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ABSTRACT

The theme of the conference session reported in this booklet was the impact of community violence on infants, toddlers, their parents, and practitioners in education. The booklet contains the edited transcript of the session, which included presentations by three speakers. Clementine Barfield described the impact of urban violence on her family and on the children with whom she works in Detroit, Michigan. The loss of her son through violence led her to found the organization Save Our Sons And Daughters (SOSAD), a project that engages in crisis intervention and violence prevention and provides support groups for those who are affected by violence. Elizabeth M. Simpson, a social worker, discussed the work of the PALS program, which was devised by the school district of East Oakland, California. This program delivers therapy, counseling, and tutoring services in two elementary schools. Some of the symptoms caused by a violent event were reviewed. Betsy McAlister Groves, also a social worker, reviewed work that she and her colleagues at Boston (Massachusetts) City Hospital have been doing concerning young children's exposure to violence. The insights and reflections of these speakers suggest that there is much that can be done to address the impact of violence. (SLD)

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Can they hope to feel safe again?

The impact of community violence on infants, toddlers, their parents and practitioners

A report from the final plenary session
Seventh Biennial National Training Institute
ZERO TO THREE/National Center for Clinical Infant Programs

December 8, 1991
Washington, D.C.

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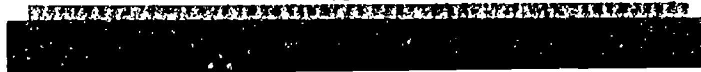

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Introduction

The December 7, 1991, edition of *The Washington Post* included a news story with the headline, "In D.C. Neighborhood, Two Killings in a Half Hour." As violence throughout the United States continues to rise, such headlines are all too common. Yet this paragraph from the middle of the news article still startles:

> (A) police officer angrily ordered a woman to remove a boy, no older than 4, who stood and watched as the dead man's bloody torso was examined in full view of the crowd. "That's what you gotta do," replied the grandmother, who said she was trying to teach the boy a lesson. "Show them real life. Don't honeycoat it."

"Real life," for millions of children, young people, and families in this country is anything but honeycoated. As the only national organization concerned solely with children and families in the earliest years of life, **ZERO TO THREE**/National Center for Clinical Infant Programs (NCCIP) has been aware since its founding in 1977 that poverty, racism, and other community and social ills constrict children's life chances even before their birth. What we are learning now is the specific impact of violence in the community on the development of infants, toddlers, and their parents.

Awareness of the dimensions of violence among youth and young adults is critical to our understanding of the impact of violence on very young children and their parents. Both the victims and perpetrators of violence may in fact be the parents of very young children; death or incarceration robs infants and toddlers of their care. And the bleak prospects for even physical survival—let alone opportunities for success in work and family life—that face, particularly, African-American and Hispanic young people rob all children and families in their communities of hope.

- Homicide is the leading cause of death among both male and female African-Americans aged 15 to 34 years (Uniform Crime Statistics, 1992).
- Homicide rates among young Hispanic males and Native American males are 4 to 5 times higher than non-Hispanic white male rates (GAO, 1992).

- The period 1989–90 has seen an 11 percent increase in murder, rape, robbery, and aggravated assault. The increase in violence by females has been greater than the increase in violence by males (Uniform Crime Statistics, 1992).

- Youths aged 16 to 19 have the highest rates of victimization for rape, robbery, and assault, and most are victims of their own age group (GAO, 1992).

- Access to guns increases the lethality of violence. In 1990, the Centers for Disease Control found that from 1984 through 1987, firearms-related homicides accounted for 80 percent of the deaths and 96 percent of the increase in the homicide rate for young African-American men aged 15 to 24 (GAO, 1992).

Research and community-based or clinical intervention will not alone solve the enormous social and public policy problems that underlie these statistics. However, research is beginning to learn more about children's exposure to community violence, so that this knowledge can be used as a basis for developing prevention and treatment programs. Most current research efforts examine the impact of community violence on children of school-age or older, not on infants and toddlers. John Richters and Pedro Martinez of the National Institute of Mental Health sought to describe the extent to which young children living in a moderately violent inner-city neighborhood had been exposed, both directly (as victims) and indirectly (as witnesses) to various forms of violence, and the correlates of these exposure patterns on the children's social and emotional functioning. Joy Osofsky, Sarah Wewers, Della M. Hann, and Ana C. Fick at Louisiana State University Medical Center conducted a similar survey in New Orleans. There were 165 children, aged 6 to 10 years, in the Washington, D.C., sample and 53 fifth-grade children in the New Orleans sample. Overall, children's exposure to violence in the two communities was similar (Richters & Martinez, *in press;* Osofsky, Wewers, Hann, & Fick, *in press*).

- Over half of the New Orleans fifth-graders had been victims of some type of violence; six percent had been victims of severe violence.

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- Over 90 percent of the children had witnessed some type of violence. Thirty-seven percent had witnessed severe violence. Almost 40 percent had seen dead bodies.
- Over 70 percent of the children had witnessed weapons being used.

Both studies revealed a high reported incidence of Post Traumatic Stress Disorder. Thirty to 40 percent of the New Orleans children and 15 to 20 percent of the Washington, D.C. children, said they worried about being safe. Children feel "jumpy" and "scared" in similar proportions. As could be expected, mothers were very concerned about their children and the kinds of environments in which they had to live. How the researchers in Washington and New Orleans are addressing the question, "What can we do?" is described in the final section of this booklet.

Neither national statistics on violence nor the findings of the Washington, D.C. and New Orleans surveys address specifically the impact of community violence on children from birth to three and their families. But since its founding in 1977, **ZERO TO THREE/** NCCIP has been as interested in identifying critical *questions* about early development as it has been in reporting promising *answers*. And everything we have learned about child and family development in the past several decades tells us that what we see in the behavior and emotional adaptation of elementary school children and adolescents can be traced in large part to experiences in the earliest months and years of life. Consequently, **ZERO TO THREE/** NCCIP Board members and staff who planned our Seventh Biennial National Training Institute felt that it was extremely important to include a session on community violence in the 1991 program. When we looked for speakers knowledgeable about the impact of community violence on children, we found that front-line professionals and advocates had a wealth of careful observations of very young children, their parents and other family members, and community practitioners, living and working in violent environments. These professionals and community advocates have developed powerful strategies to help young children and their caregivers repair the effects of violence on the development of both children and adults, and to learn conflict-resolution skills to prevent violence.

This booklet contains the edited transcript of the final plenary session of **ZERO TO THREE**/National Center for Clinical Infant Programs' Seventh Biennial National Training Institute, which took place December 6–8, 1991, in Washington, D.C. The theme of the Institute as a whole was "In This Together: Researchers, Practitioners, Parents and Policymakers Joining in Support of Infants, Toddlers, and Their Families." The final session, chaired by Robert Emde, was entitled "The Impact of Community Violence on Infants, Toddlers, Their Parents and Practitioners."

This booklet contains the edited presentations of:

Clementine Barfield, Founder and Executive Director of Save Our Sons And Daughters (SOSAD), Detroit, Michigan;

Elizabeth Simpson, Project Director, Prevention and Life Skills (PALS) Program, East Bay Activity Center, Oakland, California; and

Betsy McAlister Groves, Division of Developmental and Behavioral Pediatrics, Boston City Hospital, Boston, Massachusetts.

Material from the presentation by **Joy Osofsky,** Professor of Pediatrics and Psychiatry, Louisiana State University Medical Center, New Orleans, is included in this introduction and in the final section of this booklet.

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Clementine Barfield

I work specifically with survivors of homicide. *I* am a survivor of homicide. In July, 1986, my two sons were shot. My 15-year-old son was critically injured; my 16-year-old son was killed. The year that my children were shot, a total of 365 children in Detroit were wounded. Forty-three of those children died. One, of course, was mine.

I was compelled to *do* something. I had heard and read that children were being shot, but for whatever reason, the violence had all seemed a long way away. It didn't connect to me. Things like that didn't happen to people like us—only to the "bad" kids. Well, homicide did happen to us.

It started with a simple incident, with one of my sons talking to a girl in school. Her boyfriend felt that he was "disrespected." My sons were shot, down the street from school.

As I sat in the courtroom with the boy who killed my son and heard, as part of his defense, that he had accidentally shot and killed his little brother when he was smaller, I was not surprised that he was able to pick up a gun and shoot and kill someone else. There had obviously been no intervention for him. I was not surprised at the sentence he received—three-and-a-half years in prison for careless and reckless use of a firearm, a misdemeanor.

And I was not surprised that when this boy was released from prison, he became a professional "hit man." One of his cousins was killed in a professional "hit," and he himself was injured. Now he is back in jail.

When I was called to the hospital and told that two of my children had been shot, the nightmare began for me. But I went to the hospital hoping still that perhaps my sons had been shot in the hand or arm, had received wounds that would heal. I was told immediately that one of my children would not heal.

As I sat with my 16-year-old son, 6 feet 5 inches tall, I remembered that just that morning, as he was getting dressed for school he had said, "You know I look so good, I make this whole family look good." I had agreed with him. And as he lay there, everything about him looked the same—except that he had a hole in the center of his head and a patch behind his ear where a nine-millimeter

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bullet had exploded in the back of his head. He had been shot in the chest as well.

My youngest son, who was also shot, still has a nine-millimeter bullet in the back of his neck. He has had a series of flashbacks over the past five years. He watched his brother die. His best friend has been killed. He is 20 years old, and *all* the boys that he grew up with are either dead or in jail. He is a very decent young man, and not an unusual case.

I was talking to a 19-year-old a few weeks ago who had lost 16 friends between ninth grade and twelfth grade; two of those victims of homicide were his brothers. Two years ago, my daughter was baking a cake for me, and a friend of hers stopped by and asked her to bake one for him too. He called her at nine o'clock to say that he and his brother were on their way to pick up the cake. At nine-thirty, they were both dead.

As I talk to young people in public and parochial high schools in Detroit, I find that 100 percent of those children have friends or family members or neighbors who have been killed. *One hundred percent.* Many of them have lost four, five, ten friends and family members to homicide. As we work in elementary schools, we learn that 85 percent of the children in elementary school have had friends, family members, and neighbors killed. Many of these children have witnessed homicide.

National statistics don't capture the level of homicide in communities like Detroit or Washington, D.C. Many of our children simply do not make it out of the neighborhood.

Twelve million children in America are living in poverty. I heard a speaker at an earlier session of this conference say, "There is a future for our children (with disabilities)." I just want to say that most children living in poverty today do not have a future. They *know* they do not have a future.

> Children in elementary school will tell you that they don't have a future. One of our social workers asked her all-A-student grandson if he had decided what he wanted to do when he grew up, and he answered, "Grandma, why should I? I might not grow up."
>
> My youngest son doesn't call anyone he goes to school with a "friend." They're just "kids that he knows." He's afraid

> of being shot again—it's happening every day; he's witnessed homicide. When a schoolmate "pretended" to be following and threatening him, my son told me that if he had had a gun he would have shot the youngster because he was afraid.

This is what our children have become. This is the way they think. There really is no sense of security, no sense of safety for our children.

A child in one of our support groups was two years old when her father was killed. He was 19 years old, married to an 18-year-old; they had two children. I can imagine that this little girl was a happy baby. I am sure that she was happy on the day she drove with her father to her grandmother's house. But as the car pulled into the grandmother's driveway, it was sprayed with bullets. Her father was shot numerous times, but managed to push the little girl to the floor before the car crashed into a telephone pole. Both father and daughter had to be cut out of the car. This little girl is afraid to ride in a car. She has begun to wet the bed again. She has night terrors—she can't explain or articulate to anybody what she is seeing or fearing, as an older child might. She is scared to death. Her family has changed. Her father is gone. Her grandmother is not happy. As a two-year-old, she might think that this is all her fault. She knows that things are not happy as they used to be, and this affects her. She is a "terror" in the group—it is almost impossible to help her keep still. She is acting out her sense of loss. She can't talk about it; she doesn't know how to explain it; so she acts it out.

In Saginaw, Michigan, a woman told me the story of her three-year-old son, in day care. This woman and her husband were professionals; they had waited to start their family. They thought that they were offering their child everything, including security—protecting him, so that he would have advantages in life many other children don't have. They picked the child up from day care one day and found that he was crying because his friend's father had been killed. His friend cries all the time. Now their son cries all the time—he thinks his father will be killed, too. It is difficult to reassure children that "nothing is going to happen," that "I'm going to be all right; you're going to be all right," when they see all around them that everything is *not* all right.

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Parents are trying to keep their children safe. I know of parents who send very young children across town, or out of town, for safety. Parents who put their children in hiding because they are afraid for them. Parents are afraid for their children to walk back and forth to school: someone may try to lure them into selling drugs; they may have to walk over a dead body. This is a reality in poor communities.

I began Save Our Sons And Daughters (SOSAD) mainly to help me get through my grief—to validate the worth of my son. His life had a purpose and a meaning, and he had a chance to make it out of the community that most don't have. SOSAD is a way of validating the worth of all the children who are left.

We don't talk a whole lot about hope, but hope is what we have to instill in our young people. Our legacy from our parents was: "You *can* do better than I have done, and you *can* have a better future." Children today *do not* believe that they can have a better future. So we have to try to help empower people to believe, first of all, that they *can* have a future. Then we must work toward the preservation of that future.

At SOSAD, we do crisis intervention and violence prevention. We have separate support groups for families, for small children, and for men, because everybody in the family grieves differently, responds to violence and trauma differently. We have peer support groups for high-school-age students, where they can just sit down and rap about what they are going through. Through our Survival Institutes, we go into the schools and teach youngsters how to deal with their anger and their frustration, how to cope with trauma, and grief, and loss. How to go on with the rest of their lives. Survival Institutes are important for adolescents but especially for young children—they too have anger, they have feelings of frustration, they need to be taught peaceful ways of play. We can see conflict in the pushing and shoving of children's play; we have got to teach children alternatives to violence.

In my own family, one out of three black men has been killed, one critically wounded. None of them will ever be the person he started out to be.

If our communities are violent, and our children are a product of our communities, then we are raising violent children.

Our children adjust. No matter how bad things are, they adjust to them. But we might not like what a lot of our children become, after they have "adjusted."

Don't cross the street when you see an African-American male coming. Don't make a judgment when you hear that one African-American male has killed another. Don't ever assume that you are not, in some way, responsible.

We are all in some way responsible for what is happening to our children. We are all in some way responsible for the fact that so many of our children do not have an opportunity even to have a childhood. We are all responsible for the fact that a level of violence has become "acceptable" in our communities. We have got to empower our communities not to be so accepting of violence, of gunshots, of trauma.

There are things we can do as individuals and as communities to take a stand against the way things are and to work toward change. Teaching children to deal with their emotions, teaching them to resolve conflicts peacefully, are some of the things we can do. Since mar of you work in the community, I hope that you will help organize against the way things are, so that we can make changes.

Elizabeth M. Simpson, M.S.W.

East Oakland is not unique as an inner-city community. It is characterized by high unemployment and insufficient job training programs; by high numbers of incarcerated men and too few drug treatment programs (hardly any of which accept mothers with their children). There are too few options, period.

People in East Oakland face basic survival issues. The absence of jobs and the presence of drugs are this community's organizing principles—points of reference for every single person, whether he or she "uses" or not. In the face of these overwhelming forces, a strong extended family network offers the backbone of support for people.

Awareness that the life circumstances of children in East Oakland included drugs, poverty, domestic violence, and a pervasive lack of resources prompted the school district to devise the **Comprehensive Health and Safety Plan.** The **PALS Program,** currently in its second year of operation, is part of this comprehensive intervention with the city's youth. It was established through a school district contract with East Bay Activity Center, a private, non-profit agency that has provided day treatment for young children for 50 years; state funding (Drug, Alcohol and Tobacco Prevention money) has been guaranteed for three years.

The two elementary schools PALS delivers services are located in the square mile of East Oakland where, in 1990, the city's greatest number of homicides and shootings occurred. Each school has 1,000 students, with 35 children to a classroom. The PALS Program operates with a staff of the equivalent of two-and-one-half full-time clinical social workers, one part-time psychologist, and three high school students who work part-time as peer counselors and tutors. The services offered are:

- individual therapy;
- parent conferences or therapy;
- family therapy;
- group work with children;
- tutoring;
- case management services; and

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- consultation to teachers and school district administrators about the mental health needs of children.

As a prevention effort, we are beginning to offer an in-class life skills curriculum for children five to seven years old (grades K—2), reaching some 450 children. The curriculum addresses issues of violence, aggression, and safety in children's lives, including as topics domestic violence, community violence, aggression at school, child abuse, and general safety.

School-based services promote timely interventions, as well as consistency in treatment. If the kids make it to school, they make it to therapy. (We also make home visits). Because parents or other primary caretakers usually have some connection to the school, even if it simply involves picking up their children, we have opportunities for regular contact. School-based services appear to be quite effective in reaching those families who are at greatest risk and who tend not to be reached by traditional services. Therapeutic services in the school promote social connections between children that are ultimately sources of concrete comfort and consolation in the face of unsafe circumstances. Because the services are connected to school attendance rather than being dependent on transportation to and from a clinic, consistent, longer-term treatment is possible.

The school-based approach also allows us to reach the teachers who work with children daily. Teachers are second only to parents in terms of their potential impact upon children's development and self-confident venturing into new experiences and pursuits. As educators, teachers are aware of the forces that compete for children's attention and availability for learning. As caring adults, they are deeply affected by the experiences children recount, and welcome the chance to consult with mental health professionals about the feelings aroused. The lack of safety in the community surrounding the school has a powerful personal impact on the teachers as well.

The following case vignette illustrates how our presence at the school site and consequent access to information have made immediate intervention possible:

> Eleven-year-old Tiffany came to school and told her sixth-grade teacher that the night before, she had witnessed the shooting and killing of her cousin in front of her home. The

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teacher contacted me, and our staff saw the girl that morning. Through interviewing her, we learned that three other children at the school had also witnessed the shooting and knew the assailant. Before the day's end, we had seen these three children as well. All four children were terrified that the assailant would come back for them or their family, as they were aware that he knew them and had seen them watching. One girl knew where the assailant was hiding.

Fearing reprisals, all the children's families had forbidden cooperation with the police and had forbidden the children to talk with anyone about what had happened. For these children, who were holding a very powerful secret, we were able to provide immediate crisis intervention. We were encouraged that with assurances of confidentiality, each of these children felt compelled to talk about what had happened. Tiffany desperately needed to alert someone because she knew her 15-year-old brother had a gun and planned revenge. With this information, we were then able to intervene.

PALS staff saw all four children every day that week. After that, parental consent for treatment was obtained without breaching confidentiality; one child was seen for individual therapy and two were placed in therapeutic groups. The family of the fourth child would not provide consent for us to continue seeing him. This boy's uncle had killed the man, and the family feared retribution. Two days after our single consultation with him, the family transferred him to another school. It is unlikely that he will receive any treatment.

As many of you may witness in your own work, the children in our schools are exposed persistently to violence and danger in a number of forms:

- **Random shootings occur constantly.** It is not safe for children to play outside after school. Even at home, family members—adults and children alike—live in an atmosphere of fear, rather than safety, with children frequently awakening in terror to the sound of gunshots. Once at school, children still

are not protected. When shooting occurs, the classrooms adjacent to the city park are vulnerable, and children must "duck and cover."

- **Trauma resulting from dangerous driving by adults and car accidents is common.** Several children in our caseload have been hit by cars while on their way to or from school, or while playing outside. At one school, three of the approximately 50 children whom we are seeing have been hit and injured seriously by a car more than once. Seventy-five percent of the children we see have a family member who has been seriously injured or killed in a car accident, or have themselves been involved in an accident.

- **Children worry about their mother or caretaker's physical vulnerability and powerlessness over external forces.** Adults are often unable to protect either their children or themselves successfully. Feelings of defenselessness and vulnerability have a powerful impact on roles and relationships within the family. For example, many little boys referred to us hope that they can provide a "manly presence" to protect the family. Their failure to do so is often frightening and ego-deflating.

- **Children and adults do not feel protected by police; on the contrary, they fear gang reprisal if they report crimes or pursue legal action.** The experience of many families in the community is that the Police Department will not offer any meaningful protection to them. This is especially true when a crime is drug-related, in which case families report being treated with disdain by authorities. In addition, families are rarely offered protection when testifying in court.

- **Children witness domestic violence and abuse.** Many of the children we see have witnessed their mothers or other family members being threatened, beaten, or shot. Drugs and alcohol are often involved. The use of crack cocaine diminishes impulse control, increasing the level of domestic violence that children see and experience.

We can begin to think together about the effects on early development of persistent exposure to violence and unsafe circumstances.

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Examining some of the clinical presentations and symptom clusters we see in working with five- to seven-year-old children may assist us. When assessing children, we find it particularly challenging to try to tease out the effects of multiple layers of trauma and psychosocial stressors, weighing their impact against the strengths that are present in children and families.

> For example, in thinking about the girl who witnessed the shooting of her cousin, we must keep in mind that one and one-half years ago, when she was nine years old, she had reported the sexual abuse of herself and her sister by her father. Her mother, a drug user, was living in another state. Tiffany had testified against her father. When he was incarcerated, she and her two siblings were split up, and placed separately in foster care for six months. Subsequently, Tiffany was placed with her paternal grandmother, where she was living at the time of the cousin's shooting.
>
> Despite their mother's drug use and absence, the children's summer visits to her have allowed Tiffany to internalize some of her mother's positive attributes. The extended family is supportive of Tiffany and has proved reliable in providing a stable home life and continuity with school. Tiffany's personality structure enables her to persevere and reach out to other people for sustaining connections. In addition to her relationship with the therapist, she has two strong friendships at school.

Another challenge we face frequently in assessing children referred to us is the absence of an accurate picture of the child's course of development prior to referral. We must remain aware that we see only a "snapshot" of each child and his or her current adaptations and psychological defense structures. With young children, development and adaptation are fluid.

The symptoms that we see frequently in the children referred to us can be seen also among children who are developing normally and among children with developmental problems who are living in safe neighborhoods. Nevertheless, the frequency with which these symptoms occur in our population suggest that they represent points of fixation and regression characteristic of children who

grow up in a violent environment. These symptoms may help us to understand the early influences of a violent environment upon personality development.

- **Anxiety, lack of impulse control, poor appetite, poor concentration, and flat affect are common.** It is significant that the feeling states, both pleasant and unpleasant, of children exposed to persistent violence appear limited. There is a certain dullness about these children, a lack of creativity apparent in their restricted play. Being overly defended, some children deny any danger or fear, denying them access to a whole range of rich feelings. With other children, we see dramatic play which often seems to be a direct re-enactment of the frightening situations that they have experienced. It is full of collapsing buildings, car accidents, burning children, children thrown from windows, or children jumping from roofs. The theme of a lack of safety in the face of extremely threatening circumstances is obvious. Only after a long time in treatment can children be helped to accept and integrate other "options" for the endangered children in their dramas, options that may include safety and security. This assists with internal organization and is sometimes accompanied by a lowering of anxiety.

- **Children frequently experience sleep disturbances, including nightmares.** In response to their anxiety, children sleep with adults or older siblings far beyond the age that we might normally expect. Sleeping together provides comfort to both adults and children, but the practice challenges the children's developing, and still vulnerable, sense of autonomy. It can reinforce regressive tendencies, prompted by fear, and desires to be closer to mother or father that arise from normal libidinal urges in children this age. Granted, many families have similar sleeping arrangements due to space limitations and/or culturally prompted belief systems. However, the important distinguishing factor here is that fear and safety are the main catalysts for the sleeping arrangements in the families discussed above. The children whom we see often lose previously achieved bowel and bladder control. This loss of mastery in the face of fear and anxiety has its own impact on vulnerable ego strength and self-esteem.

• **Somatic complaints and stress-related syndromes are common.** Headaches, stomach aches, back pain, and asthma attacks occur frequently in the morning before school. When they occur during school hours, children are often inconsolable until they are sent home. Children who have spent long periods at home recovering from illness or accidents have great difficulty returning to school; their mothers commonly stay with them in the classroom upon their return. Although difficulties would be expected among many children returning to school after a prolonged illness or family trauma, the regression that we observe seems extraordinarily persistent and prolonged. Again, one wonders about the impact of environmental circumstances on vulnerable developing ego structures.

• **School phobia and school avoidance seem linked to children's fears about their parents' welfare.** School phobia and school avoidance can be symptoms of a number of disorders. We believe that, consciously or unconsciously, many children are afraid of what might happen to their mothers or younger siblings when they are away from home. Depending upon the child's defense mechanisms, this worry is either verbalized or acted out. Even when children do not avoid school altogether, their worries diminish their ability to concentrate. Coupled with other life circumstances, the high level of distraction and immersion in fantasy contribute to the academic failure of large numbers of children.

Not long ago, I saw a nine-year-old child for the first time in two weeks. I had heard rumors of some family disruption, and said to her, "You know, I have been a bit worried about you." "I know," she said. "Do you know why?" She smiled, and shook her head, yes. "Why?" I asked. She answered, "You're worried that I might get shot by someone who was meaning to shoot someone else." "Yes," I said, "and anything else I might be worried about?" "You're worried about me seeing Junior (mother's boyfriend) beat my mama the other night. I was crying so hard, and then I couldn't sleep because my mama left the house and my auntie didn't know where she went."

This extremely anxious child was referred to me as a "behavior problem"—a child who was not obeying the rules. She left

her seat frequently, walked out of the classroom, and at times left the school grounds. This girl described herself to me as being "good until Kindergarten and then couldn't stop being bad."

- **Most of the children seen in treatment face issues of abandonment, separation and loss.** It is important to think carefully about what attachment means for the children of our community, and the quality, depth, and continuity of their human relationships. I recall Erik Erikson's optimistic premise that "every personal and social crisis furnishes components that are conducive to growth" (in Maier, p. 27). However, Erikson also says that "the sanctity of the individual requires for its preservation the trust and respect of the surrounding society and culture" (ibid, p. 21). I wonder how numerous losses and persistent exposure to violence and unsafe circumstances affect children experiencing personal crises of development in the midst of a social crisis of violence. Due to the persistent effects of institutionalized racism and a continuing dearth of resources for children and families, the opportunities for normal personality development and healthy social adjustment are in fact quite limited for children in our community. I am not sure that we dare rely on the power of the developing ego to maintain a child's strength and resilience in the face of overwhelming external pressures and fragmented supports. Early exposure to fearful situations, exacerbated by insecurity in the caregiving environment, may compromise children's sense of basic trust from infancy onward. These children are at tremendous risk.

What can we do, what *are* we doing for children in violent and dangerous environments? We are quite hopeful that, given adequate resources, programs like ours can make a positive difference in the developmental course of at-risk children. However, unless prevention and intervention programs are funded on a much larger scale and serve children beginning in infancy, we need to be very worried indeed.

Reference

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Betsy McAlister Groves, M.S.W.

I would like to share with you the work that I and my colleagues, Laura Taylor and Barry Zuckerman, have been doing at Boston City Hospital on issues related to young children's exposure to violence in the community. I am a social worker in that hospital, and as part of m work I am a consultant to several day-care centers that serve young children from high-risk families. I, like all of you, have been made aware of the increasing amount of violence on the streets of our cities. My colleagues who work in the hospital see these victims daily. However, the issue was brought home to me on a much more personal, visceral level by an incident that I heard about at the day-care center.

One day, in a supervision group that I run for teachers, one of the teachers related the following incident:

> She had been on the school van with the children—two, three, and four-year-olds—as they were driven home at the end of the day. As the bus was making its way through the city streets, it swerved and was forced to stop suddenly. A man, bleeding profusely, staggered out of a storefront and collapsed in front of the bus. He apparently had been stabbed and was attempting to flee from his assailant. Since the man lay in front of the bus, it could not move until the police came and took him away on a stretcher. It was several minutes before the bus could move again. During that time, the children were mostly quiet, asking a few questions. Would the police come? Was the man hurt?

As the teacher reported this incident to us in the group, her voice began to tremble. She appeared increasingly anxious and agitated, and she started to cry. We spent the rest of that session discussing our own reactions to this gruesome event. The teachers' reactions were both understandable and appropriate. I was left with many questions about how the children who witnessed this event would react. What did they perceive? What did they understand? Were they scared? Many of these children had either been victimized by, or had witnessed, violence at home. Did this affect how they perceived this incident? Curiously enough, the children had very little to say about it the next day when they returned to school. Why

was this so? Had they forgotten? Had they simply put it aside? Was it because the child care staff did not ask?

Based on the questions that arose from this encounter, from similar reports from colleagues, and with support from the Harris Foundation, I have begun a more focused exploration of the problem of young children's exposure to violence. As you know, there are many complicated questions that arise when one begins to unravel this problem.

> First, there is the issue of definition. What is violence? We would probably agree that shooting or stabbing qualifies as violent behavior. But what about pushing or shoving? Or yelling? Is this violence? Does it affect children in the same way?
>
> Secondly, how do we separate chronic violence from acute violent episodes in children's lives? What does it mean to grow up in an environment where one hears gunshots constantly? Can we compare the children on our bus who saw the severely wounded man to the child who witnesses a family member being assaulted?
>
> Thirdly, what is the role of other risk factors among children who witness violence? These children may also witness or be victimized by domestic violence.

The research questions are plentiful, almost overwhelming. Researchers such as Joy Osofsky, John Richters, and James Garbarino are attempting to study these questions systematically. However, since I am a clinician, not a researcher, I would like to share with you, from a clinical perspective, some of what we are learning from our initial explorations.

The theoretical framework we are using comes from research on stress and coping in children. Briefly stated, the greater the stress, the greater the coping resources required to meet stress successfully. For children, the ability to cope with trauma varies by:

- age;
- developmental stage;
- the ability to utilize other resources: and
- the availability of these resources.

By virtue of age and developmental stage, preschool children are the most vulnerable to the effects of exposure to violence. That

violence and uncontrolled aggression shake a preschooler's efforts to achieve basic trust in the world is obvious. Not only are preschoolers the most vulnerable, they are also the least able to communicate their feelings and vulnerability. They often cannot verbalize to us how they react to trauma, nor do we as adults know how to ask the questions, or wish to hear their answers at times. Sometimes, it's too painful for us to hear.

Since age and developmental stage cannot be changed, it makes sense to focus on children's ability to use resources and the availability of these resources as the points for intervention. We have decided to focus on three areas of intervention as a way to learn more about the problem. These areas include:

- direct intervention with children themselves;
- intervention with child care providers; and
- intervention with parents.

Let me first address the issue of direct clinical work with young children who have witnessed violence. As part of my work with day-care centers, I receive referrals of specific children who have been exposed to violence. I'd like to highlight material from two of these cases, which give us valuable information about how young children may respond to violence and, in both of these cases, to the loss of a parent through violence.

> The first case involves a five-year-old boy who witnessed the murder of his mother in an attempted burglary in the family's apartment. Sam, who is one of six children, was sleeping in the same room as his parents when he awakened to see three intruders in the bedroom. His father awoke at the same instant and intervened as one of the intruders reached down to snatch a gold chain from Sam's mother's neck. The burglars fired a shot, which ricocheted off the father and struck the mother in the eye, killing her instantly.
>
> The second case involves a three-year-old boy, Tony, whose father was shot and killed by policemen when Tony was nine months old. Tony did not witness the death. However, his mother, believing that her child should know everything about his father, has told Tony in excruciating detail how his father was killed—how many bullet holes there were, where the bullets entered, how much blood there was. She has also

shared her belief that this was an unprovoked homicide on the part of the police. This case is remarkable because it tells us about the power of trauma for children even if it is not witnessed first-hand.

In play therapy, both children have elaborated in great detail upon the specifics of the trauma. Their play is striking in its similarity with regard to several major themes.

- **First, both children have communicated their sense of increased vulnerability and fear of annihilation following the trauma.** Sam, the five-year-old, recounts the specifics of his terror of the assailants. He described how he kept his eyes closed while his mother was shot. "If I don't open my eyes," he explained, "they won't see me. Then they won't kill me." This statement, revealing both egocentric thinking and a poignant sense of vulnerability, is clear in its message. Sam's early drawings were of boys with gaping mouths, silently screaming. He would tell some seemingly benign story to accompany the drawings, but the stark terror revealed in these screaming figures spoke louder than his words.

- **A second theme that emerged for both boys was their sense of anger at the failure of adults to protect them from loss.** Sam once said, "My father should have stopped the bullet." He plays out scenes where the father protects the mother. He expresses anger that his father had argued with his mother a few days before her death.

  Tony, the three-year-old, has endless, repetitive play where policemen are called to come help, and then shoot everyone. Tony carefully wipes blood from the heads of all the dolls who are shot. Policemen are not helpful. They kill people.

- **A third theme that has emerged is the fear of repeat trauma.** Sam builds elaborate prisons to house the thieves who kill people. Even with walls, iron bars, and guards, the thieves manage to escape. They are rounded up, put back in prison, only to escape again. After several rounds of this game, I sense the invincibility of the thieves. They cannot be locked away.

  Tony starts whenever he hears a police siren. "Why are the police coming?" I have a sense with Tony that he lives in constant apprehension, unsure of what may happen next.

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The intractability of these themes for both children—their fear of annihilation, their anger at the failure of adults to protect them, their fear of repeat trauma—has been impressive. Play therapy provides an opportunity to share the reality of the trauma with another person. It also provides an opportunity to re-work the trauma in an attempt to master it. I have been struck with the drive of these children to master and re-work the trauma in play. Both of these children were able to use therapy as a lifeline for expressing their vulnerability and fear. It also provided a forum to ask for information and correct distortions about the specifics of the event. However, we can't predict the longer term outcomes for these children. I have deep concern about their development. I wonder if they can ever feel safe again.

The second phase of our consultation has involved day-care centers and child care providers. We have met with providers in groups for the purpose of training and support. In talking with these providers, we have found that they have felt frightened, overwhelmed, and occasionally hopeless about the violence that affects the lives of children. As they hear story after story about incidents that children witness at home or on the streets, they report that they begin to feel numb about these events. Furthermore, child care providers find that they sometimes begin to avoid the issue. They feel helpless to respond once they have the information.

In our consultation, we have tried to give child care staff tools to talk to young children about violence. We have helped them process their own emotional reactions, thereby freeing them to be able to talk with children more effectively. We have also given them specific information about what is known about children's exposure to violence, and the symptoms associated with post-traumatic stress disorder in children.

Using specific cases that emerge from the centers, we have assisted child care staff in responding more appropriately and sensitively to incidents of violence and trauma. Let me give you an example, brought up by the staff of one day-care center:

> The parents of one of the children in the center had been struck and killed by a hit-and-run driver. The staff was in a panic about how to respond to this child once she returned, and how to deal with the issues that would surface in the

classroom. The child's teacher said that she could not face the child without crying. There were many questions about how the child understood death, how to deal with issues of religious belief and death.

As we discussed the tragedy, I began to sense a covert wish that this child not come back, because her presence was too unbearably painful for the staff. They felt that they could do nothing to help her, and that they had somehow failed to protect this child from the unimaginable loss of her parents.

My work with the staff in this instance was to assist them in venting all of their feelings. The staff shared memories of the family and talked about their anger at the "murderer," who was still at large. We made a list of all of the questions that the staff had raised—questions about how this child might behave upon her return, what her emotional state would be, how to handle discussion of loss and death in the classroom, and how staff would handle their own feelings. Then, we began work on these issues, one at a time. At the close of the meeting, staff reported feeling more confident and prepared. It seemed that the opportunity for staff to express their feelings freed them to better prepare for this child's return.

From this intervention we learned that it is crucial to help the nurturers of young children be able to talk about violence. It is important also to be aware of the fact that these teachers have to deal with issues of violence and safety in their own lives. Many of them come to work daily to centers that are in dangerous neighborhoods, or they live in dangerous neighborhoods. Or they may have histories of abuse and victimization in their own lives. For these teachers especially, helping a child talk about violence may involve a re-enactment of their own trauma of abuse. Their understandable tendency is to avoid and minimize the issues of violence and victimization. If child care workers can themselves feel supported to cope with the issues that emerge, they will, in turn, provide support to children and families.

The third phase of our intervention has been to talk with parents, to better understand how violence is affecting their families. I have met with parents both in focus groups and individually as part of my clinical work with children. Parents report their perception

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that their young children are confused between the images of violence they see on television and what they see on the streets. Believing that violence on the streets is not real, or that the gunshots they hear won't really hurt them, young children blur the line between fact and fantasy. This lack of awareness stands in contrast to parents' reports of their own chronic fears for the safety of their children.

Parents tell us about the many ways they attempt to mediate the environment for their children. I am particularly struck with the number of parents who don't allow their children to play outside at all, or who only allow their children outside under special circumstances. One parent told us about her system of allowing her child outside on her front steps and sidewalk only if she, the mother, was free to sit in the window and monitor the streets for any unusual movement or activity. At the slightest sign of change on the street, she would immediately pull her child inside. I wonder what this means for a child's development, both the effect on her drive for exploration and learning and what it means to be taught at such an early age that the outside world is, essentially, an unsafe place.

I've also learned about the heroic and at times creative efforts parents make to keep their children safe and to protect them from fear and worry about their own safety. I think the most vivid example of this comes from a parent whom I interviewed in the course of a child evaluation:

> A mother brought her daughter to see me after the child had awakened one night to see, as she expressed it, "hands and a face" at the window next to her bed. As she sat up in bed, the face disappeared. The mother later discovered that the screen had been slashed, and that there was clear evidence of an attempted break-in.
>
> As we discussed this incident in my office, the mother offered the speculation that the attempted break-in was connected to the group of drug dealers who lived next door. The mother then began to tell me about her efforts to take care of the situation. In extremely graphic language, she described how she had gone outside and yelled at the people next door, grabbing one of them and pushing him up against

> the wall. She told them "she didn't want them coming *near* her kid—she knew what they were doing, and she was going to call the police."
>
> As she talked, I watched the little girl, v., began to settle back in her chair, looking quite relieved and relaxed. Her relief, I must add, stood in contrast to my own growing discomfort. I, of course, was afraid that this mother was going to get killed, that such risk-taking was dangerously foolhardy. But what then occurred to me was that this mother was providing exactly what her daughter needed to cope with this event: she was providing a rational explanation—a totally convincing explanation. Of course, it was those crazy drug dealers next door who were responsible for this incident. The mother was stating, unambivalently, that she was not going to allow this to happen any more. She had made her daughter's world safe again. That was what was crucial for this little girl.

In summary, I would say that our initial explorations into the area of young children's exposure to violence have convinced us that it is a critical problem that demands more careful study. The observations that I have shared with you today probably raise more questions than have been answered. On the one hand, I have learned that it is critical for parents and caretakers to avoid feeling paralyzed and hopeless about the situation, in part because hopelessness is so easily communicated to children. On the other hand, how can parents make children feel safe when they themselves have been assaulted or victimized?

And what about the larger issue of "pathologizing" neighborhoods of high crime? One of my colleagues addressed this problem eloquently as she took me to task for my definitions of violence in her neighborhood. "What are you saying that I, as a parent, should do?" she asked. "I live in a neighborhood where we hear gunshots all the time. Am I supposed to stop every time I hear a shot and process my son's reactions? No! We go about our business—I get him dressed, we eat our meals, we go to school. We're doing all right." She makes a crucial point. By labeling entire communities as "war zones," we overlook what is positive and strong and health-promoting in these communities.

Finally, I cannot end without adding my own critique of the points I have just covered. These intervention efforts are essentially a band-aid approach to a terribly complex and pervasive problem in our society. The quantity and quality of violence we all live with—on television, in our homes, and on our streets—is a national outrage. I am reminded of the saying, "We have met the enemy, and the enemy is us." Our inability to secure tougher gun control laws is but one example of this country's failure to come to terms with the violence that surrounds us all.

As we all struggle to develop appropriate intervention strategies, we must not fail to address the larger social policy issues that also emerge.

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What can we do?

"In This Together" was the theme of **ZERO TO THREE**/National Center for Clinical Infant Programs' Training Institute. It is probably accurate to say that most of the 1500 participants in the Institute have experienced community violence only vicariously. It is also true that virtually everyone who heard the presentation recognized that we must be "in this together"—to help heal the victims of violence and to create a just society and flourishing communities where violence is unacceptable. All children in our society are exposed to violence, and violence in any community ultimately affects all children and families in the society. In his framing remarks during the plenary session on the impact of community violence, Robert Emde, M.D., a member of **ZERO TO THREE**'s Board of Directors and president of the Society for Research in Child Development said, "We are immersed in an extremely violent culture, and it is something that we have to attend to. It is easy to become overwhelmed by this problem."

The immediate response of the Board and staff of **ZERO TO THREE** was to create a study group on the impact of violence on infants, toddlers, and their families. The publication and dissemination of this booklet represent the first activities of the group.

This booklet is an alert, not a solution. As the insights and reflections of the speakers at the National Training Institute suggest, there is much that can be done to address the impact of violence on infants, toddlers, and their families, including:

- Helping victims of violence immediately and over time, recognizing that the internalization of exposure to violence can have effects lasting over generations;
- Supporting parents as they protect their children's physical and emotional well-being, and organize to strengthen each other's efforts;
- Training front-line service providers to address the developmental impact of exposure to violence on infants, toddlers, and their families;
- Providing ongoing consultation and emotional support to front-line service providers;

- Training parents and child care providers to help very young children learn conflict resolution;
- Addressing the impact of violence on television; and,
- Shaping public policy in all areas of prevention and intervention that are related to violence—including community development as well as crime prevention and control.

Such complex efforts are possible through partnership among individuals, organizations, and community systems. For example, **ZERO TO THREE** Board member Irving B. Harris encouraged Joy Osofsky and her colleagues to develop a study that would link two major community systems in New Orleans: the police department and the child mental health community. The objective was to work together at the time that homicides are reported, so that a mental health person can be available to the police to help children and families who are exposed to homicides. Such a model program has been developed in New Haven, CT. The New Orleans police have been very open to trying to develop ways to implement these ideas of community policing to help children and families. Both the Louisiana state government and private foundations have expressed interest in funding such a project.

ZERO TO THREE is working to identify other research, intervention, and policy initiatives that address the impact of violence on children and families. We are eager to help practitioners and researchers with expertise on infants, toddlers, and their families use their special knowledge and skills in both targeted and broad-based initiatives.

As a next step, **ZERO TO THREE** will sponsor a symposium entitled *The Impact of Violence on Infants, Toddlers, and Their Families: Epidemiology and Intervention,* in Washington, D.C., on December 4, 1992. This symposium will bring together: representatives from violence study groups and commissions formed by national associations and organizations, front-line practitioners who work with victims of violence, parents, and community activists. The goal will be to develop strategies for policy and practice. A special feature of the symposium will be a three-hour poster session. This event will provide an opportunity for dialogue

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between symposium participants and principals in programs and community initiatives from across the country that focus on community violence.

For more information about the symposium and other activities, write or call Beverly Roberson Jackson, Ed.D., Director of Public Policy and Public Education, **ZERO TO THREE**/National Center for Clinical Infant Programs, 2000 14th Street North, Suite 380, Arlington, VA 22201-2500, tel: (703) 528-4300, fax: (703) 528-6848.

National Center for Clinical Infant Programs

ZERO TO THREE/National Center for Clinical Infant Programs is the only national nonprofit organization dedicated solely to improving the chances for healthy physical, cognitive and social development of infants, toddlers and their families.

Established in 1977, **ZERO TO THREE** is committed to:

- exercising leadership in developing and communicating a national vision of the importance of the first three years of life and of the importance of early intervention and prevention to healthy growth and development;
- developing a broader understanding of how services for infants and toddlers and their families are best provided; and
- promoting training in keeping with that understanding.

For ordering information and additional **ZERO TO THREE** publications, contact **ZERO TO THREE**/KCMS toll free: 1-800-544-0155.

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