Enhancing Safety-planning through Evidence-based Interventions with Preschoolers Exposed to Intimate Partner Violence

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Preschool children who witness severe intimate partner violence (IPV) are at increased risk for a wide range of emotional, behavioural, cognitive, and health problems. Although much of intervention research has focused on alleviating their psychological symptoms, we know little about efforts to provide these children with preventative safety training. The Preschool Kids’ Club Program is a 10-session intervention that addresses the psychological adjustment of children and mothers exposed to IPV. It is based on the Kids’ Club Program, which has already proved effective for school-aged children in decreasing behaviour problems and increasing safety-planning skills. The current study describes specific therapeutic strategies for teaching young children safety-planning, and uses qualitative methods to examine children’s baseline knowledge of safety-planning and whether or not knowledge of safety-planning improves following participation in the Preschool Kids’ Club Program. Results indicate preschool-aged children are able to learn adaptive safety-planning skills through intervention, but high rates of non-response indicate that much more needs to be done to reinforce safety-planning skills in young children. Clinical implications and recommendations for future research of the current findings are discussed.

Introduction

Worldwide, up to 275 million children are exposed to intimate partner violence (IPV) each year, which encompasses any incident of threatening behaviour, violence, or abuse between adults who are or have been intimate partners (UNICEF, 2005).
In the United Kingdom, at least 750,000 children each year witness IPV (Department of Health, 2002). Children exposed to IPV are at risk for a variety of serious adjustment problems, including: diagnosable emotional and behavioural problems, cognitive deficits, physical health problems, and post-traumatic stress symptoms and disorders (for example, Graham-Bermann, De Voe, Mattis, Lynch & Thomas, 2006; Graham-Bermann & Perkins, 2010; Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Lazenbatt, 2010). A recent meta-analysis reviewing 60 international studies found moderate effects in the relationship between exposure to IPV and childhood internalising and externalising symptoms and a larger effect size for the relationship between exposure to IPV and childhood trauma symptoms (Evans, Davies, & DiLillo, 2008). While most of the research on the effects of IPV has focused on detrimental outcomes for children, less is known about evidence-based interventions designed to help them. Further, even less is known about strategies for enhancing safety-planning skills in these at-risk children.

Safety-planning strategies are widely used by shelters and domestic violence hotlines, but these strategies typically focus on safety-planning with abused women and are not directly reviewed with children in the home (for example, Findlater & Kelly, 1999). Although many of these safety-planning resources encourage women to inform their children of the safety plan and to practice it, no research exists that examines whether this transfer of knowledge occurs. While some mothers may inform their children of the safety strategies, there are a number of reasons why mothers may choose not to discuss safety plans with their younger children. Mothers may believe that discussing a safety plan with a young child is developmentally inappropriate, or assume that they will be able to take care of these young children during threatening situations. Unfortunately, in severely violent homes, mothers may be incapacitated by injuries or reacting to the violence and therefore may be unable to effectively execute a safety plan or protect their children from harm. Thus, it seems critical to include safety-planning strategies in interventions with children exposed to IPV; to date, however, there is a lack of documented strategies for developing safety-planning skills in these children.

The lack of information regarding safety-planning with children exposed to IPV is particularly problematic given evidence that children are likely to be present when IPV occurs. According to the UK Department of Health, the majority of children witness the violence that occurs in the home, and in 80% of cases they are in the same or the next room (Department of Health, 2002). Research indicates that young children are at even greater risk of exposure than older children or adolescents (Finkelhor, Ormrod, Turner, & Hamby, 2005). Thus, while the cognitive and emotional development of older children provides them with better skills for avoiding and coping with potentially traumatic experiences of violence, younger children probably lack the resources to escape and manage potentially traumatic situations.

This has a number of important developmental implications for preschool-aged children. First, research has shown that preschoolers exposed to violence have suppressed cognitive abilities, scoring lower on measures of verbal ability than their same-aged peers (Graham-Bermann, Howell, Miller, Kwek & Lilly, 2010). In addition,
as preschoolers are highly egocentric, they are more likely than much older children to attribute events in their environment, such as marital conflict, as being caused by or having to do directly with their own actions (Grych & Fincham, 1990; Piaget, 1952). Therefore, after exposure to IPV, preschoolers may be more likely than older children to develop maladaptive patterns of self-blame and guilt that place them at risk for problems with depression and anxiety (Ablow, Measelle, Cowan, & Cowan, 2009; Miller, Howell & Graham-Bermann, in press). Further, exposure to IPV may critically jeopardise the development of emotion-regulation abilities in preschool children. Evidence suggests that exposure to IPV during the preschool years disrupts biological processes contributing to emotion-regulation abilities. Specifically, preschoolers exposed to IPV showed smaller increases in baseline vagal tone, a physiological measure of emotion-regulation, at age nine compared with preschoolers without exposure to IPV (Rigterink, Katz, & Hessler, 2010). Because directly witnessing violence places children at heightened risk for physical and psychological harm, it is essential to teach young children appropriate safety-planning strategies in order to minimise the negative consequences of living in a home where IPV is present.

Previous research on group intervention for families experiencing IPV has indicated that the majority of mothers and children report positive effects of intervention (Sudermann, Marshall, & Loosely, 2000). Group intervention strategies with children have the benefit of providing age-appropriate themes and activities to help address issues of secrecy, support children to feel less isolated, and strengthen peer relationships (Humphreys, Houghton, & Ellis, 2008). Group interventions for preschoolers exposed to IPV are also able to target topics such as definitions and understanding of abuse, beliefs and attitudes about violence, perceived responsibility for abuse, alternatives to violence, and help-seeking skills (Sudermann et al., 2000). While few studies to date have looked at group interventions including teaching safety-planning to children exposed to IPV, research on safety-planning with children around issues of child sexual abuse has been conducted with children as young as preschool age. For example, preschoolers participating in a behavioural-skills training programme were found to demonstrate greater knowledge and higher levels of personal-safety skills compared with children in the control group, suggesting that preschool-age children can benefit from participating in developmentally appropriate personal safety programmes (Wurtele & Owens, 1997).

The Intervention Programme

While literature exists on safety-planning with children around sexual abuse, there is currently a dearth of research on safety-planning with children exposed to IPV. In order to prevent negative physical and psychological outcomes in children who witness IPV, it is crucial that research identify strategies for improving the safety behaviour of children in the context of violence in the home. Although not exclusively focused on the issues of safety-planning, the Preschool Kids’ Club intervention (Graham-Bermann & Follett, 2001) is a 10-session group-treatment
programme aimed at helping children who have witnessed IPV by targeting the learned harmful patterns of behaviour, attitudes, and beliefs children may have developed as a result of observing violence in the home. Each session of the programme centres on different topics related to IPV, based on research studies and clinical work with children exposed to violence (Graham-Bermann & Follett, 2001).

In the first five sessions, preschoolers engage in activities designed to identify and express emotions in general, as well as feelings associated with family violence. Safety-planning is initially addressed in the fifth session of the programme (described below), and is then reviewed in following sessions. The sixth session focuses on conflict-resolution strategies and encouraging the children to develop alternatives to fighting. Safety-planning is also addressed in this session by revisiting strategies that can be used during conflict, such as locating a trusted adult. The final sessions of the programme address issues beyond fighting in the family, such as gender roles, what boys and girls can be when they grow up, and review and practice of topics covered throughout the programme, including safety-planning.

The Preschool Kids’ Club Program is an adaptation of the original Kids’ Club Program, designed for children six to 12 years old, which was found effective in a clinical trial for increasing children’s knowledge about family violence and safety-planning, improving social skills and emotion-regulation abilities, and decreasing internalising and externalising symptoms (Graham-Bermann, Lynch, Banyard, De Voe, & Halabu, 2007). The intervention is typically conducted in community settings, such as education centres or shelter outreach programmes. Both the group format of the intervention and community setting have been shown to be effective formats for intervention with preschoolers in other studies (for example, Sudermann et al., 2000).

Safety-Planning

Safety-planning is the central topic of the fifth session and the focus of the present study. While safety-planning is the primary theme of this session, it continues to be reviewed and applied in each later session in programme (Graham-Bermann & Follett, 2001). Group therapists begin by helping preschoolers to define the meaning of a general safety plan, which might be related to fire safety, safety at school, or safety when crossing the street. With puppets, children are encouraged to act out various scenarios related to the “safety” issue. Research on cognitive development indicates that preschool-aged children are better able to report general cognitive schemas (i.e. generalised information about situations, such as how to behave at a restaurant) than they are able to provide accurate detail about more specific cognitive schemas (e.g. how to behave tomorrow at the restaurant) (Hudson & Nelson, 1986). Therefore, rather than focus on safety-planning with the children individually for specific scenarios, a more general approach was used. Namely, once the basic concept of a safety plan is established, group leaders introduce safety plans for when there is fighting in the family with no reference to specific violent encounters experienced by group members. Group leaders use puppets to act out family violence in displacement, while children are given the opportunity to brainstorm a safety plan.
Such a plan might include hiding in a safe place, calling 911 if it is safe to do so, or calling a trusted family member. The children are then encouraged to act out these safety options with their puppets. Also in this session, children are familiarised with calling 911, distinguishing when to call and what is a real emergency, such as having a stomach ache versus parents fighting. Finally, during the safety-planning session, the therapists ask about safe places in the home where children might be able to hide when parents are fighting, such as in a closet or under a bed. Throughout this session, it is emphasised to children that they should not become directly involved in a fight between their parents but should instead get away from the fighting.

Research Aims and Hypotheses

Because so little research has addressed safety-planning for young children, the current study has two basic aims: to discern whether children between the ages of four and six can describe what a safety plan is prior to any intervention services; and to examine the impact of the Preschool Kids’ Club intervention programme in teaching children specific and adaptive safety-planning strategies.

The first aim is addressed using children’s qualitative reports of safety-planning at baseline, prior to intervention. This descriptive analysis of children’s knowledge provides a springboard for further discussion of the specific needs of children experiencing IPV. As a part of this first aim, the study assesses the following questions:

- Are children able to describe a safety plan?
- Are children’s baseline ideas of safety plans generally adaptive or maladaptive ways of reacting in the context of family violence?

The second aim is to explore changes in children’s knowledge of safety-planning skills following intervention. We hypothesise that:

- More children in the intervention programme will identify adaptive safety-planning strategies post intervention than will children who do not participate in the intervention programme.
- Fewer children who participate in the intervention programme will identify maladaptive safety-planning than will children who do not participate in the intervention programme.

Method

Participants

Participants were part of a larger randomised control trial of the effectiveness of mother and child group interventions for families exposed to IPV (Graham-Bermann 2006–2011). The sample consisted of 110 preschool-age children (55 boys) from southeast Michigan who were exposed to IPV within the past two years. Children in
the experimental and control groups had similar levels of violence exposure, with an average of 173 acts of violence or direct threats towards the mother in the past year (standard deviation [SD] = 131.85). On average, mothers reported acts of psychological aggression (e.g. “My partner called me fat or ugly”) 89 times (SD = 52.70), physical violence 48 times (SD = 55.39), and sexual violence 23 times in the past year (SD = 36.14). Children ranged in age from four to six years (mean = 4.93, SD = 0.87). The sample was ethnically diverse, with mothers identifying 40% of the children as European-American, 36% as African-American, 17% as Biracial, 5% as Hispanic, and 1% as Native American. The sample had diverse socio-economic backgrounds, although considerably more families were low-income (monthly income mean = US$1,412, SD = US$1,596). While previous involvement in interventions was not evaluated, one-half of the families in the sample completed at least an intake at a local shelter at some point in their life. As a part of this intake, shelter staff discussed safety-planning with the mothers, but did not engage in any safety-planning with the children. Experimental families attended an average of 5.7 sessions (SD = 3.2).

Procedures

Prior to interviewing families, the current study obtained approval by the university Institutional Review Board, an organisation that ensures adherence to current research ethics and makes provisions for the protection of research participants. As a part of these protections, participants were given a full description of their involvement in the programme, its potential effects, and emergency contact information for the principal investigators and the university Institutional Review Board. In addition, all families requesting assistance were given appropriate referrals for psychological, legal, and shelter services. Families were recruited using flyers distributed to low-income housing units, stores, churches, domestic violence shelters, and local mental health agencies with a toll-free number for the programme offices. Mothers completed a brief telephone screen to determine study eligibility; namely, having experienced IPV within the past two years and having a child between the ages of four and six. Qualifying families who indicated an interest in participation were scheduled for a baseline interview, which lasted approximately one and a half hours for mothers and 30–45 minutes for children. Interviewers were trained in research ethics and clinical interviewing with at-risk populations. Mothers were compensated $25 for each interview and their child received a gift worth approximately $4 for their time. Precautions were taken to assure the comfort and safety of those who participated in this study, such as ensuring that the interview took place at a safe and private location.

Families were assigned to either the experimental or control group using a modified random assignment procedure whereby the first five families were assigned to the experimental condition and the next five to the wait-list control condition, and so on. Both experimental and control groups completed the baseline interview approximately one week prior to the start of the Preschool Kids’ Club intervention.
The experimental families then participated in the five-week intervention while the control families received treatment as usual. Treatment as usual was defined as community resources and support sought out by the mother or provided by the local domestic violence shelter (e.g. contact information for legal services). These resources were available to both experimental and control families. Within one week of finishing the Preschool Kids’ Club Program, both experimental and control groups completed the post-intervention interview, which involved the exact same procedures as the baseline interview. At that time, the control families were also given the opportunity to participate in the intervention programme.

Measures

Demographics

Demographic information including child age, ethnicity and gender was ascertained from a brief demographic questionnaire completed by the mother.

Number of sessions

The Preschool Kids’ Club intervention programme consists of 10 sessions, with two sessions held each week. Group therapists for the intervention programme kept attendance records for each family.

Safety-planning

During both the baseline and post-intervention interviews, children were asked two questions to assess their knowledge of safety-planning: “What is a safety plan?” and “What can a kid do when there is fighting in the family?” The study opted to use this type of measure over other standardised measures available (for example, Sudermann et al., 2000) because one of the goals of the intervention was to teach safety-planning skills in such a way that they could be spontaneously recalled, rather than recognised. Therefore, asking open-ended questions about safety-planning more clearly fit the aims of the current project. Children’s responses were recorded verbatim and entered into a Microsoft Word document. Because children frequently only responded to one of these two questions, children’s responses were analysed conjointly to reflect their overall knowledge of safety-planning both generally and in regard to family violence.

Intimate partner violence

The level of violence at baseline was reported by the mother using the Conflict Tactics Scale – Revised (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The CTS2 is a 78-item instrument measuring the severity and frequency of Psychological Aggression, Physical Assault, Injury, Sexual Coercion, and Negotiation over the past year in an intimate relationship. Because only the mothers participated in the study, a
total of 39 maternal questions were administered. For each item, mothers were asked to estimate the frequency with which their partner used different violence tactics toward them within the past year. The reliability for the CTS2 Total Scale in the present study was $\alpha = 0.81$.

Qualitative Data Analysis and Rationale

The child safety-planning data were analysed qualitatively with three coders who individually read through all responses and noted emerging themes. The coders then met to compare their identified themes. There was high agreement on the identified themes and all disagreements were discussed until consensus was achieved. From this thematic analysis, specific subcategories of responses were developed such that subcategories were mutually exclusive (with each response fitting into only one of the identified categories). A total of 10 subcategories emerged: no answer (including no response or “I don’t know”), helpless (e.g. “I can’t do anything”), direct involvement in the fight (including responses indicating verbal or physical involvement), active help-seeking (including calling the police or a family member), leaving (including distraction behaviours or ignoring the situation), hiding (e.g. “I can hide in my closet”), dysregulation (including aggressive responses or yelling/crying behaviour), unusual (including off-topic or fantastical coping responses, “no one will touch you because they’re afraid of monsters”), non-IPV safety responses (e.g. “stop, drop, and roll” or “only swim when there is a lifeguard”), and vague references to safety (e.g. “be safe”). Following the creation of these coding categories, research assistants were trained on the coding system and independently coded the children’s responses. Inter-rater reliability amongst the three coders was 89%.

Following initial coding, children’s responses were grouped into adaptive and maladaptive categories based on relevant research and on the goals of the programme. One goal of the Preschool Kids’ Club programme is to help children develop safety skills and a sense of empowerment in the face of IPV. Children’s direct involvement in parents’ conflicts places children at risk for victimisation, and research has found that children’s dysregulated and aggressive behaviour also relates to increased risk of injury (Jokela, Power, & Kivimaki, 2009). Unlike direct involvement and dysregulated behaviour, a helpless response to IPV is not likely to place a child in immediate danger of injury. According to learned helplessness theory, experiencing uncontrollable events (such as IPV) can lead to beliefs that nothing one does can change future events; these negative beliefs then lead to motivational, cognitive, and emotional deficits (Maier & Seligman, 1976). Further, research suggests that preschoolers who display helpless responses to challenges are more likely to experience depressive symptoms and negative self-worth in middle childhood (Kistner, Ziegert, Castro, & Robertson, 2001). For these reasons, the specific content categories of direct involvement, dysregulated behaviour, and helplessness were coded as maladaptive safety-planning strategies.

The Preschool Kids’ Club intervention programme aims to teach children safety-planning strategies that will help remove them from the violence (hiding, leaving) as
well as strategies that will end the violence without their direct involvement in the
violent incident (active help-seeking). These goals are based on research suggesting
that young children are likely to be present when violence occurs (Finkelhor et al.,
2005) and that witnessing this violence has negative psychological effects (Graham-
Bermann et al., 2006). Thus, the specific content categories of hiding, leaving, and
active help-seeking were coded as *adaptive* safety-planning strategies.

**Results**

There were 110 children interviewed at baseline (65 control and 45 experimental) and
90 children completed the post-intervention interview (50 control and 40 experi-
mental). Safety-planning response codes and examples are presented in Table 1.

**Responses to Safety-Planning Question at Baseline**

Response rates for each type of safety response are presented in Table 2. Children
frequently reported more than one type of strategy; therefore, the percentages
reported in Table 2 are not cumulative. At baseline, the majority of children reported
that they did not know what a safety plan was. For those children who did report
knowledge of a safety plan at baseline, there were a number of different safety-
planning strategies ranging in utility and content. Of the maladaptive strategies,
children most frequently reported they would become directly involved when their
parents fought. For example, one child reported: “Make them [the parents] stop. Hit
them”. Other children reported more adaptive strategies, but violent content
commonly remained a part of their response. For example, one child reported: “If
you hide, nobody will find you – nobody can shoot you”.

At the baseline interview, only 27 children (25% of the overall sample) were able to
identify an adaptive safety plan for family violence, 18 children in the control group
and nine children in the experimental group. For example, one child responded that a

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Safety-planning Coding Schema: Sample Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response category</td>
<td>Sample response</td>
</tr>
<tr>
<td>No response</td>
<td>“I don’t know”</td>
</tr>
<tr>
<td>Maladaptive responses</td>
<td></td>
</tr>
<tr>
<td>Helpless</td>
<td>“I can’t do anything”</td>
</tr>
<tr>
<td>Direct involvement</td>
<td>“I try to break it up”</td>
</tr>
<tr>
<td>Dysregulated</td>
<td>“A kid can scream into the air”</td>
</tr>
<tr>
<td>Adaptive responses</td>
<td></td>
</tr>
<tr>
<td>Active help-seeking</td>
<td>“Go to your neighbor’s house and ask for help”</td>
</tr>
<tr>
<td>Leaving</td>
<td>“A kid can ride bikes around the block until the parents stop fighting”</td>
</tr>
<tr>
<td>Hiding</td>
<td>“I hide in my room and cuddle with stuffed animals”</td>
</tr>
<tr>
<td>Other responses</td>
<td></td>
</tr>
<tr>
<td>Off topic</td>
<td>“I like cookies”</td>
</tr>
<tr>
<td>Other safety</td>
<td>“Stop, drop, and roll”</td>
</tr>
<tr>
<td>Vague</td>
<td>“A plan so that kids can be safe when there is fighting”</td>
</tr>
</tbody>
</table>
A safety plan was to “go in room and close door, and go to Auntie’s house until parents stop fighting and throwing stuff”. Twenty-six children (24% of the overall sample) identified a maladaptive safety-planning strategy, 14 children in the control group and 12 children in the experimental group. For example, one child responded that children should “break them [the parents] up when there is fighting in the family”.

### Changes in Safety-planning Strategies from Baseline to Post Intervention

Notably, non-response was quite high, even for those children participating in the intervention. Because of this, the number of participants in each response category was small, and changes in safety-planning from baseline to post intervention were therefore examined from a qualitative perspective. The examination of specific content categories for children’s responses to safety-planning revealed that 10 children (26% of the group) from the intervention group reported active-help seeking strategies post intervention, compared with just two children at baseline (4% of the group). Alternatively, three children from the control condition reported active help-seeking strategies at baseline, with no additional active help-seeking strategies at post-intervention follow-up. For example, at baseline one child in the intervention group indicated that she would become directly involved in the fight to try and stop it. After intervention, she reported that when there was fighting in the family “a kid can hide”. More children in the experimental group learned an adaptive safety plan (n = 5) while only one additional child in the control group learned an adaptive safety plan between baseline and follow-up interviews. Similarly, there was no decrease in maladaptive safety-planning for the control group, but five fewer children

### Table 2 Children’s Safety Plans

<table>
<thead>
<tr>
<th>Response category</th>
<th>Baseline interview</th>
<th>Follow-up interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control (n = 65)</td>
<td>Experimental (n = 45)</td>
</tr>
<tr>
<td>No response</td>
<td>46 (70.8%)</td>
<td>25 (55.6%)</td>
</tr>
<tr>
<td>Maladaptive responses</td>
<td>14 (21.5%)</td>
<td>12 (26.6%)</td>
</tr>
<tr>
<td>Helpless</td>
<td>4 (6.2%)</td>
<td>4 (8.9%)</td>
</tr>
<tr>
<td>Direct involvement</td>
<td>11 (16.9%)</td>
<td>7 (15.6%)</td>
</tr>
<tr>
<td>Dysregulated</td>
<td>0 (0.0%)</td>
<td>1 (2.2%)</td>
</tr>
<tr>
<td>Adaptive responses</td>
<td>18 (27.6%)</td>
<td>9 (20.0%)</td>
</tr>
<tr>
<td>Active help-seeking</td>
<td>3 (4.6%)</td>
<td>2 (4.4%)</td>
</tr>
<tr>
<td>Leaving</td>
<td>11 (16.9%)</td>
<td>5 (11.1%)</td>
</tr>
<tr>
<td>Hiding</td>
<td>4 (6.2%)</td>
<td>2 (4.4%)</td>
</tr>
<tr>
<td>Other responses</td>
<td>26 (40.0%)</td>
<td>12 (26.6%)</td>
</tr>
<tr>
<td>Off topic</td>
<td>8 (12.3%)</td>
<td>1 (2.2%)</td>
</tr>
<tr>
<td>Other safety</td>
<td>9 (13.8%)</td>
<td>2 (4.4%)</td>
</tr>
<tr>
<td>Vague</td>
<td>9 (13.8%)</td>
<td>9 (20.0%)</td>
</tr>
</tbody>
</table>
in the experimental group reported maladaptive strategies at follow-up than the original number at baseline (see Table 2).

**Discussion**

The first aim of the current study was to assess baseline knowledge about safety-planning in preschoolers exposed to IPV. Findings suggest that prior to intervention the majority of preschool-aged children neither know what a safety plan is nor know safe strategies to use when IPV occurs. Given that children in this age range are likely to be present when such violence takes place (Finkelhor et al., 2005), it is concerning that such a large percentage of children may lack the necessary skills to keep themselves safe. There are a number of reasons that it is important for children to have adaptive safety-planning strategies for violent situations. First, there is a significant overlap between IPV and child abuse (Jouriles et al., 2008). Thus, children need to escape violent situations in order to minimise risk of victimisation. Second, witnessing violence - even without direct victimisation - is associated with a number of detrimental consequences for children including post-traumatic stress disorder, behavioural problems, anxiety, depression, and cognitive deficits (for example, Graham-Bermann, De Voe, Mattis, Lynch & Thomas, 2006; Graham-Bermann, et al., 2010; Graham-Bermann & Perkins, 2010; Grych et al., 2000).

Of greater concern are the 26 children who reported maladaptive safety-planning strategies at baseline. Particularly troubling is the finding that 18 of the children indicated strategies of direct involvement (e.g. “I would break them up”) at baseline, which physically places these children at risk for direct victimisation by the violent parent. Helpless responses to family violence, although putting children at lower immediate risk of injury than direct involvement, are also problematic as these strategies are linked to future internalising problems as well as future risk for multiple violence victimisation (Nolen-Hoeksema, Girus, & Seligman, 1986; Peterson & Seligman, 1983). Safety-planning seems essential to protect the physical and emotional health of young children. Given the current findings, it is clear that preschool-aged children need a great deal more training in safety-planning than is currently provided naturally in their environments.

The second aim of the current study was to explore the impact of an evidence-based intervention programme on children’s safety-planning skills. The children in the intervention group did retain some information about safety-planning skills, and eight more children reported active-help seeking strategies at post-intervention follow-up than at baseline. While this change is arguably a small one, these children represented 26% of the intervention sample group at follow-up. In contrast, only 4% of the intervention group was able to report active help-seeking strategies at baseline. In addition, the intervention group showed a reduction in the use of maladaptive responses to IPV while the control group showed no such reduction. These qualitative findings indicate that many preschool-aged children are capable of learning and remembering information about safety-planning. In addition, these findings suggest that, without intervention, preschoolers may not be aware of ways to
get help from other adults (e.g. policemen, neighbours, other family members) during incidents of family violence. Since children in this developmental period continue to rely on adults for cues on emotion-regulation and problem-solving (for example, Berlin & Cassidy, 2003), preschoolers may greatly benefit from involvement of adults via active help-seeking.

These findings, however, must be considered in light of the large number of children who still were not able to name any kind of safety plan at post-intervention follow-up. As the majority of children in both groups failed to provide safety responses post intervention, these findings also suggest that more can be done to facilitate children’s learning. It may be that active help-seeking was the best retained strategy because this was the only strategy that was specifically role-played in the treatment groups. Role-playing may be a particularly effective strategy for skill-building with preschool-aged children for two reasons. First, research on preschool populations has reinforced the success of role-playing as an effective mechanism for skill-building in other areas (e.g. social skills; Goldstein & Cisar, 1992). More importantly, in a study examining safety-planning with preschoolers surrounding sexual abuse prevention, the majority of parents felt most comfortable with role-playing as a teaching mechanism (Wilson & Golub, 1993). Building active strategies for safety-planning may also reduce the likelihood that children will engage in maladaptive responses to IPV exposures (e.g. direct involvement, learned helplessness).

Clinical Implications

Given the current findings, a variety of implications for clinical practice, communities, and families are evident. As preschoolers appear to generally lack an understanding of safety-planning even following intervention, it is crucial that efforts be made across environments to improve children’s knowledge of and comfort with safety skills. Research findings suggest that children have the most information when it is presented multiple times (Petros & Hoving, 1980). Thus, in clinical practice, developing safety plan strategies should be the central point of one particular group session, but also practiced in subsequent sessions to produce maximum benefit.

Information on safety plans should also be presented using developmentally appropriate strategies that foster a sense of mastery in each child. The literature on interventions for preschool-aged children recommends that information be offered in an active, dynamic manner through the use of games, movement, or visual materials (Kozlowska & Hanny, 2001; Tutty & Wagar, 1994). Finally, it is critical that clinicians make safety-planning an explicit component of the mothers’ parenting groups. Evidence suggests that involving both mothers and children in intervention services will enhance treatment effects (Graham-Bermann et al., 2007). Research on safety-planning with children around sexual abuse also suggests that treatment success improves when parents are involved and when parents provide the instruction compared with teachers (Boyle & Lutzker, 2005; Deblinger, Stauffer, & Steer, 2001).
Repeatedly presenting information on safety-planning in a dynamic and engaging way, while incorporating both mothers and children into safety plan development, may serve to increase preschoolers’ knowledge of and comfort with safety skills; however, future research is necessary to substantiate this hypothesis.

Further work should also be done at the community level to help children exposed to IPV develop safety-planning skills. All preschoolers, not just those exposed to IPV, would probably benefit from having a safety plan for what to do if they are in a violent situation (e.g. neighbourhood violence, peer violence); preschools, libraries, and community centres are likely to be good venues for classes focused on developing plans for how children can stay safe when they are in violent situations. Research into school-based programmes may help inform larger, community-wide public health initiatives for preschool children. School-based services reach a broad base of young people without stigmatising those at increased risk of violence, and may increase the possibility of reaching parents with the message of violence prevention (Ellis, 2004). Such an approach could be implemented with preschool children by offering more comprehensive services in daycare settings or community centres.

**Limitations**

While this study adds to the literature by describing preschool-aged children’s safety-planning strategies and identifying a critical need for safety-planning in preschoolers exposed to IPV, the study has a number of limitations. First, the majority of preschoolers did not respond to the safety questions. The lack of responses could reflect preschoolers’ difficulty in verbally expressing strategies for safety-planning. Previous research has indicated that preschoolers exposed to IPV have lower verbal ability than their non-exposed same-age peers, which may make verbal descriptions of safety-planning more challenging (Graham-Bermann et al., 2010). Future studies should attempt to understand the role of verbal ability in reports from preschoolers’ about safety-planning strategies. Additionally, fewer families participated in the post-intervention interviews than the baseline interviews.

An additional limitation is that the current study addressed children’s reports of possible safety strategies and did not assess whether or not children actually use these strategies when faced with IPV. Even if children are able to report a safety skill under calm conditions, they may not remember or be able to use the safety skill when emotionally aroused in a stressful moment. Future studies should investigate preschoolers’ abilities to use safety skills during moments of distress (e.g. with a laboratory-based stress task). However, caution should be used and methodology should be thoughtfully developed so as to not further traumatise children with histories of exposure to IPV and other potentially traumatic events.

Finally, while the current study organised preschoolers’ safety strategies into adaptive and maladaptive categories based on programme goals for safety and clinical literature, it is possible that strategies identified here as maladaptive could function adaptively in real-life situations, either for an individual child or in general. For example, given findings linking helpless responding to later maladaptive outcomes
(for example, Kistner et al., 2001), helpless responses were placed in the maladaptive category. However, it is possible that “doing nothing” in response to family violence may be adaptive, at least in the moment. Different safety strategies may also be more or less adaptive depending on the severity and pattern of the violence (e.g., violence meant to control versus violence erupting from frustration), family characteristics (e.g., number or ages of family members), or the developmental age of the child (e.g., emotional and cognitive skills of a five-year-old versus those of a 10-year-old). In addition, behaviours labelled as adaptive for the current study could potentially have unintended negative consequences for children (e.g., calling 911 during a violent episode, but then becoming a target of the abuser’s anger). Future research is necessary to better understand the function of safety behaviours in children in order to clarify which behaviours are generally maladaptive in real-life situations for children of different ages.

**Future Directions**

Future studies might work to identify ways to engage both mothers and children in developing safety strategies in order to maximise the intervention benefits for the family. It may also be useful to include other important family members, such as siblings or grandparents, in preschoolers’ safety-planning in order to provide more reinforcement of the safety plan in the child’s home environment. Research might also identify the most developmentally appropriate techniques for skill-building in the preschool population. Group leaders may also require more specialised training around safety-planning in children, and research could identify ideal length of specialised training as well as the necessary content for these trainings. Further, as children will need to remember and use safety strategies during moments of distress, research could also assess and compare which therapeutic strategies best improve recall and retention of safety strategies in preschoolers under stressful conditions.

**References**


