The Mental Health and Service Needs of Young Children Exposed to Domestic Violence: Supportive Data

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ABSTRACT

As the visibility of domestic violence (DV) continues to increase, so too does our awareness of the needs of the children in violent families. This study documents the various needs and problems of over 40,000 children as reported by their battered caretakers. What follows is a description of the findings from data collected between 1990 and 1995 from approximately 50 DV agencies in a Midwestern state. The findings indicate that large proportions of children had emotional and social problems whereas about one quarter had physical health and educational difficulties. Common problems included being very protective of family members, discipline issues, mood swings, and difficulty leaving parents. The implications of these findings and ideas for future planning are identified.

Over the past 30 years, domestic violence (DV) has gained increasing visibility within the mental health community as well as among the public at large. Growing awareness of the prevalence and consequences of DV has shed light on the fact that along with approximately 1.5 million women being victimized every year, there are multigenerational components to the transmission of violence, including to other victims within the family—most notably, children (see Tjaden & Thoennes, 2000, for full discussion of repeat victimization that increases the total to 4.8 million).

In an attempt to better understand the impact of DV on children, the present study examined the characteristics, problems, and service needs of all children between the ages of 1 and 12 who entered Illinois' DV service system with an adult client between July 1990 and June 1995. Data about their age, race, gender, circumstances of the adult abuse, and problems the children experienced are explored as well as their service needs at the time of intake. A thorough analysis of these data provides a better understanding of the factors associated with problems among such children and suggests interventions that may be most useful.

Literature Review

Estimates of prevalence rates regarding children who witness DV vary, depending on the age of the child and methods used to arrive at them. The most widely cited rates have been derived from Carlson (1984), who estimated that approximately 3.3 million children between the ages of 3 and 17 are affected, and Straus (1992), who maintained that 10 million teenagers are exposed to parental violence on an annual basis (as cited in Edleson, 1999a).

Edleson, (1999b) in a review of the literature related to the co-occurrence of woman battering and child maltreatment, noted that a majority of studies indicated co-occurring violence in 30%–60% of families in which either child maltreatment or spouse battering was occurring (p. 136; see also Dietz & Craft, 1980; Lundy & Grossman 2001). Although Edleson (1999b) noted that there are methodological problems making comparisons between studies problematic, an overview of these works indicates that the victims of adult abuse were most often mothers, and the type of child abuse most frequently reported was some type of physical abuse. The legacy of such abuse has been clearly documented in the child abuse literature, including a number of mental health problems (Lehmann & Carlson, 1998; Pearce & Pezzot-Pearce, 1997; Straus, 1992; Wolak & Finkelhor, 1998). In fact, studies reveal a significant link between victimization in childhood and later involvement in violent crimes, suggesting an ongoing cycle of violence as well as a greater likelihood of substance abuse, future delinquency, and adult criminality (Groves, Augustyn, Lee, & Sawires, 2002; Lee, 2001; Wolfe, Zak, Wilson, & Jaffe, 1986, p. 96).

More specifically, children exposed to violence exhibit many more problems than children who do not witness violence at home, including anxiety; aggression; depression and temperament problems (Christopoulous et al., 1987; Holden & Ritchie, 1991; Hughes, 1988; Hughes, Parkinson, & Vargo, 1989; Westra & Martin, 1981); less empathy and self-esteem (Hughes, 1988); and lower verbal, cognitive, and motor abilities (Westra & Martin, 1981). Furthermore, the American Academy of Pediatrics reports that children who witness DV are likely to become sufferers of posttraumatic stress disorder, "a long-term mental health condition characterized by flashbacks, anxiety, withdrawal, nightmares, developmental regression, and self-blame" (Lee, 2001, p. 1; see also Groves et al., 2002, p. 5).

Age is an important factor related to the impact of violence. The research literature indicates that infants and toddlers who have been exposed to violence either at home or in their community have a tendency toward immaturity, irritability, distressed emotionality, and fear of being alone as well as regressive behavior around language and toileting (Osofsky, 1999, p. 2). Infants are extremely dependent on their caregivers and sensitive to their affective experience. If upset, they will cry inconsolably and, ultimately, fail to respond to adults (Wolak & Finkelhor, 1998, p. 87). Generally, toddlers do not understand and cannot control their own emotions, requiring adults to provide structure, which may be difficult for depressed and overwhelmed mothers, further impacting the child's experience of emotional expression. Furthermore, some research suggests that preschoolers are especially likely to feel responsible for violence between their parents because of their developmentally appropriate egocentrism and inability to view things from the perspectives of others (Hughes, 1997; Lehmann & Carlson, 1998; Wolak & Finkelhor, 1998).

School-age children show more internalizing behaviors, for example, withdrawal and anxiety, more often seen in girls, and/or externalizing behaviors, for example, aggressiveness and delinquency, more often seen in boys (Osofsky, 1999). Latency-age children (6–12 years of age) have more resources, greater sophistication, and knowledge to bring to the circumstances of intrafamilial violence. They often receive information about family violence within the school, and, hopefully, they also have available to them responsible adults within the school system who can either respond directly to their needs or refer them for longer term therapy and accommodation with respect to the circumstances in which they live. This also includes referrals to child welfare (for a full discussion of the implications of child welfare referrals, see Edleson, 2001; Roberts & Kurst-Swanger, 2002). Often, the behaviors of children in this age group bring them to the attention of teachers and school social workers—for example, acting out, conduct problems, emotional neediness, fearfulness, anxiety, academic problems, difficulties with peers, sadness, depression, low self-esteem, isolation, and shame about their homes, resulting in isolation from their peers (Hughes, 1997; Lehmann & Carlson, 1998; Wolak & Finkelhor, 1999).

In addition to age considerations, both gender and race may be important to consider in relationship to the impact of family violence on children, yet discrepancies often exist across studies related to the role of such characteristics (see Holden & Ritchie, 1991; Hughes, 1988, regarding age differences; see also Edleson, 1999a, for a discussion on gender differences; Osofsky, 1999). Variations in findings may relate to differences in the demographic and situational variables that are examined. Small samples often prevent researchers from examining all the relevant factors. Yet, the literature suggests this type of exploration would help social workers in responding to the needs of children who witness violence directly and/or who must deal with the consequences of that abuse when the abused parent decides to leave.

Much of the information about the impact of violence on children is derived from data collected from studies done with children and their mothers who are in DV shelters (Edleson, 1999a, 1999b). Women who are victims of DV frequently need to leave their homes quickly and find safety, taking their children with them. Often these programs are not specifically geared to meet the needs of children but rather are focused on helping the adult victim of violence (Edleson, 1999b; Peled & Edleson, 1999). Accommodations must be made for children, including gaining an understanding of their response not only to the crisis but also to the lack of consistency and dependability in their lives and the corresponding developmental needs.

Methodology

The data used in this study were collected by the Illinois Coalition Against Domestic Violence (ICADV, or the Coalition), a not-for-profit organization whose primary purpose is to advocate for and assist service providers with

DV policy issues and education and training at local program and state administrative levels (Humm, 1996, p. 1). ICADV required funded agencies to provide data on clients by using a variety of standardized forms, based on both client input and worker assessments.[1] These included an adult intake form, containing basic demographic information and data about the circumstances of abuse, as well as a child information form, which asked about the child's age, gender and race, custody, grade in school, special needs, and service needs of each child who entered a program with his or her parent. In addition, the child information form contained a series of questions related to difficulties in four problem areas: emotional, social, physical, and educational. There were no specific questions about each problem that the child might have on the form. Rather, the worker had a list of symptoms relevant to each of the four areas of emotional, social, physical, and educational problems, and the adult client was presumably asked about each of these. The symptoms relate to difficulties that may be typical of children who were witnesses of DV, although they did not come from a standardized instrument.[2] Our presentation of the data and the symptoms listed in each of the four problem areas included here are based on how these symptoms were listed on the child information form. For example, under emotional problems, the form included the following items: has difficulty leaving a parent, has mood swings, cries often, is often afraid, accepts things without question, has frequent nightmares, does not interact often with others, hurts self on purpose and is suicidal. We subsequently report the percentage of children who were apparently assessed or reported to have each of these symptoms. The same format was used to identify and discuss symptoms in each of the other three problem areas.

In this analysis, we focus on clients who were served between July 1990 and June 1995 and the children who came to services with them. Earlier analysis of the data for the whole population of service users indicated very little variation in relevant client characteristics by year (see Grossman & Lundy, 2000). Therefore, we combine years and present data for the 5-year period as a whole.[3] A total of 132,428 adult clients were served over this time period. Of this total, 19,997, or 15.1%, had at least one child age 12 or under who entered services with them, for a total of 40,636 children.

While each individual year does not purposely contain duplicate cases, about 15.0% of all adult clients showed up in the data in multiple fiscal years. Indeed, there is some evidence that clients entering services with children were somewhat more likely to be repeat service users (28.7% of all adults who did not have children with them between 1990 and 1995 were repeat service users vs. 44.2% of those who had children with them when they entered services). Nonetheless, we decided to include all adult clients who entered services with children between 1990 and 1995 in the present analysis, even those who entered more than once, because we were trying to get a picture of the service needs and problems of all children in the service system over the 5-year period. It is possible that a parent entered services one year with her children and another year she did not, or that different children of the same parent were seen on different years. Furthermore, the same child may have been seen multiple years, but his or her problems may have changed as he or she aged. Thus, by including all adult clients who entered services with a child at some point over the 5 years, even if they entered more than one year, we were able to obtain a fuller picture of the children and their problems.

Characteristics of Adults

The majority of adult clients were women (99.5%) and, we assume, were the mothers (or grandmothers in some instances) of the children they brought with them to the programs. Their average age was 29.2 years, but they ranged in age from 15 to 90. About half of all adult clients with children in services were married (53.6%), and slightly more than one quarter (27.6%) were never married. The average number of children per adult was 2, but the range was from 1 to as many as 9 children.

Data were collected related to the three types of abuse that the adult client may have experienced: physical, emotional, and sexual. Categories of abuse were not mutually exclusive, and many women suffered multiple types. Determination of the type of abuse was based on client reports and/or the assessment of the intake worker. It is important to note, however, that definitions of these types of abuse were not clearly specified in the instructions for form completion. Individuals were eligible for services if they had been "victims of or threatened with domestic violence or abuse, either physical or mental violence as defined by the Illinois Domestic Violence Act of 1986" (ICADV, n.d., p. 1), and the Act itself defines abuse in broad terms (Illinois Compiled Statutes, 1986). Whether this inflated or deflated the percentage of alleged victims in a given area is unclear. Emotional abuse was most common (96.5%), followed by physical abuse (88.0%). A smaller percentage of clients (21.8%) were judged to be or reported that they were victims of sexual abuse. Apart from their experience with abuse, only 2.6% had a special need or disability at the time they entered the program.

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1 See Grossman and Lundy, 2000, for a discussion of how missing data were handled.

2 We note that assessment of child problems was based on information from the parent and not necessarily based on a clinical assessment of the child, although this may have also occurred. Thus, it would be incorrect to assume that the picture presented here is based on a diagnostic interview. Assessments may be more inconsistent than would be the case if a standardized assessment tool had been utilized. This is not to criticize the assessment skills of those conducting the intake interview or the knowledge of the parent as to the problems of her child. It is important to remember the context of the information provided, however.

3 Data for clients served in the last three months of fiscal year 1993–1994 are missing which depresses total figures slightly. This was a year when the Coalition lost and then regained funding and we believe that the interruption may have affected data collection. Previous analysis indicates that the results for this fiscal year, even with 3 months of missing data, were similar to the trends in other years. See Grossman & Lundy, 2000.

Analysis

We first present data on the demographic characteristics of the children. Following this overview, we focus on problem areas and service needs, looking more closely at three distinct age groups: those being 1–2, 3–5, and 6–12 years of age. We chose these groups because of their developmental significance. The analysis primarily involves the description of each relevant group. The descriptive analysis includes the whole population of children age 12 and under who were involved in the service system over the 5-year period. Because we include the whole population, statistical tests, which are typically conducted to predict from a sample to a population and to determine the extent to which differences in the sample represent "true" differences in the population, were not used. We focus, instead, on describing the experiences of each age group.

Multivariate analysis. After looking at problems for the whole group of children, we conducted logistic regression in order to explore the characteristics associated with the likelihood of having at least one problem in each of the four areas examined. While these analyses are more exploratory than theoretical, we included them because we believed they may help service providers to better target children at greater risk for certain kinds of problems. Accordingly, we included the following variables as covariates in each equation: gender (female = 1, male = 2); ages 6–12 (1) versus 5 or younger (0); White (1) or non-White (0); parent had special service needs[4] (1) or not (0); parent experienced sexual (yes = 1, no = 0), physical (1 = yes, 0 = no) and/or emotional abuse (yes = 1, no = 0); and the relationship between the adult victim and the abuser (current or former husband [1] vs. current of former male friend [0]). Clearly, our choice of variables was constrained by the limitations of the existing data. However, many of these variables are ones that the literature suggests may explain differences in symptomatology (Edleson, 1999a; Osofsky, 1999). We chose to look at preschool versus school-age children because of the developmental significance of this distinction and because the literature has suggested a difference in exposure to abuse because of age. We included the variables assessing special needs of the adult because we felt that such needs may be associated with a child's difficulties. Similarly, we may expect differences in symptoms related to the type of adult abuse to which a child has been exposed, which is why we included the three types of abuse in our analysis. Finally, the variable related to the relationship between the adult abuser and victim was included because of evidence about the importance of this relationship to subsequent problems (see Sullivan, Juras, Bybee, Nguyen, & Allen, 2000).

Because many adult clients who came to services with children had more than one child with them, we decided to randomly select only one child between the ages of 1 and 12 per adult client for inclusion in the multivariate analysis. We note that this process did not eliminate children whose mothers received services in more than one year. Indeed, some children may still have been included more than once, especially if they were the only child of a mother who sought services over several different years. What it did allow us to do, however, because only one child per family was included, was to ensure that observations were independent and that family size was not influencing the result. It also reduced the number of children involved, but because selection was random, it should not have biased the results.[5] After completing this process, we further limited the analysis to include only children who entered service with an adult client (presumably their mother) who was abused by either a current or a former husband or a current or a former male friend. We restricted that analysis to these two categories because the work of Sullivan and her colleagues (2000) suggested that whether the abuser was a parent was an important factor in the impact of the abuse and because almost all children whose mothers were not abused by a current or a former spouse had mothers who were abused by a current or a former male friend (93.8% of all children were in one of these two categories). Thus, in order to reduce the number of categories of abusers and better understand the dynamics involved, we decided to limit the comparison to these two categories. Following these reductions, and deleting all remaining cases that were missing on any of the variables included in the logistic regression, we were left with a sample of 15,740 children, which was still quite large. In light of this, and the fact that the statistic used to determine the strength of the coefficients in logistic regression, chi-square, was especially sensitive to large numbers of cases, we considered coefficients with alpha levels of .0001 to be statistically significant in our discussion of these results.

Results

Characteristics of All Children in Service

As noted, a total of 40,636 children between the ages of 1 and 12 entered services with an adult client between 1990 and 1995. Almost equal proportions of children were female (49.8%) and male (50.2%). The majority of children (54.9%) were White, whereas about one third (31.2%) were African American, and 9.1% were Hispanic. Only very small proportions of children were Native American (0.3%), Asian (0.7%) or biracial (3.9%). Among all children ages 1–12, it is evident that about one third were very young: 1–2 years of age (31.5%), whereas slightly more than one quarter (27.9%) were 3–5 years of age, with the

[4] Adult clients who had one or more of the following problems were considered to have special needs: impaired hearing, visual impairment, need for assistance feeding, dressing or toileting, use of a wheelchair, immobility, developmental disabilities, need for assistance administering medication and requiring a special diet.

[5] Appendix Table A contains data on the characteristics of the random sample. There are only minor differences between this group and the entire population used in the descriptive analysis. The most notable of these are very slight differences in race and age, with the random sample slightly more likely to be White and between the ages of 6 and 12 and slightly less likely to be younger than three compared to the total population of children included in the descriptive analysis.

Table 1. *Emotional Problems of Children Ages 1–12 by Age Group*

Variable	1–2 years (*n* = 12,832)	3–5 years (*n* = 11,337)	6–12 years (*n* = 16,467)
% children with 1 or more emotional problems	37.9%	58.0%	58.2%
Children from previous group with 1 or more emotional problems	(*n* = 4,857)	(*n* = 6,580)	(*n* = 9,528)
% who have difficulty leaving a parent	67.7	52.1	33.1
% who have mood swings	31.7	48.0	59.3
% who cry often	41.9	38.9	32.1
% who are often afraid	30.8	41.2	43.2
% who accept things without questions	14.6	22.7	26.4
% who have frequent nightmares	15.6	22.1	18.0
% who do not interact often with others	11.3	13.8	15.7
% hurt self on purpose	6.8	7.0	6.4
% who are suicidal	0.1	0.5	3.0
Average number of problems for	2.20	2.46	2.37
Children with an emotional problem (range)	(1–8)	(1–9)	(1–9)

remaining being 6 to 12 years old (40.4%). The average age was 4.98 years. More than two thirds (68.1%) were in the custody of their mothers, and almost all of the remaining one third were in the custody of both parents (29.2%). Very small percentages were in the custody of their fathers (1.0%) or an "other" person (1.7%).[6] Data on visitation indicated that the majority of abusers had visitation rights (58.1%; $n = 21{,}942$).

Of all children age 12 and under, 9.7% had some type of special service need or disability. Among those with such problems ($n = 3{,}961$), the most common limitation was a special medical consideration; one third had this limitation (33.2%), although we have no details on the specific health problems involved. Developmental delays in speech were the next most common problem, affecting 29.3% of all children age 12 and under who had special service needs. Perhaps related to this, 18.1% had limited English proficiency, whereas visual and hearing impairments affected 14.5% and 11.9% of children, respectively. Furthermore, 11.5% had motor development delays. Smaller percentages had problems such as special diets (7.7%), physical and mental delays (5.6% and 5.2%, respectively), and an inability to care for self (3.8%). Very few children with special needs were dependent on wheelchairs (0.8%), most likely because programs may have had difficulty accommodating such children.

Characteristics of Child Problem Areas

The varied factors that impact children in violent homes, and the diverse manifestation of their experiences, present extremely complex situations that are difficult to understand. Tables 1–4 examine categories of problems that children from violent homes experienced. Of note is that analysis of the percentage of children who had at least one problem in the four areas examined revealed that slightly more than one third (38.5%) had no problems in any of the areas discussed here.

Emotional Problems. Approximately 51.7%, or 21,019 children, had an emotional problem, with the average number of problems falling at 2.36 and ranging from 1 to 9. Table 1 contains a breakdown of emotional problems, as listed on the child information form, by the three age groups: 1-to-2-year-olds, 3-to-5-year-olds, and 6-to-12-year-olds. The data indicate that the youngest group of children were less likely to have any of these emotional problems compared with the other two age groups. Almost identical proportions of all children 3–5 years old and 6–12 years old had one or more emotional problem (about 58.0%), whereas only 37.9% of those 1–2 years old had such difficulties. Younger children were more likely to have problems related to difficulties leaving parents (67.7%) and crying often (41.9%). About one third (31.7%) experienced mood swings or were often afraid (30.8%). Older children, particularly those 6–12 years old, were less likely to have difficulty leaving parents (33.1%) but more likely to experience mood swings (59.3%) and to often be afraid (43.2%). About one quarter (26.4%) of children in this age group accepted things without question, and almost one third (32.1%) cried often. Children who were 3–5 years old were more similar to the older group in that they were more likely to have mood swings (48.0%) and to be afraid often (41.2%), compared with younger children. But like very young children, a large proportion (52.1%) had difficulty leaving parents and cried often (38.9%). We note that only very small percentages of children in any of the age groups hurt themselves on purpose or were suicidal.

Social Problems. Almost half (46.3%) of all children experienced one or more of the social problems listed on the child information form. Among those who had at least one problem in this category, ($n = 18{,}833$), the average number of problems experienced was 2.39 and ranged from 1 to 8 problems. The data in Table 2 indicate that younger children, those under age 3, were less likely to have a social problem (19.1%) compared with children in the other two age groups. More than half of all children ages 3–5 and 6–12 had a social difficulty.

[6] Responses to custody questions may indicate who had custody of the child at the time of intake or legal custody.

TABLE 2. *Social Problems of Children Ages 1–12 by Age Group*

VARIABLE	1–2 YEARS (*n* = 12,832)	3–5 YEARS (*n* = 11,337)	6–12 YEARS (*n* = 16,467)
% of children with 1 or more social problems	19.1	55.7	57.7
Children from previous group with 1 or more social problems	(*n* = 2,448)	(*n* = 6,316)	(*n* = 9,493)
% who are very protective of family members	60.1	58.3	64.7
% who resist guidance and discipline	56.7	50.9	44.1
% who try to act like a parent (role reversal)	26.8	37.0	46.5
% who are possessive of toys (age 3 and older only)	—	40.0	21.5
% who hit, bite, shove frequently (age 3 and older only)	—	41.1	31.1
% who behave like a younger child	13.4	22.3[a]	22.1[b]
% who play with fire	3.9	5.6	7.4
% who harm small animals	5.2	4.4	2.8
Average number of problems for	1.67#[c]	2.60[d]	2.40[e]
Children with a social problem (range)	(1–6)	(1–8)	(1–8)

Note. Dashes represent data that were not obtained or are not reported.
represents only 6 items that were included in the scale for children ages 1–2.
[a]*n* = 6,314. [b]*n* = 9,490. [c]*n* = 2,448. [d]*n* = 6,316. [e]*n* = 9,493.

TABLE 3. *Physical Health Problems of Children Ages 1–12 by Age Group*

VARIABLE	1–2 YEARS (*n* = 12,832)	3–5 YEARS (*n* = 11,337)	6–12 YEARS (*n* = 16,467)
% of children with 1 or more physical health problems	9.6	21.7	27.0
Children from previous group with 1 or more physical health problems	(*n* = 1,237)	(*n* = 2,456)	(*n* = 4,446)
% who are more active than other children	55.5	59.4	43.8
If yes,			
% in a special class	2.5[a]	4.2[b]	10.7[c]
% who have frequent illness	45.3	25.6	23.8
% who bed wet (over age 4 only)	—	50.0#[d]	35.8
% who have weight problems	16.0	14.5	22.6
Average number of problems for	1.17##	1.20	1.26
Children with a physical health problem (range)	(1–3)	(1–4)	(1–4)

Note. Dash represents data that were not obtained or are not reported. # includes only children 4 and older in the analysis for this problem.
include only three possible problems for children ages 1–2.
[a]*n* = 686. [b]*n* = 1,459. [c]*n* = 1,947. [d]*n* =1,016.

Regardless of age group, the majority of children with social problems fell into the category of being very protective of family members. Those children 6–12 years of age had the highest proportion of children with this problem (64.7%), whereas parents of those 3–5 years of age had the lowest (58.3%). Of children under age 3, 56.7% resisted guidance and discipline, and 26.8%, even in this very young age group, engaged in role reversal and tried to act like a parent. Children ages 3–5 had a similar pattern of problems. About half, or 50.9%, resisted guidance and discipline, and 37.0% engaged in role reversal. In addition, 40.0% were possessive of their toys (children younger than 3 were not assessed for this problem), and 41.4% were frequently aggressive. Almost one quarter (22.3%) also acted younger than their biological age. Children ages 6–10 were less likely to engage in aggressive behaviors such as hitting, kicking, biting, and shoving (31.1%), and only about one fifth (21.5%) were possessive of toys. They were less likely than the other age groups to resist guidance and discipline, although 44.1% of children in this age group had this problem. They were more likely than younger children to engage in role reversal (46.5%), however, and 22.1% behaved like a younger child.

Physical Health Problems. Physical health problems listed in the child information form primarily relate to somatization. Twenty percent of all children age 12 and under had at least one of the four physical problems that were included for this analysis.[7] Of those with such problems (*n* = 8,139), the average number of problems was about 1. The data in Table 3 show that children under age 3 were less likely to have physical health problems compared with older children; only 9.6% of all children under age 3 had a problem in this category.

The greatest proportion had problems related to being more active than other children (55.5%). Frequent illness was also a fairly common problem for children of this age (45.3%), whereas 16.0% had weight problems. Approximately one fifth of all children between the ages of 3 and 5 had a problem in this area (21.7%). Similar to younger children, the greatest proportion of children ages

7 Also included but eliminated from the analysis were questions about drug and alcohol abuse that did not appear to be reliable, especially for very young children. In addition, we did not include children under 5 when looking at the proportion who wet their beds. Children under 5 were considered to have a physical health problem if they had any one of three problems while those 5 and older were considered to have such problems if they had one of four problems.

TABLE 4. *Educational Problems of Children Ages 5–12 (n = 19,996)*

PROBLEM TYPE	PERCENTAGE
Children with 1 or more educational problems	21.6
Children from previous group with 1 or more educational problems	(*n* = 41,232)
% who have learning problems	47.2
If yes,	
% in special class	42.0[a]
% who have problems obeying rules at school	42.0
% who have behavior problems	41.6
If yes,	
% in special class	19.2[b]
% who miss school often not because of medical reasons	15.9
Average number of educational problems for	1.47
Children from previous group with an educational problem (range)	(1–4)

[a]*n* = 2,036. [b]*n* = 1,793.

TABLE 5. *Service Needs of Children Ages 1–12 by Age Group*

VARIABLE	1–2 YEARS (*n* = 12,832)	3–5 YEARS (*n* = 11,337)	6–12 YEARS (*n* = 16,467)
% who need parent–child support	80.6	78.7	77.9
% who need individual support	67.1	73.7	76.9
% who need group activity	69.2	79.6	79.4
% who need shelter/emergency shelter	75.3	62.2	56.3
% who need advocacy with community resources	11.1	11.9	12.3
% who need medical/physical assistance	12.4	10.5	9.5
% who need transportation	10.9	10.7	10.9
% who need advocacy with school	2.5	9.2	18.4
% with 1 or more service needs	99.7	99.4	99.2
Average number of service needs for those with any	3.30[a]	3.39[b]	3.44[c]
Number of service needs for those with any (range)	(1–8)	(1–8)	(1–8)

[a]*n* = 12,792. [b]*n* = 11,267. [c]*n* = 16,335.

3–5 had problems related to being more active than other children (59.4%). Of children ages 4 and up in this age group, 50.0% also had bed-wetting problems, 25.6% had frequent illnesses, and 14.5% had weight problems. Children ages 6–12 had a similar pattern. Twenty-seven percent of all children in this age group had a physical health problem. Of this group, 43.8% were seen as being more active than other children, 35.8% had problems related to bed-wetting, 23.8% had frequent illnesses, and 22.6% had weight problems.

Educational Problems . Analysis of the number of children with educational problems, presented in Table 4, included only school-age children, eliminating all children under age 5 from the analysis. Thus, of the 19,966 children between the ages of 5 and 12, about one fifth, or 21.6%, had one or more of the educational problems listed on the child information form. The average number of problems, for those who had at least one educational problem, was 1.47 on a 4-point scale.[8] Of those with problems in this area, 47.2% had learning problems, but fewer than half (42.0%) of children with such problems (n = 2,036) were in a special class for such difficulties. Of those, 41.6% also were reported as having behavior problems. Nonetheless, only 345 children, or 19.2%, of those with behavior problems (n = 1,793) were in a special class for these behaviors. Forty-two percent had problems obeying the rules of the school, and 15.9% missed school often for reasons other than medical.

Service Needs. Virtually all children (99.4%) had at least one of the service needs included on the child information form, and among those with needs, the average number was 3.38. The data in Table 5 reveal that the three age groups were very similar with respect to the percentage of those who had at least one need in this area, and for all three groups, four needs stood out as being quite prevalent. These included shelter/emergency shelter, individual support, group activity, and parent–child support. Of children younger than 3, 80.6% needed parent–child support. Within this age group, the next largest area of need was shelter/emergency shelter (75.3%), followed by group activity (69.2%) and individual support (67.1%). Among those 3 to 5 years old, 79.6% needed group activity, 78.7% needed parent–child support, 73.7% needed individual support, and 62.2% needed shelter/emergency shelter. An almost identical pattern existed among those 6 to 12 years old. Smaller proportions of children in all age groups needed advocacy-with-schools support, although among those 6- to 12 years old, 18.4% needed this service. About 10.0%–12.0% of children in each age group needed the

[8] Problems in this category on the Child Information Form originally included dropping out of school. Because we felt this would not be applicable to this age child, we did not include it in the analysis of educational problems.

TABLE 6. *Summary of Results From Logistic Regression Using Chi-Square Statistics (and Beta Coefficients)*

	LIKELIHOOD[a] OF EMOTIONAL PROBLEMS		LIKELIHOOD[a] OF SOCIAL PROBLEMS		LIKELIHOOD[a] OF HEALTH PROBLEMS		LIKELIHOOD[b] OF EDUCATIONAL PROBLEMS		LIKELIHOOD[a] OF ANY PROBLEMS	
Intercept	23.74*	(0.5599)	83.98*	(-1.0908)	278.48*	(-2.5360)	141.74*	(-2.7253)	11.00	(-0.3888)
Male	0.0715	(-0.00869)	3.39	(0.0610)	56.95*	(0.3065)	121.64*	(0.6526)	3.60	(0.0638)
White	100.52*	(0.3443)	84.75*	(0.3245)	29.79*	(0.2378)	28.00*	(0.3363)	84.52*	(0.3255)
Between the ages of 6 & 12	202.97*	(0.4859)	674.24*	(0.8917)	324.49*	(0.7366)	—		468.33*	(0.7865)
Adult client										
Had special needs at intake	15.84*	(0.4219)	24.52*	(0.5189)	35.33*	(0.6570)	18.05*	(0.6719)	18.39*	(0.4930)
Sexually abused	56.83*	(0.3017)	45.91*	(0.2726)	28.98*	(0.2549)	11.24	(0.2258)	43.92*	(0.2783)
Physically abused	0.0725	(-0.0146)	0.8214	(-0.0497)	0.0371	(-0.0128)	1.71	(-0.1151)	0.2803	(-0.0302)
Emotionally abused	2.02	(0.1272)	1.36	(0.1091)	1.47	(0.1466)	2.55	(0.3024)	2.71	(0.1487)
Alleged abuser										
Husband or ex-husband	32.38*	(0.1994)	20.14*	(0.1617)	0.9306	(0.0431)	0.3162	(-0.0375)	29.78*	(0.1963)
-2 log likelihood of intercept and co-variates compared with intercept-only model	518.65*		986.95*		509.27*		190.23*		791.59*	

Note. Dash represents data that were not obtained or are not reported.
[a]*n* = 15,740. [b]*n* = 7,068.
**p* £ .0001

remaining services, which included medical/physical assistance, advocacy with community resources and transportation.

Factors Related to the Likelihood of Having Various Problems

Table 6 contains the results of the logistic regression for each of the four problem areas, modeled separately. It also includes a fifth model that looks at factors associated with the likelihood of having a problem in any of the four areas examined. All models included the same covariates, with the exception of the model predicting educational problems, from which the age variable was deleted because only children 5 and older were included in the analysis. To meet the assumption of independent observations required for logistic regression and also to reduce any bias related to family size, we again note that a random sample comprised of 1 child randomly selected from each household was used for this analysis.

Given the still large number of cases involved in the analysis, it is perhaps not surprising that all models attained statistical significance when covariates were added, compared with the intercept-only model (likelihood ratio). Looking specifically at the four problem areas, it is evident that similar variables attained statistical significance ($p < .0001$) in each area. These variables were (a) age (except in the model of educational problems, which did not include this variable), (b) race, (c) whether or not the child entered the shelter with an adult client with a special need or disability, and (d) whether or not the child entered the shelter with an adult who reported sexual abuse. In addition, the gender variable and the variable assessing whether the abuser was a current or a former spouse or boyfriend each attained statistical significance in two models. The relationships can be summarized as follows:

Characteristics associated with a greater likelihood of experiencing 1 or more *emotional problems*:

- Child is White;
- Child is between the ages of 6 and 12;
- Child entered the program with an adult client who had special needs;
- Child entered the program with an adult client who reported or was assessed as being sexually abused;
- Alleged abuser was the current or former husband of the adult client.

Characteristics associated with a greater likelihood of experiencing 1 or more *social problems*:

- Child is White;
- Child is between the ages of 6 and 12;
- Child entered the program with an adult client who had special needs;
- Child entered the program with an adult client who reported or was assessed as being sexually abused;

Characteristics associated with a greater likelihood of experiencing 1 or more *physical health problems*:

- Child is male;
- Child is White;
- Child is between the ages of 6 and 12;
- Child entered the program with an adult client who had special needs;
- Child entered the program with an adult client who reported or was assessed as being sexually abused.

Characteristics associated with a greater likelihood of experiencing 1 or more *education-related problems*:

- Child is male;
- Child is White;
- Child entered the program with an adult client who had special needs;

- Child entered the program with an adult client who reported or was assessed as being sexually abused.

Characteristics associated with a greater likelihood of experiencing 1 or more problems in *any of the four areas examined (emotional, social, physical, or educational):*

- Child is White;
- Child is between the ages of 6 and 12;
- Child entered the program with an adult client who had special needs;
- Child entered the program with an adult client who reported or was assessed as being sexually abused;
- Alleged abuser was the current or former husband of the adult client.

Discussion

The data presented here are particularly useful because of the large number of clients and the fact that data on very young children were available. They suggest that children who enter the DV system have a variety of problems and that some children, given the type of abuse experienced by their caretakers and the relationship between the abuser and the caretaker, are more likely to have difficulties.

Limitations

Before drawing any conclusions on the basis of this analysis, it is important to note the limitations of the data, especially because the findings reported here suggest that these children have fewer problems than we anticipated. Several factors may explain this trend. First, assessments of child problems were not made using a standardized instrument. Rather, they were based on both parental input and observations of staff. There is evidence that parental assessments tend to differ from child self-reports of distress (Hughes et al., 1989) and may be biased by the mother's own depression or defensiveness (for a discussion, see Edleson, 1999a; Hughes, 1988). Second, several authors pointed out that the period of program entry may be a high-stress period for children and may lead to an overassessment of difficulties that tend to dissipate over time (Christopoulous et al.,1987; Edleson, 1999a; Hughes et al., 1989; Wolfe et al., 1986). If assessments were delayed for some children in this study, they may have exhibited fewer problematic behaviors. Another limitation includes the fact that there was no control group. Although there were children who did not have problems, but we do not know whether the proportion of children who were problem free and those who had difficulties were similar to what we would have found in a group of children whose caretakers were not victims of DV. We have included normative data in our subsequent discussion to at least contextualize the extent of difficulties that were apparent in this population of children; however, the child information form did not use a standardized instrument, making comparison difficult. Many of the behaviors and problems listed are similar to those on the Child Behavior Checklist (CBCL; Achenbach, 2001), but comparisons to this instrument are problematic because all items on the CBCL are not on the child information form, and this form was not scored in a way that allowed us to derive a total score for purposes of comparison. Similarly, a parent's report that a child has a learning problem is not the same as a diagnosed learning disability.

Other disadvantages include the items on the child information form. First, some of the symptoms that were included on the form were not intended to apply to younger children. This may explain why children who were younger were less likely to have difficulties. Second, while the logistic regression allowed us to tease out the "grosser" factors contributing to the likelihood of difficulties, it did not allow us to look at the more subtle individual and interpersonal qualities that allow children to cope, an aspect of violence research that needs attention. Again, the fact that we were limited to those variables about which data were collected constrained our analysis in this area. Third, some factors, such as developmental delays or special medical needs of children, may be both the result of as well as an additional stressor contributing to family violence, but there was no way in this cross-sectional study to determine the causal path of such important factors. Lastly, related to services, because workers and clients were working from a comprehensive but still not exhaustive list of services related to needs, unanticipated service needs may not have been mentioned by clients or noted by workers. This consequently limits our understanding of the complete service needs of these children. Nonetheless, the data do provide some guidance related to children who may need special services, at least during the time they are in the DV service system.

Children's Problems

Data on children's problems corresponds with the literature that describes children's struggles in violent families. Half of all children had an emotional problem, and an almost equally high percentage had social problems. Smaller but still notable percentages of children had physical health and educational problems. Clearly, these children are in need of services.

The data on emotional problems indicate that the most common emotional difficulties—mood swings, difficulty leaving a parent, frequent fear and crying—are more active and, in some ways, demanding responses to stress. The child is letting his or her fear and/or unhappiness be heard, albeit in a fashion that may create even more problems for the child, considering the fatigue and anger of the mother and the anger and violence of the father or father figure. The second set of responses—accepting things without question, nightmares, and failure to interact with others—seem much more passive and withdrawn, possibly indicative of a child who has given up trying to have his or her needs met or fears consoled, or who is trying to prevent additional stress on his or her mother. We know that children whose parent(s) is (are) experiencing severe problems often deny any problems

themselves, at least until their parent is better able to function and handle the situation (Elbow & Mayfield, 1991; Finkelhor & Browne, 1985; Massat & Lundy, 1999).

Younger children in this population, particularly those who are toddlers, seem to exhibit behaviors associated with emotional distress less often than older children, but more than the other age groups, they appear to have difficulty leaving parents. Presumably, this is more than the age-appropriate response and reflects overconcern about separation, or attachment issues, that may be critical to address in this age group. Older children, however, seem to display mood swings more often and appear to be more afraid.

The social difficulties that children suffer as a result of exposure to violence can include problems with social interaction; increased avoidance of and resistance to the parent; poor social interactions with peers as well as adults; trouble making friends; deficits in prosocial behavior, for example, smiling; delays in a number of interactive play skills; a higher incidence of emotional difficulties, for example, lower levels of self-esteem; and feelings of hopelessness, depression, and low self-worth (Barnett, Miller-Perrin, & Perrin,1997, p. 55). It is critical to note that many of these behaviors have been historically identified with and related to attachment problems (Osofsky, 1999; see also the discussion in Shonkoff & Phillips, 2000, as cited in Osofsky, 2004). The data presented here reflect many of these difficulties. Overprotectiveness of family members, even among very young children, and role reversal were common problems among the children who came to services with their mothers. Resistance to guidance and discipline was also a frequent problem, particularly among children in the younger age groups. While this may be age appropriate to some extent, presumably what is reported here is behavior that is beyond the normal age-related resistance. Aggressive behavior and possessiveness were also somewhat common behavior problems, particularly among children 3–5 years of age. Older children were somewhat less likely to exhibit these behaviors, but almost one third of those 6–12 were frequently aggressive. More than one fifth of children ages 3–5 and 6–12 also exhibited behavior that was not age appropriate and more characteristic of younger children, suggesting regression of some kind.

As discussed, comparison data related to emotional and social problems is difficult to provide because problems on the child information form were not derived from standardized measures. However, we can get some sense of the severity of problems among these children from a review of the prevalence of psychopathology in preschool children that was conducted by McDonnel and Glod (2003). After reviewing seven studies focusing on children ages 1–9 that relied primarily on nonclinical samples, the authors noted the following prevalence rates: separation anxiety disorder, from 0.5% to 3.1%; overanxious disorder, from 0.8% to 4.7%; posttraumatic stress disorder, from 0.4% to 0.1%; major depressive disorder, from 0.9% to 1.1%; oppositional defiant disorder, from 0.7% to 26.4%; and conduct disorder, from 0.8% to 4.6% (McDonnel & Glod, 2003, p. 145). While the symptoms reviewed in this article are not singularly the same as diagnoses for each of these disorders, these data suggest that there was a high prevalence of problems in this population of children.

> … it may be expeditious to coordinate services with agencies that have experienced counselors with expertise in providing case management and therapy to children as well as to their mothers exposed to DV.

Physical health problems were somewhat less common among children age 12 and under, especially among children under 3 years of age, but there were only a small number of problem behaviors specifically included in this area, particularly for very young children. Among those with a physical problem in this very young group, overactivity was quite common, as were frequent illnesses, which might be indicative of somatization. However, frequent illness might also serve as a stressor in a family system and contribute to distress and, ultimately, violence. Among older children, frequent illnesses were reported less often as a problem, but overactivity was the most likely physical problem.

Data from the Child Trends Databank (2003a) further suggests that the amount of overactivity within this population of children was high if we compare these children with those diagnosed by a doctor or health professional as having attention deficit hyperactivity disorder (ADHD) in 2002. According to this national data, 6.8% of all children between the ages of 5 and 11 were diagnosed as having ADHD, whereas 1.0% of those ages 3 and 4 had this diagnosis (Child Trends Databank, 2003a). Clearly, overactivity is not necessarily comparable to ADHD, but it suggests that the children in our population were atypical in the extent to which they were seen as being overly active. Unfortunately, small percentages of those who were overactive were in special classes to address the problem, classes and perhaps instruction not available at a shelter for DV, further compromising the child's needs. Even among the oldest group, those ages 6–12 who were school age, only 10.7% of those who were reportedly overactive were in special classes. It is possible that the overactivity was not severe enough to warrant such attention. It is also possible that the overactivity was periodic, related to episodes of violence and

more obvious at the time the child came to services because of the crisis at hand. However, the data indicate that some children with special needs in this area may be underserved by the school system, requiring greater advocacy.

Given that the average age of this population was almost 5 years, many of the children in programs were school age. This suggests a need for special consideration of the impact of shelter living on school attendance and performance. The fact that advocacy with schools was included as a category of service for children reflects that staff of DV programs are aware of this service need. Indeed, the service data indicate that 18.4% of all children 6 to 12 years of age were seen as needing this service.

Data on school problems indicate that difficulties in school affected about one fifth of all children who were 5 to 12 years old. Of those affected, difficulties included problems obeying rules at school as well as behavior and learning problems. Data from the Child Trends Databank (2003b) indicates that in 2002, 8% of all children age 5–11 were diagnosed by a school or health professional as having a learning disability. Our population is well above that percent, and even though having a learning problem is not the same as a diagnosed learning disability, this comparison suggests that at a minimum, the children in this study were having more problems in school than is typically the case.

Frequent school interruptions may account for some of these difficulties. They may also be further manifestations of the social and emotional problems associated with exposure to violence. Whereas only about 19% of all children with a behavior problem were in a special class to address it, 42% of those with learning problems were reportedly in special classes.

The multivariate analysis suggests that several factors lead to problems and that each contribute to problems independently. Thus, male children who enter services are more at risk for problems in physical health and educational problems, and perhaps social difficulties, compared with girls, but there was clearly no gender difference related to emotional problems. This supports some of the literature that suggests that boys may be more vulnerable to certain types of problems (Wolfe et al., 1985, as cited in Christopoulous et al., 1987). In addition, it appears that White children are more likely to have difficulties in the four areas examined. The exact mechanisms involved remain unclear, however, and tend to contradict studies finding no racial differences (O'Keefe, 1994, as cited in Edleson, 1999a). The results suggest that older children are more likely to have difficulties than younger children with emotional, social, and physical health problems. However, younger children were excluded from the analysis of several specific problems, and this may have biased the results. Still, our findings related to age are compatible with the existing literature (see Christopoulous et al., 1987, p. 612, for a full discussion and list of citations).

Perhaps it is not surprising to find that children whose mothers had special needs were also more likely to experience problems. Although only a very small proportion of all mothers had such needs (2.5%), it is likely that such problems may lead to difficulties among children regardless of whether they witnessed DV. Because shelter programs often cannot accommodate victims with physical disabilities, it is unlikely that many women with such limitations will be among the adult service population, but the importance of this factor as a predictor of the likelihood of problems for children indicates that identification of such difficulties in the caretaker is critical, as is the targeting of children from these families.

Although the demographic data on adult clients indicate that almost all the mothers who brought children with them were victims of emotional abuse, and a large proportion also experienced physical abuse, neither of these types of abuse were specifically associated with problems in any of the four models, most likely because they were so common. And although sexual abuse was the only type of abuse to be associated with difficulties, because emotional and physical abuse were so prevalent, the results more accurately indicate that sexual abuse in addition to emotional and physical abuse is what matters. Thus, these findings suggest that exposure to sexual abuse may be particularly problematic for children, in light of other kinds of abuse. Undoubtedly, the direct witnessing of sexual abuse or rape is devastating for a child. However, even indirect exposure, including involvement with a mother who has just been victimized, may be equally painful. These results indicate that children who enter the service system after their mothers have been sexually abused may need specific targeting.

Related to this issue are the demographic data indicating that a large proportion of abusers had visitation rights.[9] The data indicate that about 57.7% are husbands or former husbands who allegedly abused the adult victim. Given that the literature suggests children may be more vulnerable to abuse themselves at the hands of their mother's male abusers, and the fact that the analysis presented here indicates that children whose mothers have been abused by a current or a former spouse are more likely to have problems in certain areas, it seems important to monitor such visitations and to ensure that children receive adequate subsequent support. Some states provide supervised visits by highly qualified social workers who are trained in child development and family dynamics; many states do not. The coordination of these types of arrangements would greatly ensure the safety as well as the social and emotional and perhaps educational well-being of children exposed to intimate family violence.

Conclusion

On the basis of our analysis and review of the literature, we make the following recommendations: First, contradictions within the present research findings make it imperative that more comprehensive, and perhaps longitudinal, research

[9] It is possible that this finding is a statistical artifact in that large numbers of cases were missing information on this variable. Missing cases may have been ones in which the abuser was not related to the child and would not have visitation rights. However, further analysis revealed no consistent pattern as to who was missing.

studies be conducted so that the true nature and manifestation of children's difficulties are better understood. Qualitative studies that further clarify some of the nuances of child problems would be especially helpful. Racial and ethnic differences should be explored as well. In addition, the literature indicates that many children exposed to violence are quite resilient and coping well with the difficulties within their families (Wolak & Finkelhor, 1998, p. 81). Some of the children in our study were seemingly problem free. Still, we know little about the experiences of children whose mothers do not utilize the formal DV service system. What, if any, resources are available to these children? Do they experience the same problems as children in the service system? Admittedly, this sample may be more difficult to access, but the outcome information of such a study would be valuable.

Second, children whose mothers have been abused by a current or a former husband, presumably the father of the child, may be at greater risk for emotional and social difficulties. Interestingly, the relationship between the abuser and the mother did not seem to be related to the likelihood of having educational or health problems. It is possible that this is because the types of problems included in these areas are not affected by this relationship compared with the more extensive difficulties listed under the social and emotional problem areas.

Third, the findings that the majority of children with social problems were reported as being very protective of family members, not just parentified in their role or engaged in role reversal, gives mental health professionals some insight into the functioning of the child. These children likely need the opportunity to become less responsible, to not have to be so concerned about the welfare of the parent, in essence, to return to their childhood. This is certainly a function that can be offered by shelters and shelter staff—to provide a safe space for children to engage in childlike pursuits.

Fourth, there is clearly a need for ongoing counseling services for children as well as education and support. Data on service needs of children make it clear that children need individual support and both they and their mothers need parent–child support. The literature indicates that one of the most important factors in the resilience of children is a secure parent–child or adult–child attachment (Bowlby, 1988). The problems these children manifest suggest that there needs to be an explicit focus on assessment and intervention around issues of attachment. As stated by Osofsky (2004), trust, competence, empathy, and curiosity emanate from the foundation in a child's life of a secure attachment. Indeed, one of the major developmental tasks of childhood is attachment with a primary caregiver(s). Backed by the research literature and reported in Shonkoff and Phillips (2000), Osofsky noted that without secure attachments, children's development can erode, leading to cognitive, learning, relational, emotional, and mental health problems, similar to what seems to be occurring to the children in these data. Shelters are aware that the children they see are in need of services, and these data suggest a specific area of concern. Therefore, until a parent is able to become dependable, children need the support and guidance of therapists and/or other dependable adults (Hughes, 1997; Lehmann & Carlson, 1998; Wolak & Finkelhor, 1999). Because of the expertise required, shelters may need to consider coordinating services with mental health agencies, building on the suggestions made by Warsaw and Maroney (2002).

Fifth, many of the children who entered the service system with their mothers needed shelter or emergency shelter. If the mother left the abusive situation and had no place to leave her children, they would have to come with her to the DV program. However, shelter life is not necessarily geared to the needs of children. The apparent need for group activity, in fact, suggests that children may be bored and/or isolated while at the shelter and that special activities for them may be essential.

Finally, because of the apparent need and potential severity of the child problems, it may be expeditious to coordinate services with agencies that have experienced counselors with expertise in providing case management and therapy to children as well as to their mothers exposed to DV. This would provide additional expert resources for the participants in the programs. In addition, there may be need for the coordination of other services. For example, some children needed special education services, but they were not receiving them. The evaluation process for special education may need to be streamlined for children who are either in longer term shelters and/or in transitional housing, or who have been known to experience family violence. Mental health providers need to work together with the school systems, especially the special education divisions, to provide the needed educational environment for these children. Furthermore, as Edleson (1999b) and Sullivan et al. (2000) note, there is a need for the child welfare and DV service system to work together and to coordinate functions that provide for the safety and security of all family members, but surely the most vulnerable, the children.

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Appendix

Characteristics of Random Sample of Children (One Per Family) Utilized for the Logistic Regression Analysis (*N* = 18,390)

Variable	%
Gender (*N* = 18,376)	
% Female	50.0
% Male	50.0
Race (*N* = 17,704)	
% White	57.8
% African American	29.0
% Hispanic	8.2
% Native American	0.3
% Asian	0.8
% biracial/other	4.0
Age (*N* = 18,390)	
Average age	4.76 yrs.
% 1–2 years of age	35.7
% 3–5 years of age	27.1
% 6–12 years of age	37.3
Custody (*N* = 18,309)	
% with mother	67.9
% with both mother and father	29.5
% with father	1.1
% with other guardian	1.5
% where abusers have visitation rights (*n* = 9,802)	58.5

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