resilience framework for research policy and practice. In S.S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 1-28). New York: Cambridge University Press.

McCloskey, L.A., & Walker, M. (2000). Posttraumatic stress in children exposed to family violence and single-event trauma. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 108. Retrieved October 7, 2002, from Health Reference Center-Academic database.

McFarlane, J., Parker, B., & Soeken, K. (1995). Abuse during pregnancy: Frequency, severity, perpetrator and risk factors of homicide. *Public Health Nursing*, 2 (5), 284-289.

Moser, C. (2004). Urban violence and insecurity: An introductory roadmap. *Environment & Urbanization*, 16 (2), 1-16.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA : Sage.

Naples, N. (2003). *Feminism and method*. New York: Routledge.

Norton, D.G. (1994). My mommy didn't kill my daddy. In J.D. Osofsky & E.S. Fenichel (Eds.), *Caring for infants and toddlers in violent environments: Hurt healing and hope* (pp. 16-19). Arlington, VA: Zero to Three/National Center for Clinical Infant Programs.

Osofsky, J.D. (Ed.). (1997). *Children in a violent society*. New York: Guilford Press.

Osofsky, J.D. (1999). The impact of violence on children. *The Future of Children*, 9 (3), 33-48.

Osofsky, J.D., Cohen, G., & Drell, M. (1995). The effects of trauma on young children: A case of 2-year-old twins. *International Journal of Psycho-Analysis*, 76, 595-607.

Osofsky, J.D., & Fenichel, E.S. (Eds.). (1994). *Caring for infants and toddlers in violent environments: Hurt, healing and hope*. Arlington, VA: Zero to Three/National Center for Clinical Infant Programs.

Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pence, E. (2001). Advocacy on behalf of battered women. In C.M. Renzetti, J.L. Edelson, & R.K. Bergen (Eds.), *Sourcebook on violence against women*. (pp. 329-344). Thousand Oaks, CA: Sage Publications.

Perry, B. (1997). Incubated in terror: Neurodevelopmental factors in the cycle of violence. In J. Osofsky (Ed). *Children in a violent society*. (pp. 124-149). New York: Guilford Press.

Ptacek, J. (1988). Why do men batter their wives?. In K. Yllo, & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 133-157). Newbury Park, CA: Sage Publications.

Ptacek, J. (1997). The tactics and strategies of men who batter: Testimony of women seeking restraining orders. In P.A. Cardarelli (Ed.), *Violence among intimate partners: Pattern, causes and effects*. (pp. 104-123). Boston: Allyn & Bacon.

Pynoos, R.S., & Eth, S. (1985). Children traumatized by witnessing acts of personal violence: Homicide, rape or suicide behavior. In R. Pynoos & S. Eth (Eds.) *Posttraumatic stress disorder in children* (pp. 17- 44). Washington, D.C.: American Psychiatric Association.

Radford, J., & Russell, D. E. H. (1992). *Femicide: The politics of woman killing*. New York: Twayne Publishers.

Reinharz, S. (1992). *Feminist methods in social research*. New York: Oxford University Press.

Rennison, C.M. & Welchans, S. (2000). Bureau of Justice Statistics special report: Intimate partner violence. Retrieved November 12, 2007, from <http://www.ojp.usdoj.gov/bjs>

Renzetti, C.M. (1997). Violence and abuse among same sex couples. In A.P. Cardarelli (Ed.), *Violence between intimate partners: Patterns, causes and effects* (pp. 70-89). Boston: Allyn & Bacon.

Rose, H.M. & McClain, P.D. (1990). *Race, place and risk: Black homicide in urban America*. Albany, NY: State University of New York Press.

Rosenbaum, M. (1990). The role of depression in couples involved in murder-suicide and homicide. *American Journal of Psychiatry*, 147, 1036-1040. Retrieved June 28, 2001, from Expanded Academic ASAP database.

Russell, D. E. H., & Harmes, R. A. (Eds.). (2001). *Femicide in global perspective*. New York: Teachers College Press.

Saakvitne, K.W., & Pearlman, L.A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton.

Scerbo, A.S., & Kolko, D.J. (1995). *Emotion regulation as a protective factor in childhood aggression*. Paper presented at the 75th Annual meeting of the Western Psychological Association in Los Angeles. In Karr-Morse, R. & Wiley, M.S. (1997). *Ghosts in the nursery*. New York: Atlantic Monthly Press.

Schechter, S. (1982). *Women and male violence: The visions and struggles of the battered women's movement*. Boston: South End Press.

Schechter, S. & Edleson, J.L. (1999). *Effective intervention in domestic violence and child maltreatment: Guidelines for policy and practice*. Reno, NA: National Council of Juvenile and Court Judges.

Shakespeare, W. (1969). *Hamlet: Facsimile reprint of 1751 edition*. London: Cornmarket Press.

Silvern, L., Karyl, J., & Landis, T. (1995). Individual psychotherapy for the traumatized children of abused women In E. Peled, P.G. Jaffe, & J.L. Edelson (Eds.), *Ending the cycle of violence: Community responses to children of battered women*. (pp. 43-76). Thousand Oaks, CA: Sage Publications.

Stamm, B.H., (1997). Work Related Secondary Traumatic Stress. *PTSD Research Quarterly*, 8 (2). Retrieved August 4, 2005, from <http://www.uic.edu/orgs/convening/vicariou.htm>

Straus, M.A., & Gelles, R.J. (1986). Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. *Journal of Marriage and Family*, 48, 465-479.

Tjaden, P., & Thoennes, N. (1998). *Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey*. (NCJ No. 172837). Washington, DC: U.S. Government Printing Office.

Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the National Violence Against Women Survey*. National Institute of Justice (NCJ No. 181867). Retrieved June 9, 2002, from <http://www.ncjrs.org/txtfiles1/181867.txt>

Valente, R., Hart, B. Zeya, S., & Malefyt, M. (2001). The Violence Against Women Act of 1994: The federal commitment to ending domestic violence, sexual assault, stalking and gender-based crimes of violence. In C.M. Renzetti, J.L. Edelson, & R.K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 279-302). Thousand Oaks, CA: Sage Publications.

Vaux, A. (1988). *Social support: Theory, research and intervention*. New York: Praeger.
Violence Policy Center. (n.d.). *Facts on firearms and domestic violence*. Retrieved June 10, 2002, from http://www.vpc.org/fact_sht/domviofs.htm

Websdale, N. (1999). *Understanding domestic homicide*. Boston: Northeastern University Press.

Werner, E. (2000). Resilience Research: Past, present and future. In R. DeV. Peters, B. Leadbeater, & R.J. McMahon (Eds.), *Resilience in children, families and communities: Linking context to practice and policy* (pp.3-12). New York: Kluwer Academic/ Plenum Publishers.

Wolfe, D.A., & Jaffe, P.G. (1999). Emerging strategies in prevention of domestic violence. *The Future of Children*, 9 (3), 133-144.

Wolfelt, A.D. (1996) *A child's view of grief: A guide for parents, teachers and counselors*. Fort Collins, CO: Companion Press.

Worden, J.W. (1996). *Children and grief: When a parent dies*. New York: Guilford Press.

Worden, J.W., & Silverman, Phyllis. (1996). Parental death and adjustment of school-age children. *Omega: Journal of Death and Dying*, 33 (2), 91-102. Retrieved October 15, 2002, from <http://80-newfirstsearch.oclc.org.er.lib.ksu.edu/WebZ/FSPage?pagename=record;pagetyp>

Zeanah, C.H. (Ed.) (1993). *Handbook of infant mental health*. New York: Guilford Press.

Zeanah, C.H. (2000). *The handbook of infant mental health* (2nd ed.). New York: Guilford Press.

Zeanah, C.H., & Scheeringa, M.S. (1997). The experience and effects of violence in infancy. In J.D. Osofsky (Ed.), *Children in a violent society* (pp. 97-123). New York: Guilford Press.

Ziller, R.C., & Stewart-Dowdell, B.J. (1991). Life after parental death: Monitoring a child's self-concept before and after family violence. *Death Studies, 15*, 577-586.


Zink, T., Elder, N., & Jacobson, J. (2003). How children affect the mother/victim's process in intimate partner violence. *Archives of Pediatric & Adolescent Medicine, 157*, 587-592.

Appendix A - Institutional Review Board Approval



Kansas State University
 University Research
 Compliance Office
 203 Fairchild Hall
 Lower Mazzarini
 Manhattan, KS 66506-1133
 785-532-3224
 Fax: 785-532-5944
<http://www.ksu.edu/~uarcrc/comp>

TO: William Meredith
 FSHS
 302 Justin Hall

FROM: Rick Scheidt, Chair 
 Committee on Research Involving Human Subjects

DATE: December 8, 2005

RE: Proposal #3536.1, entitled "Social Support for Children Who Have Had a Parent Killed by Intimate Partner Violence"

A MINOR MODIFICATION OF PREVIOUSLY APPROVED PROPOSAL #3536,
 ENTITLED, "Social Support for Children Who Have Had a Parent Killed by Intimate
 Partner Violence"

APPROVED UNTIL: June 23, 2006

The Committee on Research Involving Human Subjects at Kansas State University has approved the proposal identified above as a minor modification of a previously approved proposal. This is an administrative approval by extension from the earlier approval and shares the same expiration date.

All approved proposals are subject to continuing review at least annually, which may include the examination of records connected with the project. Announced in-progress reviews will be performed during the course of this approval period by a member of the University Research Compliance Office staff. Injuries or any unanticipated problems involving risk to subjects or to others must be reported immediately to the Chair of the committee, the University Research Compliance Office, and if the subjects are KSU students, to the Director of the Student Health Center.

It is important that your human subjects project is consistent with submissions to funding/contract entities. It is your responsibility to initiate notification procedures to any funding/contract entity of any changes in your project that affects the use of human subjects.

Appendix B - Informed Consent Documentation

Consent for Participation in a Research Study
Social Support for Children Who had a Parent Killed by Intimate Partner Violence
Ekaine Spencer-Carver, MSW

Invitation to Participate

You are invited to participate in a research study that will explore the social support that children experience when they have a parent killed by intimate partner violence.

Who will Participate

Six mental health professionals will be interviewed to explore their knowledge about the social support that their child clients who had experienced this loss received. Only mental health professionals who have worked with these children will be included in the study.

Purpose

The purpose of this study is to learn more about the social support that children need when they have had a parent killed by intimate partner violence. I do not need to know specific details of the psychological condition or development of these children. However, I am very interested in availability of social support and services or the lack of the same. My goal is to develop training for professionals and family members so that they can better help children cope with this loss.

Description of Procedures

The research includes one face to face interview at a mutually agreed upon time and place. Interviews will be taped recorded in order to insure accuracy. You may turn the recorder off if there are portions that you do not want recorded. I will either transcribe the tapes or will supervise them being transcribed by a graduate assistant trained in and committed to confidentiality. A copy of the transcript of the interview will be sent to you so that you can check the accuracy and can make additions and corrections as needed. The transcripts of the six interviews will be examined to determine common themes and experiences. These common themes will serve as the findings of the study.

The information that you share may be included in my dissertation or future publications, however your name or identifying information will never be used. In order to uphold HIPAA regulations, it will be imperative that you do not share any identifying information about your clients with me. Please do not bring clinical records to the interview as this could also violate HIPAA regulations. Please be aware that the professional accrediting bodies for your profession may have more stringent regulations than those found in the HIPAA regulations please adhere to the most stringent requirements.

Form Revision Date: 9/15/04

UNIVERSITY OF MISSISSIPPI
SOCIAL SCIENCES
INSTITUTIONAL REVIEW BOARD
APPROVED from: *1/15/08*

Voluntary Participation

Your participation in this research study is completely voluntary. You may refuse to answer any interview question that I may ask you. You may choose not to participate in the study, stop the interview at any time and request a break or terminate the interview. Deciding not to participate or choosing to leave the study will not result in any penalty or loss of benefits to which you are entitled. If you decide to leave the study the information you have already provided will be destroyed.

Fees and Expenses

There will be no costs involved in your participation.

Compensation

You will be given a copy of the booklet: A Child's View of Grief written by Alan D. Wolfelt as a resource that can be used in your work with children.

Risks and Inconveniences

There are no known risks involved in participating in this study.

Benefits

Though there are no direct personal benefits from participating in this research study, you will receive a report on the findings of the study that will give you new information and knowledge regarding the social support resources and needs of children who had a parent killed by intimate partner violence.

Alternatives to Study Participation

The alternative is to not participate in the study.

Confidentiality

At the time of the transcription your name will be changed to an identifying number to insure confidentiality. Committee members, Dr. William Meredith, Dr. Karen Myers-Bowman of Kansas State University and graduate colleagues will be verifying the substantive significance of thematic analysis of the taped information and are the only other people who will have contact with this information. The tapes and transcripts will be maintained by the researcher for a period of 3 years and will be kept in a locked file cabinet and then will be destroyed. While every effort will be made to keep confidential all of the information you complete and share, it cannot be absolutely guaranteed. individuals from the University of Missouri-Kansas City Institutional Review Board

(a committee that reviews and approves research studies), Research Protections Program, and Federal regulatory agencies may look at records related to this study for quality improvement and regulatory functions.”

In Case of Injury

“The University of Missouri-Kansas City appreciates the participation of people who help it carry out its function of developing knowledge through research. If you have any questions about the study that you are participating in you are encouraged to call Elaine Spencer-Carver, the investigator, at 816-236208 or 785-341-6073. Although it is not the University’s policy to compensate or provide medical treatment for persons who participate in studies, if you think you have been injured as a result of participating in this study, please call the Administrator of UMKC’s Social Sciences Institutional Review Board, at(816) 235-1764.

Questions

If you have any questions regarding any aspect of this research study please call Elaine Spencer-Carver at (816) 235-6073 or (785) 341-6073, or you may email me at carverc@umkc.edu.

Authorization

Participant's name	Signature	Date
Investigator's name	Signature	Date

SOCIAL SCIENCES
INSTITUTIONAL REVIEW BOARD
APPROVED from: *[Signature]* 1/5/08