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Examining child care and child care subsidies for intimate partner violence survivors and their children: a mixed methods study

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EXAMINING CHILD CARE AND CHILD CARE SUBSIDIES FOR INTIMATE PARTNER VIOLENCE SURVIVORS AND THEIR CHILDREN: A MIXED METHODS STUDY

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For Jane and Ethan.

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EXAMINING CHILD CARE AND CHILD CARE SUBSIDIES FOR INTIMATE PARTNER VIOLENCE SURVIVORS AND THEIR CHILDREN: A MIXED METHODS STUDY

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ABSTRACT

There are well-established links between early exposure to intimate partner violence (IPV) and negative developmental outcomes for young children. Emerging evidence suggests that early care and education (ECE), an existing and widely used resource within children's communities, may be a promising means to support and address the needs of young children experiencing adversity. However, little is known about ECE or ECE policies in the IPV context. This three-paper dissertation employs a triangulation mixed methods design to address these gaps in our current knowledge.

Chapter 2 investigates the influences of ECE on the behavioral outcomes of children exposed to IPV. Four waves of national, longitudinal data from the Fragile Families and Child Well Being Survey (N=3,108) were used to examine the moderating roles of informal, formal home-based, and center-based child care on respective associations between children's IPV exposure and internalizing and externalizing behavioral problems (IBP, EBP). Results from ordinary least squares regression models with interaction terms and subgroup analyses using inverse probability of treatment weighting (IPTW) suggest that non-parental child care, particularly center-based care,

can attenuate the negative influences of some forms of IPV exposure on young children's behavioral outcomes.

Chapter 3 draws on primary data from in-depth, semi-structured interviews with 17 IPV survivor mothers of young children aged 0–5 to understand their ECE and child care subsidy decisions and arrangements. A data-driven thematic analysis revealed pervasive influences of IPV on mothers' ECE access and utilization. Despite IPV perpetrators' interference with and restraint of ECE, mothers sought child care arrangements they believed would enhance children's well-being, particularly with respect to children's IPV-related needs and safety. Social and structural factors (e.g., social isolation and ECE affordability and availability) also importantly influenced mothers' ECE arrangements, and child care subsidies were a critical resource for some.

Chapter 4 explores the mechanisms by which ECE can promote children's resilience during and following IPV exposure, using data from the same 17 interviews with IPV survivor mothers as well as interviews with 6 ECE professionals with experience working with children exposed to IPV. Results from data-driven thematic analyses indicate that reduced exposure to IPV and associated risks, prevention of abusers' unsafe contact with children, nurturance, enriching activities, stability, a balance of consistency and flexibility, access to therapeutic services, and support of children's emotion regulation and social development may serve as key protective mechanisms for children exposed to IPV within ECE environments.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ACF	Administration for Children and Families
ADHD	Attention Deficit and Hyperactive Disorder
ASD	Autism Spectrum Disorder
CAPS	Childcare and Parent Services
CASA	Court Appointed Special Advocate
CCDBG	Child Care and Development Block Grant
CCDF	Child Care Development Fund
CDC	Centers for Disease Control
COVID-19	Coronavirus Disease of 2019
CPP	Child-Parent Psychotherapy
CPS	Child Protective Services
DV	Domestic Violence
EBP	Externalizing Behavioral Problems
ECE	Early Care and Education
ECMHC	Early Childhood Mental Health Consultant
FCC	Family Child Care
IBP	Internalizing Behavioral Problems
IPTW	Inverse Probability of Treatment Weighting
IPV	Intimate partner violence
NICHD	National Institute of Child Health and Human Development
OLS	Ordinary Least Squares

PTSD	Posttraumatic Stress Disorder
TANF	Temporary Assistance for Needy Families
YWCA	YWCA USA Inc. (formerly Young Women's Christian Association of the United States of America, Inc.)

CHAPTER ONE

INTRODUCTION

Approximately one third of all U.S. women experience intimate partner violence (IPV) during adulthood, and 60% report their first IPV experience before age 25 (Breiding et al., 2014; Smith et al., 2015). Among women experiencing homelessness and receiving Temporary Assistance for Needy Families (TANF) benefits, IPV rates may be as high as 80% and 74%, respectively (Aratani, 2009; Cheng, 2013). The most recent 24-hour census of U.S. domestic violence shelters and transitional housing programs identified 42,964 fleeing adults and children, as well as 11,336 individuals whose shelter requests were unmet that day (NNEDV, 2020).

It is estimated that nearly 30% of U.S. children live in married or cohabiting households where any IPV has occurred, and over 13% where severe IPV has occurred (McDonald et al., 2006). Very young children are more likely than older children to be at home when IPV occurs and often maintain close physical proximity to their mothers. This places them at higher risk for being exposed to IPV and for directly witnessing abuse when it occurs (DeJonghe et al., 2005, 2011; Finkelhor et al., 2015). Studies have found that witnessing IPV is among the most commonly experienced types of violence during infancy and that 64% of children exposed to IPV initially witness it during their first year (Graham-Bermann & Perkins, 2010; Hamby, S., Finkelhor, D., Turner, H., & Ormrod, 2011).

Impact of IPV on Young Children

Early childhood represents a critical period of development and experiences

during this sensitive period have far-reaching consequences. Infants and toddlers who lack recourse to flee from IPV are affected directly by exposure through impaired neurobiological development and physiological functioning, which may lead to significant cascading influences (Masten & Cicchetti, 2010; Perry et al., 1995). Young children are also affected through the direct negative influences of IPV perpetrators' harsh parenting and child maltreatment, and indirectly by the effects of IPV on survivors' well-being (Levendosky et al., 2006; Margolin et al., 2003). Fathers who perpetrate IPV have been shown to be authoritarian, neglectful, verbally abusive, lack empathy toward their children, and use children to control and coerce mothers (Beeble et al., 2007; Cater & Forssell, 2014; Guille, 2004). Abuse has also been shown to increase survivor mothers' risk for mental health problems, while undermining their self-sufficiency and isolating them from friends and family who would normally provide support (Levendosky et al., 2012; Postmus et al., 2012). The relationship between IPV and maternal parenting is complex. Some studies indicating that IPV is positively associated with mother-child attachment and parenting effectiveness (Austin et al., 2019; Levendosky et al., 2003), while other studies have found IPV to increase mothers' parenting stress and negatively influence their parenting practices—influences that are associated with negative outcomes for children (Austin et al., 2019; English et al., 2003; Huth-Bocks & Hughes, 2008; Owen et al., 2009).

A growing literature has documented the negative outcomes of IPV exposure on young children's well-being during early childhood. These include emotion regulation problems and severe separation anxiety, high rates of irritability and crying,

hypervigilance, adjustment problems, sensitivity to inter-adult conflict, eating problems, sleep disturbances, and language and neurological delays (Alessi & Hearn, 1984; DeJonghe et al., 2005, 2011; Levendosky et al., 2006; Lundy & Grossman, 2005; McDonald et al., 2007). Research also points to longer-term outcomes of early IPV exposure, including peer bullying perpetration and victimization, delinquency, mental health problems, and the intergenerational transmission of IPV (Carr et al., 2013; Ehrensaft et al., 2003; Huang et al., 2015, 2021).

Interventions for Young Children Exposed to IPV

Children have been shown to exhibit heterogeneous outcomes, however, depending on their individual characteristics and protective factors within their environments (Fogarty et al., 2020). As described in greater detail in Chapter 4, research to date has primarily focused on protective individual and family characteristics for children exposed to IPV. Interventions for children exposed to IPV emerged in the 1980s and 1990s and have since expanded to include an array of child-centered and conjoint child-mother programs and services (Hughes et al., 2004; Romano et al., 2021). In addition to play-based interventions for young children exposed to IPV, common trauma-specific modalities include child-parent psychotherapy (CPP) for children aged 0–6 and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children aged 3–18. A recent meta-analysis of interventions for children and adolescents exposed to IPV found an overall medium effect size, leading the authors to conclude that child centered IPV interventions can help to improve children's emotional and behavioral outcomes (Romano et al., 2021).

However, as previous researchers have pointed out, families' access to these targeted interventions varies considerably (Anderson & van Ee, 2018; Howell, 2011). Moreover, mental health service utilization among young children overall is very low. An estimated 9.5–14.2% of young children in the U.S. experience emotional, relational, or behavioral disturbance, and one in six has a diagnosed mental, behavioral, or developmental disorder (Cree et al., 2018). Yet, as of 2021, only 3.5% of children aged 3–5 had received any developmentally appropriate mental health treatment within the past year (Child and Adolescent Health Measurement Initiative, 2021).

Possible Benefits of ECE for Children Exposed to IPV

A much greater proportion of U.S. children—nearly 60%—regularly take part in early care and education (ECE) (Loomis, 2018; Tekin, 2021). Numerous studies have documented the benefits of high quality ECE for young children. Positive associations include increased child emotional engagement, social competence and development, and lower risk for later behavior problems (Burchinal et al., 2008; Love et al., 2005; Mortensen & Barnett, 2016; Peisner-Feinberg et al., 2001). A growing body of literature has explored the potentially disparate effects of child care arrangements and quality for young children experiencing early adversity. Children who experience parental maltreatment, whose mothers have lower education levels, and who are socioeconomically disadvantaged have all been shown to benefit more from high quality child care than do their comparatively advantaged peers (Mortensen & Barnett, 2016; Peisner-Feinberg et al., 2001; Votruba-Drzal et al., 2016).

Additionally, stable, quality child care arrangements have been shown to buffer

certain risks among young children. One recent study found that for children experiencing high levels of household chaos, greater hours of child care were positively related to more optimal social and cognitive outcomes (Berry et al., 2016). The researchers also found that the negative effects of household chaos on executive functioning, vocabulary, and social behaviors were greatly attenuated by participation in full-time child care (Berry et al., 2016). Findings from two other studies suggest that formal child care may also moderate the effects of maternal depression on toddlers' internalizing and externalizing behavior problems (Giles et al., 2011; Herba et al., 2013). In both studies, researchers found that group-based child care had a more protective influence on toddlers with depressed mothers, compared to informal, home-based care. Although these studies did not examine families experiencing IPV, the study findings are of particular relevance to families experiencing IPV, given the strong associations between mothers' IPV victimization and depression, and the significant co-occurrence of household chaos and IPV (Coe et al., 2020; Raver et al., 2015). Finally, one previous study found that non-parental care can buffer the negative impact of what the authors conceptualized as parents' IPV *risk*—measured based on self-reported relationship tension and difficulty—on Japanese children's health-related quality of life (Kita et al., 2021).

Taken together, this extant research on the benefits of ECE for children experiencing early adversity and trauma provides reason to believe stable, quality ECE can benefit children exposed to IPV. Key protective factors for children exposed to IPV include reduced frequency and severity of IPV exposure, supportive relationships with

safe caregivers, emotion regulation skills, and stable, consistent routines (Baker & Cunningham, 2004; David et al., 2015; Harding et al., 2013; Howell, 2011; Sturge-Apple et al., 2010). These protective factors conceptually align with some of the resources and benefits offered by quality child care.

IPV Survivor Mothers' ECE Access and Utilization

Research indicates that child care and child care subsidies are critical resources to promote the safety and well-being of IPV survivors and their children. Hendy and colleagues (2003) developed the evidence-based Decision to Leave Scale to assess women's reasons for staying in abusive relationships and the barriers they face in trying to leave. Of the seven subscales that emerged, three were based on personal dimensions, and four—including "child care needs"—were based on the situational dimensions most associated with survivors' relationship decisions (Hendy et al., 2003). The authors reported that child care needs were greatest for survivors residing in shelters and were significantly greater for women who had decided to leave abusive relationships than for women who stayed in abusive relationships. In exploring women's use of supportive services in the aftermath of violence, Postmus and colleagues (2009) found that, within a sample of 423 Midwestern women reporting histories of childhood and/or adulthood victimization, 67 (15.9%) had used subsidized child care following violence. Based on participant rankings, subsidized child care was identified as the most helpful of 24 listed supports (Postmus et al., 2009). In another study, among the 141 survivor mothers surveyed, 57.1% reported needing child care and nearly half indicated that child care services would help them feel safer (Dichter & Rhodes, 2011).

Despite the evident importance of child care and child care subsidies to survivor mothers during and following victimization, no studies to date have investigated survivors' ECE decisions or arrangements. It is known that mothers of young children who experience IPV are disproportionately young and disadvantaged (Geffner et al., 2014). Studies have found that young and lower income mothers are less likely to use center-based care and less likely to receive child care assistance, compared with older and more advantaged mothers (Enchautegui et al., 2015; Liu & Anderson, 2012; Rachidi, 2016). Family structure transitions have also been found to be associated with child care disruptions and changes for young children (Crosnoe et al., 2014)—potentially relevant to children whose mothers have left their abusive partners.

ECE Policy Context

Child care subsidies, funded by the Child Care and Development Fund (CCDF), are available to low-income families. For the first time since 1996, Congress reauthorized the Child Care and Development Block Grant (CCDBG) in 2014 with bipartisan support. The CCDBG Act of 2014 added and updated a number of provisions to improve the quality of child care and accessibility to subsidies. It strengthened requirements for health and safety, quality of care, and licensing regulations, and expanded eligibility (including a 12-month eligibility re-determination period for subsidies) and consumer education. This act, and the associated 2016 CCDF Final Rules, also required the Administration of Children and Families (ACF) to report to Congress about whether state lead agencies were sufficiently prioritizing services to underserved populations, such as homeless children, children with special needs, and children from very low-income families.

Underlying these latter policy changes is an implied acknowledgement that parents who are in crisis—for instance, because of financial instability or homelessness—require explicit policy support. However, unlike these other risk groups that are prioritized by current federal CCDF regulations, families experiencing IPV are not.

Within the parameters of federal requirements, states have some flexibility in operating their respective CCDF programs. To date, only five states, including California, Georgia, New York, Pennsylvania, and Rhode Island, have implemented policies that explicitly prioritize families experiencing IPV. In California, families are prioritized to receive child care subsidies based on a number of factors, including being "a domestic violence survivor." Georgia law added "persons experiencing domestic violence" as a priority group in 2016, making survivors eligible for a 90-day exemption from verification documentation requirements. In New York, while IPV survivors are not a priority population at the state level, local departments of social services (LDSS) have the authority to establish local priority populations in addition to those federally mandated, and "victims of domestic violence" are considered a priority group among some of these. As of 2022, Florida offers priority status, and in some cases waived family co-payments, to children "in the custody of a parent who is considered a victim of domestic violence and is receiving services through a certified domestic violence center." Families in Pennsylvania who are experiencing domestic violence may have their co-payments waived to the lowest tier ($5/week as of 2023). In Rhode Island, they can request waivers for child support enforcement cooperation, a requirement for subsidy receipt in the state.

There is yet very little known about how these and other CCDF policies influence

IPV survivors' use of child care subsidies or affect their families' well-being. In 2022, the state of Maryland passed legislation that included adoption of "presumptive eligibility" for child care subsidies (a grace period that allows children and families to apply for child care subsidies and begin participating in child care programs while waiting for the state to determine final eligibility) and the removal of child support enforcement as a condition of families' eligibility for child care subsidies. This legislation required the Maryland State Department of Education (MSDE) to complete a study on these factors, in partnership with the Center for Law and Social Policy (CLASP). The mixed methods MSDE/CLASP study found that these policy changes had each specifically benefitted survivors of IPV and their children (Gomez et al., 2022). Presumptive eligibility helped parents escaping domestic violence situations who did not have all required documentation but needed care immediately. Further, as seeking child support from former abusers had previously placed survivor parents in compromised positions, removing this requirement enhanced their safety (Gomez et al., 2022).

Current Study

Aims

The central aim of this dissertation is to develop a foundational understanding of ECE in the lives of young children exposed to IPV. Given the dearth of empirical knowledge on this topic, the current dissertation also aims to lay groundwork for future research. To better understand ECE's impact on the well-being of children exposed to IPV, as well as the processes underlying these impacts, this research utilizes a mixed-methods approach. It first examines the associations between non-parental care types and

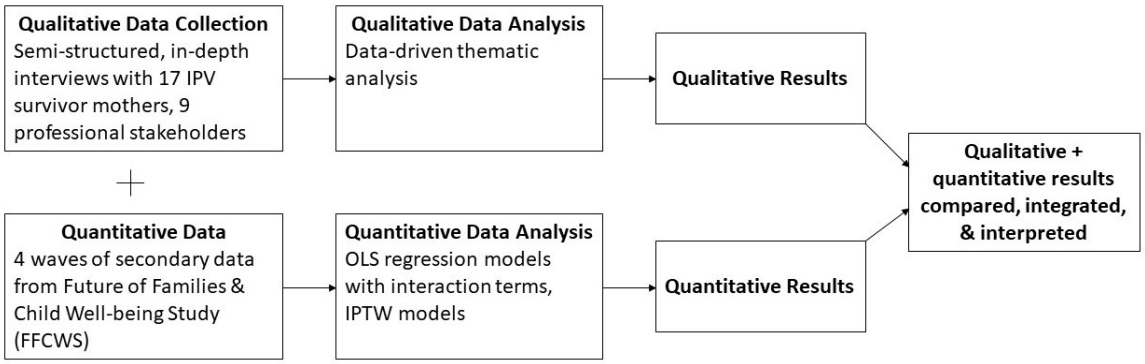
children's developmental outcomes, then qualitatively explores IPV survivor mothers' and ECE professionals' perceptions and experiences relating to child care decisions and the role of ECE in supporting children's resilience. These analyses represent the three related but distinctive chapters of this dissertation, outlined below. This dissertation was developed based on a thorough literature review, multiple informational meetings with domestic violence advocates and community-based health case managers working with New England families experiencing IPV, input from CCDF lead agencies in two New England states, and my professional experience working with survivor mothers in a community-based advocacy setting in New England.

Research Design

As depicted in Figure 1.1, this three-paper dissertation employs a triangulation mixed methods design. This approach is generally used to understand a research problem through different but complementary data on the same topic (Creswell & Pioano Clark, 2007). It involves separate quantitative and qualitative analyses and brings together the respective strengths and weaknesses of each method. Following completion of analyses, findings are compared and contrasted during the interpretation phase (Creswell & Pioano Clark, 2007). The purpose of this approach is to draw well-substantiated conclusions about a phenomenon. This design is well aligned with the current study aims, especially given demographic and temporal differences between the quantitative and qualitative samples (e.g., secondary data for Study 1 was collected between 1998–2005, whereas primary data for Studies 2 and 3 were collected between 2021–2023). As part of the triangulation mixed methods design, interpretation accounts for strengths and weaknesses

of each data source and approach. For instance, there is value in using national panel data to investigate the broad influences of child care for children experiencing IPV, as well as in using qualitative data to understand the complex mechanisms involved in survivors' ECE decisions and ECE influences on children within a contemporary context. All findings are interpreted within the limits of these respective samples. Thus, an integrated interpretation of separate quantitative and qualitative analyses can produce a more complete picture of ECE for children exposed to IPV.

Figure 1.1 Triangulation Mixed Methods Design



Chapter 2 of this dissertation, comprising the first study, investigates relationships among young children's IPV exposure, child care arrangements, and behavioral outcomes. While early exposure to IPV is associated with a number of adverse outcomes, internalizing and externalizing behavioral problems (IBP, EBP) are among the most extensively researched. While a growing literature shows the potential for non-parental child care to buffer the negative effects of early adversity on children's behavioral development (Berry et al., 2016; Giles et al., 2011; Herba et al., 2013), no studies to date have investigated these potential influences for children exposed to IPV. Therefore, this first, quantitative study investigates whether child care arrangement moderates

associations between children's IPV exposure and their subsequent IBP and EBP. Four waves of national, longitudinal data from the Fragile Families and Child Well Being Survey (N=3,108) were used to examine the moderating role of informal, formal home-based, and center-based child care on associations between children's IPV exposure and behavioral outcomes. Ordinary least squares regression models with interaction terms and subgroup analyses using inverse probability of treatment weighting (IPTW) were employed. After adjusting for child, mother, and household characteristics, non-parental child care significantly modified associations between children's exposure to frequent, physical, and coercive IPV and IBP, and between children's exposure to frequent and physical IPV and EBP. Subgroup analyses generally confirmed these results, in that frequent, physical, and coercive IPV were associated with both IBP and EBP for children in parental care; low frequency, physical, and coercive IPV were associated only with increased EBP for children in home-based care; and no measures of IPV were associated with IBP or EBP for children in center-based care. Findings suggest that non-parental child care, particularly center-based care, may attenuate the negative influences of some forms of IPV exposure on young children's behavioral outcomes.

Chapter 3 is a qualitative examination of survivor mothers' ECE decision making. Currently, divisions of household labor in the U.S. result in mothers shouldering more responsibility for child care: not only for caring for children within the home, but also for arranging non-parental care. Thus, in general, young children's ECE arrangements—which can importantly influence their outcomes—are heavily determined by their mothers. While an extensive literature has explored parents' ECE decision making, very

little is known about how IPV may affect decisions about child care arrangements. This study examined primary data from in-depth, semi-structured interviews with 17 IPV survivor mothers of young children aged 0–5 residing in three New England states who had needed and/or used non-parental child care during their young children's lifetimes. Interviews were analyzed using data-driven thematic analysis (Braun & Clarke, 2006). Results revealed pervasive influences of IPV on mothers' ECE decisions. In addition to the direct physical and psychological harm that IPV perpetrators inflicted on mothers and children, which in some cases influenced their child care needs, perpetrators also interfered with and restrained mothers' child care options and arrangements and isolated them from their support systems, including potential informal caregivers. Despite these influences of IPV, mothers sought child care arrangements they believed would enhance children's well-being, particularly with respect to children's IPV-related needs and safety. Social and structural factors (e.g., related to ECE affordability and availability) also importantly influenced mothers' decisions. Findings from this study may have implications for ECE and other systems-level efforts to increase access and utilization among children exposed to IPV.

Chapter 4 explores young children's needs from ECE and the mechanisms by which ECE can promote children's resilience during and following IPV exposure. It utilizes Masten and Coatsworth's (1998) classification of risk-focused, resource-focused, and process-focused strategies to promote competence, i.e., positive functioning, among children exposed to early adversity to frame findings. This study also drew on data from the 17 interviews with IPV survivor mothers described above, as well as interviews with

6 ECE professionals with experience working with children exposed to IPV. Interviews were analyzed using data-driven thematic analysis (Braun & Clarke, 2006). Results indicated that reduced exposure to IPV and associated risks, prevention of abusers' unsafe contact with children, nurturance, enriching activities, stability, a balance of consistency and flexibility, access to therapeutic services, and support of children's emotion regulation and social development may serve as key protective mechanisms for children exposed to IPV. Findings help explain the possible mechanisms by which ECE can buffer the negative impacts of IPV on children's well-being.

References

Alessi, J. J., and Hearn, K. (1984). Group treatment of children in shelters for battered women. In A. R. Roberts (Ed.), *Battered women and their families: Intervention strategies and treatment programs (pp. 49–62).* New York: Springer.

Anderson, K., & van Ee, E. (2018). Mothers and children exposed to intimate partner violence: a review of treatment interventions. *International Journal of Environmental Research and Public Health*, *15*(9). https://doi.org/10.3390/ijerph15091955

Aratani, Y. (2009). *Homeless children and youth: Causes and consequences*. National Center for Children in Poverty.

Austin, A. E., Shanahan, M. E., Barrios, Y. V., & Macy, R. J. (2019). A Systematic Review of Interventions for Women Parenting in the Context of Intimate Partner Violence. *Trauma, Violence, and Abuse*, *20*(4), 498–519. https://doi.org/10.1177/1524838017719233

Baker, L., & Cunningham, A. (2004). *Helping children thrive / supporting woman abuse survivors as mothers: A resource to support parenting*. London, ON: Centre for Children & Families in the Justice System.

Beeble, M. L., Bybee, D., & Sullivan, C. M. (2007). Abusive men's use of children to control their partners and ex-partners. *European Psychologist*, *12*(1). https://doi.org/10.1027/1016-9040.12.1.54

Berry, D., Blair, C., Willoughby, M., Garrett-Peters, P., Vernon-Feagans, L., Mills-Koonce, W. R., Cox, M., Burchinal, P., Burton, L., Crnic, K., Crouter, A., Greenberg, M., Lanza, S., & Werner, E. (2016). Household chaos and children's cognitive and socio-emotional development in early childhood: Does childcare play a buffering role? *Early Childhood Research Quarterly*, *34*, 115–127. https://doi.org/10.1016/j.ecresq.2015.09.003

Breiding, M. J., Chen, J., & Black, M. C. (2014). Intimate Partner Violence in the United States — 2010. *Centers for Disease Control and Prevention*, 1–96.

Burchinal, M., Howes, C., Pianta, R., Bryant, D., Early, D., Clifford, R., & Barbarin, O. (2008). Predicting child outcomes at the end of kindergarten from the quality of pre-kindergarten teacher-child interactions and instruction. *Applied Developmental Science*, *12*(3). https://doi.org/10.1080/10888690802199418

Carr, C. P., Martins, C. M. S., Stingel, A. M., Lemgruber, V. B., & Juruena, M. F. (2013). The role of early life stress in adult psychiatric disorders: A systematic review according to childhood trauma subtypes. In *Journal of Nervous and Mental Disease* (Vol. 201, Issue 12). https://doi.org/10.1097/NMD.0000000000000049

Cater, Å., & Forssell, A. M. (2014). Descriptions of fathers' care by children exposed to intimate partner violence (IPV) - relative neglect and children's needs. *Child and Family Social Work*, *19*(2). https://doi.org/10.1111/j.1365-2206.2012.00892.x

Cheng, T. C. (2013). Intimate Partner Violence and Welfare Participation: A Longitudinal Causal Analysis. *Journal of Interpersonal Violence*, *28*(4). https://doi.org/10.1177/0886260512455863

Child and Adolescent Health Measurement Initiative (2021). 2021 National Survey of Children's Health (NSCH) data query. Available from www.childhealthdata.org

Coe, J. L., Parade, S. H., Seifer, R., Frank, L., & Tyrka, A. R. (2020). Household Chaos Moderates Indirect Pathways Involving Domestic Violence, Parenting Practices, and Behavior Problems among Preschool Children. *Journal of Family Violence*, *35*(5). https://doi.org/10.1007/s10896-019-00093-9

Cree, R. A., Bitsko, R. H., Robinson, L. R., Holbrook, J. R., Danielson, M. L., Smith, C., Kaminski, J. W., Kenney, M. K., & Peacock, G. (2018). Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders and Poverty Among Children Aged 2–8 Years — United States, 2016. *MMWR. Morbidity and Mortality Weekly Report*, *67*(50). https://doi.org/10.15585/mmwr.mm6750a1

Creswell, J., & Pioano Clark, V. (2007). Introducing a mixed method design. *Designing and Conducting Mixed Methods Research*, 58–89. https://www.sagepub.com/sites/default/files/upm-binaries/10982_Chapter_4.pdf

Crosnoe, R., Prickett, K. C., Smith, C., & Cavanagh, S. (2014). Changes in Young Children's Family Structures and Child Care Arrangements. *Demography*, *51*(2), 459–483. https://doi.org/10.1007/s13524-013-0258-5

David, K. B., LeBlanc, M. M., & Self-Brown, S. (2015). Violence Exposure in Young Children: Child-Oriented Routines as a Protective Factor for School Readiness. *Journal of Family Violence*, *30*(3), 303–314. https://doi.org/10.1007/s10896-015-9676-z

DeJonghe, E. S., Bogat, G. A., Levendosky, A. A., Von Eye, A., & Davidson, W. S. (2005). Infant exposure to domestic violence predicts heightened sensitivity to adult verbal conflict. *Infant Mental Health Journal*, *26*(3). https://doi.org/10.1002/imhj.20048

DeJonghe, E. S., von Eye, A., Bogat, G. A., & Levendosky, A. A. (2011). Does witnessing intimate partner violence contribute to toddlers' internalizing and externalizing behaviors? *Applied Developmental Science*, *15*(3), 129–139. https://doi.org/10.1080/10888691.2011.587713

Dichter, M. E., & Rhodes, K. V. (2011). Intimate Partner Violence Survivors' Unmet Social Service Needs. *Journal of Social Service Research*, *37*(5), 481–489. https://doi.org/10.1080/01488376.2011.587747

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational transmission of partner violence: A 20-year prospective study. *Journal of Consulting and Clinical Psychology*, *71*(4). https://doi.org/10.1037/0022-006X.71.4.741

Enchautegui, M. E., Johnson, M., & Gelatt, J. (2015). *Who minds the kids when mom works a nonstandard schedule?* Washington, DC: Urban Institute.

English, D. J., Marshall, D. B., & Stewart, A. J. (2003). Effects of Family Violence on Child Behavior and Health during Early Childhood. *Journal of Family Violence*, *18*(1). https://doi.org/10.1023/A:1021453431252

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of Childhood Exposure to Violence, Crime, and Abuse. *JAMA Pediatrics*, *169*(8). https://doi.org/10.1001/jamapediatrics.2015.0676

Fogarty, A., Giallo, R., Wood, C., Kaufman, J., & Brown, S. (2020). Emotional-behavioral resilience and competence in preschool children exposed and not exposed to intimate partner violence in early life. *International Journal of Behavioral Development*, *44*(2). https://doi.org/10.1177/0165025419830241

Geffner, R. A., Igelman, R. S., & Zellner, J. (2014). The effects of intimate partner violence on children. *The Effects of Intimate Partner Violence on Children*, 1–308. https://doi.org/10.4324/9781315044026

Giles, L. C., Davies, M. J., Whitrow, M. J., Warin, M. J., & Moore, V. (2011). Maternal depressive symptoms and child care during toddlerhood relate to child behavior at age 5 years. *Pediatrics*, *128*(1). https://doi.org/10.1542/peds.2010-3119

Gomez, A. L., Hardy, A., Fortner, A., Schmit, S., & Ferrette, T. (2022). *Early childhood development – Child care scholarship program Study (Ch. 525 HB995/SB920)*. The Center for Law and Social Policy.

Graham-Bermann, S. A., & Perkins, S. (2010). Effects of early exposure and lifetime exposure to intimate partner violence (IPV) on child adjustment. *Violence and Victims*, *25*(4). https://doi.org/10.1891/0886-6708.25.4.427

Guille, L. (2004). Men who batter and their children: An integrated review. In *Aggression and Violent Behavior* (Vol. 9, Issue 2). https://doi.org/10.1016/S1359-1789(02)00119-2

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). Children's Exposure to Intimate Partner Violence and Other Family Violence. *Office of Juvenile Justice and Delinquency Prevention*.

Harding, H. G., Morelen, D., Thomassin, K., Bradbury, L., & Shaffer, A. (2013). Exposure to Maternal- and Paternal-Perpetrated Intimate Partner Violence, Emotion Regulation, and Child Outcomes. *Journal of Family Violence*, *28*(1). https://doi.org/10.1007/s10896-012-9487-4

Hendy, H. M., Eggen, D., Gustitus, C., McLeod, K. C., & Ng, P. (2003). Decision to leave scale: Perceived reasons to stay in or leave violent relationships. *Psychology of Women Quarterly*, *27*(2), 162–173. https://doi.org/10.1111/1471-6402.00096

Herba, C. M., Tremblay, R. E., Boivin, M., Liu, X., Mongeau, C., Séguin, J. R., & Coté, S. M. (2013). Maternal depressive symptoms and children's emotional problems can early child care help children of depressed mothers? *JAMA Psychiatry*, *70*(8), 830–838. https://doi.org/10.1001/jamapsychiatry.2013.1361

Howell, K. H. (2011). Resilience and psychopathology in children exposed to family violence. *Aggression and Violent Behavior*, *16*(6), 562–569. https://doi.org/10.1016/j.avb.2011.09.001

Huang, C. C., Chen, Y., & Cheung, S. (2021). Early childhood exposure to intimate partner violence and teen depression symptoms in the U.S. *Health and Social Care in the Community*, *29*(5). https://doi.org/10.1111/hsc.13240

Huang, C. C., Vikse, J. H., Lu, S., & Yi, S. (2015). Children's Exposure to Intimate Partner Violence and Early Delinquency. *Journal of Family Violence*, *30*(8), 953–965. https://doi.org/10.1007/s10896-015-9727-5

Hughes, H. M., Graham-Bermann, S. A., & Gruber, G. (2004). Resilience in children exposed to domestic violence. *Domestic Violence in the Lives of Children: The Future of Research, Intervention, and Social Policy.*, 67–90. https://doi.org/10.1037/10408-004

Huth-Bocks, A. C., & Hughes, H. M. (2008). Parenting stress, parenting behavior, and children's adjustment in families experiencing intimate partner violence. *Journal of Family Violence*, *23*(4). https://doi.org/10.1007/s10896-007-9148-1

Kita, S., Sato, I., Sakka, M., Soejima, T., & Kamibeppu, K. (2021). Does the Use of Childcare Services Reduce the Impact of Intimate Partner Violence on the Quality of Life of Children?: Multiple-Group Structural Equation Modeling. *Applied Research in Quality of Life*, *16*(5). https://doi.org/10.1007/s11482-020-09847-w

Levendosky, A. A., Huth-Bocks, A. C., Shapiro, D. L., & Semel, M. A. (2003). The Impact of Domestic Violence on the Maternal - Child Relationship and Preschool-Age Children's Functioning. *Journal of Family Psychology*, *17*(3). https://doi.org/10.1037/0893-3200.17.3.275

Levendosky, A. A., Lannert, B., & Yalch, M. (2012). The effects of intimate partner violence on women and child survivors: An attachment perspective. *Psychodynamic Psychiatry*, *40*(3), 397–434. https://doi.org/10.1521/pdps.2012.40.3.397

Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davidson, W. S., & Von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology*, *20*(4). https://doi.org/10.1037/0893-3200.20.4.544

Liu, M., & Anderson, S. G. (2012). Neighborhood effects on working mothers' child care arrangements. *Children and Youth Services Review*, *34*(4), 740–747. https://doi.org/10.1016/j.childyouth.2011.12.021

Loomis, A. M. (2018). The Role of Preschool as a Point of Intervention and Prevention for Trauma-Exposed Children: Recommendations for Practice, Policy, and Research. *Topics in Early Childhood Special Education*, *38*(3), 134–145. https://doi.org/10.1177/0271121418789254

Love, J. M., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., Brooks-Gunn, J., Chazan-Cohen, R., Tarullo, L. B., Brady-Smith, C., Fuligni, A. S., Schochet, P. Z., Paulsell, D., & Vogel, C. (2005). The Effectiveness of Early Head Start for 3-Year-Old Children and Their Parents: Lessons for Policy and Programs. *Developmental Psychology*, *41*(6). https://doi.org/10.1037/0012-1649.41.6.88

Lundy, M., & Grossman, S. R. (2005). The mental health and service needs of young children exposed to domestic violence: Supportive data. *Families in Society*, *86*(1). https://doi.org/10.1606/1044-3894.1873

Margolin, G., Gordis, E. B., Medina, A. M., & Oliver, P. H. (2003). The co-occurrence of husband-to-wife aggression, family-of-origin aggression, and child abuse potential in a community sample: Implications for parenting. *Journal of Interpersonal Violence*, *18*(4). https://doi.org/10.1177/0886260502250835

Masten, A. S., & Cicchetti, D. (2010). Developmental cascades. In *Development and Psychopathology* (Vol. 22, Issue 3). https://doi.org/10.1017/S0954579410000222

McDonald, R., Jouriles, E. N., Briggs-Gowan, M. J., Rosenfield, D., & Carter, A. S. (2007). Violence Toward a Family Member, Angry Adult Conflict, and Child Adjustment Difficulties: Relations in Families With 1- to 3-Year-Old Children. *Journal of Family Psychology*, *21*(2). https://doi.org/10.1037/0893-3200.21.2.176

McDonald, R., Jouriles, E. N., Ramisetty-Mikler, S., Caetano, R., & Green, C. E. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology*, *20*(1). https://doi.org/10.1037/0893-3200.20.1.137

Mortensen, J. A., & Barnett, M. A. (2016). The role of child care in supporting the emotion regulatory needs of maltreated infants and toddlers. *Children and Youth Services Review*, *64*, 73–81. https://doi.org/10.1016/j.childyouth.2016.03.004

National Network to End Domestic Violence (NNEDV) (2020). Domestic violence counts report: National executive summary. Retrieved at: https://nnedv.org/wp-content/uploads/2020/03/Library_Census_2019_national_summary.pdf

Owen, A. E., Thompson, M. P., Shaffer, A., Jackson, E. B., & Kaslow, N. J. (2009). Family variables that mediate the relation between intimate partner violence (IPV) and child adjustment. *Journal of Family Violence*, *24*(7). https://doi.org/10.1007/s10896-009-9239-2

Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Culkin, M. L., Howes, C., Kagan, S. L., & Yazejian, N. (2001). The relation of preschool child-care quality to children's cognitive and social developmental trajectories through second grade. *Child Development*, *72*(5). https://doi.org/10.1111/1467-8624.00364

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits." *Infant Mental Health Journal*, *16*(4). https://doi.org/10.1002/1097-0355(199524)16:4<271::AID-IMHJ2280160404>3.0.CO;2-B

Postmus, J. L., Plummer, S. B., McMahon, S., Murshid, N. S., & Kim, M. S. (2012). Understanding Economic Abuse in the Lives of Survivors. *Journal of Interpersonal Violence*, *27*(3), 411–430. https://doi.org/10.1177/0886260511421669

Postmus, J. L., Severson, M., Berry, M., & Yoo, J. A. (2009). Women's experiences of violence and seeking help. *Violence Against Women*, *15*(7), 852–868. https://doi.org/10.1177/1077801209334445

Rachidi, A. (2016). Child care assistance and nonstandard work schedules. *Children and Youth Services Review*, *65*. https://doi.org/10.1016/j.childyouth.2016.03.023

Raver, C. C., Blair, C., Garrett-Peters, P., Vernon-Feagans, L., Greenberg, M., Cox, M., Burchinal, P., Willoughby, M., Mills-Koonce, R., & Ittig, M. (2015). Poverty, household chaos, and interparental aggression predict children's ability to recognize and modulate negative emotions. *Development and Psychopathology*, *27*(3). https://doi.org/10.1017/S0954579414000935

Romano, E., Weegar, K., Gallitto, E., Zak, S., & Saini, M. (2021). Meta-analysis on interventions for children exposed to intimate partner violence. *Trauma, Violence, and Abuse, 22*(4). https://doi.org/10.1177/1524838019881737

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2015). *National Intimate Partner and Sexual Violence Survey: 2015 Data Brief-Update Release*. Atlanta, GA: National Center for Injury Prevention. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

Sturge-Apple, M. L., Davies, P. T., Cicchetti, D., & Manning, L. G. (2010). Mothers' parenting practices as explanatory mechanisms in associations between interparental violence and child adjustment. *Partner Abuse*, *1*(1). https://doi.org/10.1891/1946-6560.1.1.45

Tekin, E. (2021). An overview of the child care market in the United States [White paper]. National Bureau of Economic Research. https://www.nber.org/sites/default/files/2021-10/White%20Paper-Tekin-101.06.21_revised.pdf

Votruba-Drzal, Coley, R. L., & Chase-Lansdale, P. L. (2004). Child care and low-income childrens development: Direct and moderated effects. *Child Development*, *75*(1), 296–312. https://doi.org/10.1111/j.1467-8624.2004.00670.x

CHAPTER TWO

INTIMATE PARTNER VIOLENCE, CHILD CARE, AND CHILDREN'S BEHAVIORAL OUTCOMES

Background

Intimate partner violence (IPV) affects an estimated 16% of all children in the U.S. (Finkelhor et al., 2015; Smith et al., 2015). Very young children are more likely than older children to be at home and maintain close physical proximity to their mothers, placing them at higher risk for directly witnessing the abuse when it occurs (Fantuzzo & Fusco, 2007; Finkelhor et al., 2015; Levendosky et al., 2013). There are well-established links between early IPV exposure and negative developmental consequences for young children, and increasing studies have explored child, parent, and family characteristics that can moderate those associations, including children's cardiac reactivity, father contact, and parental acceptance (Cipriano et al., 2011; Hunter & Graham-Bermann, 2013; Tajima et al., 2011). Lacking is the evidence about protective features in children's extrafamilial environments that can potentially attenuate the relationships between early IPV exposure and adverse childhood outcomes. More than 60% of preschool age children in the U.S. are regularly cared for by non-parental caregivers (U.S. Census Bureau, 2013), and a growing literature shows the potential for non-parental child care (i.e., regular care provided by non-primary caregivers) to buffer the negative effects of early adversity on children's behavioral development (Berry et al., 2016; Giles et al., 2011; Herba et al., 2013). Yet, no studies to date have investigated the influences of child care

arrangements on behavioral outcomes for children exposed to IPV.

IPV and behavioral development. Among children exposed to violence, those aged 3–6 are at especially high risk for developing behavioral problems (Howell & Graham-Bermann, 2011; McDonald et al., 2007). Children's developing brains are particularly sensitive to stress, and trauma has well-documented deleterious effects when it occurs during early childhood due to young children's rapid emotional and physiological development, developmentally-based coping skills, and strong dependence on caregivers (Carpenter & Stacks, 2009; de Young et al., 2011; Lieberman, 2007). Early exposure to violence can dysregulate young children's stress physiology and lead to increased cortisol reactivity in toddlerhood, which is linked with childhood behavioral problems (Bair-Merritt et al., 2012; Hibel et al., 2011; Lopez-Duran et al., 2009). Emotion dysregulation, the inability to moderate negative emotions, is a related mechanism through which IPV can affect young children's behavioral functioning (Geffner et al., 2014; Grych et al., 2000). A number of studies have identified links between early IPV exposure and adverse behavioral outcomes during childhood. These include internalizing problems, such as heightened sensitivity to inter-adult conflict, anxiety, and depression, and externalizing problems, such as aggression and delinquency (DeJonghe et al., 2005, 2011; Graham-Bermann & Levendosky, 1998; Grych et al., 2000; Huang et al., 2015; Levendosky et al., 2002).

Possible protective role of child care. Young children who participate in non-parental child care spend fewer hours per day in their home environments and thus fewer hours with their maternal attachment figures. From this perspective, non-parental child

care may negatively influence children due to disrupted caregiver bonds (Belsky & Rovine, 1988). For children exposed to IPV, however, spending fewer hours per day in home environments where IPV occurs may decrease their direct exposure to abuse.

Further, studies have demonstrated possible harmful influences of IPV on parenting. The care of young children by an abusive parent can be detrimental, and in some cases dangerous. Research indicates that fathers who perpetrate IPV are typically authoritarian, neglectful, verbally abusive, and lack empathy toward their children (Cater & Forssell, 2014; Guille, 2004). In addition, perpetrators often use children to control, frighten and coerce their partners, or intentionally turn children against their mothers in order to retain control over the family unit (Beeble et al., 2007). Research findings relating to the influence of IPV on survivors' parenting are mixed, with some studies identifying positive effects on mothers' parenting effectiveness, more secure attachments to their children, and increased empathy and protectiveness (A. E. Austin et al., 2019; Levendosky et al., 2000, 2003). Other studies have shown IPV to undermine survivors' parenting. Mothers experiencing IPV have reported higher levels of stress and difficulty with routine caregiving responsibilities than non-victimized mothers (Graham-Bermann & Levendosky, 1998; Ybarra et al., 2007). Perpetrators may also impair survivor mothers' mental health and intentionally undermine their parenting practices and engagement, emotion regulation, and attachment bonds with children (Boeckel et al., 2017; Levendosky et al., 2006; Pico-Alfonso et al., 2006; Postmus et al., 2012; Tabb et al., 2018).

Numerous studies have documented the benefits of high quality non-parental

child care, including sensitive caregiving, stable routines, and fostering of emotion regulation and other forms of social and emotional development (M. Burchinal et al., 2008; Love et al., 2005; McCartney et al., 2007; Mortensen & Barnett, 2016; NICHD Early Child Care Research, 1998; Peisner-Feinberg et al., 2001; Phillips et al., 1987). These attributes closely align with key protective factors for children exposed to IPV, which include strong relationships with protective and responsive caregivers, consistency, and routines (David et al., 2015; Harding et al., 2013; Howell, 2011; Masten & Cicchetti, 2010; Sturge-Apple et al., 2010). It is therefore possible that in some cases, non-parental child care can directly compensate for developmental setbacks within this vulnerable population. Additionally, engagement in non-parental child care may indirectly support IPV exposed young children by relieving survivors' stress and improving their well-being—e.g., by granting survivors structured time to balance work and the urgent legal, medical, and mental health needs resulting from IPV victimization.

There is reason to believe that among non-parental care types, formal, and particularly center-based, child care may provide the most supportive environment for young children exposed to IPV. In general, the quality of formal, regulated child care in center-based and home-based settings tends to be higher than that of unregulated, informal care (Ha et al., 2017). Center-based care participation is associated with positive cognitive outcomes for children overall (Loeb et al., 2007). While findings pertaining specifically to children's behavioral outcomes have been mixed, center-based care is associated with positive behavioral outcomes for vulnerable groups, including low income and immigrant children and those residing with non-parental caregivers

(Brandon, 2004; Loeb et al., 2007; Votruba-Drzal et al., 2004; Yamauchi & Leigh, 2011).

Accumulating evidence suggests that formal child care experiences can buffer the negative effects of early adversity on young children's development (Berry et al., 2016; Giles et al., 2011; Herba et al., 2013). Berry and colleagues (2016) found that for children experiencing high levels of household chaos, greater hours of child care were positively related to more optimal social and cognitive outcomes. Two studies that focused on children's behavioral outcomes found that formal child care modified the effects of maternal depression on toddlers' internalizing and externalizing problems (Giles et al., 2011; Herba et al., 2013). In each of these analyses, researchers found that group-based child care had a more protective influence on toddlers with depressed mothers, compared to informal, in-home care. Taken together, these findings are of particular relevance given the strong associations between IPV and maternal depression, and the significant co-occurrence of household chaos and IPV (Kendall-Tackett, 2007; Raver et al., 2015).

Despite the potential benefits of non-parental child care for young children exposed to IPV, there is a striking paucity of studies exploring early care in the IPV context. Only one study to date has examined the protective influence of child care for children exposed to IPV. Kita and colleagues used data from a cross-sectional study of caregivers across Japan to examine relationships between child care arrangements and family outcomes among a sample of 884 Japanese parents of children aged 6 or younger (Kita et al., 2021). Using multiple-group structural equation modeling to examine families using, and not using, childcare services, the authors found that use of non-parental child care services was likely to buffer the negative impact of parents' IPV risk

on children's health-related quality of life and parents' depressive symptoms. Although findings provide the first evidence that child care may modify the negative effects of IPV on young children, the study did not use a direct measure of IPV (it assessed parents' risk for IPV based on self-reported relationship tension and difficulty), used a binary measure of child care that was not clearly defined, and was conducted in a context that differs from the U.S. with regard to IPV and child care.

No studies have examined the role of child care for children exposed to IPV in the U.S. context or examined how child care might influence behavioral outcomes for children exposed to IPV. This study addresses this knowledge gap and contributes to a growing literature that has identified non-parental child care as a potential buffer for early adversity.

Methods

Data and sample. This study uses four waves of longitudinal data from the Future of Families and Child Well Being Study (FFCWS), the only large-scale, longitudinal national dataset that includes in-depth information about children's early IPV experiences, child care involvement, and developmental outcomes. The FFCWS is a longitudinal cohort study of births in 20 large U.S. cities that oversamples low-income families (Reichman et al., 2001). Between 1998 and 2000, baseline interviews were conducted with 4,898 mothers of focal children at their time of birth. Follow-up mother surveys were conducted when children were approximately 1, 3, 5, 9, and 15 years old. At years 3 and 5, focal children were respectively 30 and 51 months old, on average. This study used data from the baseline wave and follow-up surveys at years 1, 3, and 5, which

3,675 mothers completed. Among them, 3,402 mothers lived with their child all or most of the time and responded to questions relating to IPV, child care arrangements, and children's behavioral problems. After excluding cases with missing data pertaining to other study variables, I retained an analytic sample comprising 3,108 mother-child dyads. Toward understanding the impact of missing data on results, I conducted supplementary analyses using multiple imputation by chained equations (MICE), with ten imputed datasets, to predict missing information for all predictor variables. These analyses and the complete case analyses produced very similar results.

Measures. ***IPV.*** IPV exposure was measured using 3 different indicators, all measured at year 3: (1) IPV frequency, (2) physical IPV, and (3) coercive IPV. Mother surveys at year 3 included 6 items relating to physically violent and coercive behaviors perpetrated by the child's father or current partner, irrespective of marital or cohabitation status (Lloyd, 2014; Straus et al., 1996). Three items comprised physical (including sexual) IPV: "He slaps or kicks you," "He hits you with his fist or a dangerous object," and "He tries to make you have sex or do sexual things you don't want to do." Items corresponding to coercive IPV were "He keeps you from seeing friends/family," "He prevents you from going to work/school," and "He withholds money, makes you ask for money, or takes your money." Mothers reported the frequency of perpetration by responding "often," "sometimes," or "never" to each of these items. First, as previous studies have suggested that higher frequency of IPV exposure is related to higher levels of child problems (Adhia et al., 2019; Garrido et al., 2011; Spilsbury et al., 2008), and have recommended against the continuous measure of IPV frequency (Straus et al.,

1996), a categorical variable was used to measure the frequency of IPV exposure. This variable includes three categories, denoting mothers who reported "never" experiencing these behaviors as *no IPV* (the reference category), "sometimes" (but never "often") experiencing one or more behaviors as *low frequency*, and "often" experiencing one or more behaviors as *high frequency* (Adhia et al., 2019). Informed by research pointing to distinct influences of physical and coercive IPV on children's behavioral outcomes (Grasso et al., 2016; Greene et al., 2018; Huang et al., 2015; McDonald et al., 2011; Renner & Boel-Studt, 2017), binary indicators representing the respective presence of physical and coercive IPV at year 3 were derived. These were measured as 1 if mothers responded either "sometimes" or "often" to one or more items of each measure.

Child care arrangement. Following measures used in prior studies that considered the quality and structural nature of child care (Ha et al., 2017; Johnson et al., 2011), a categorical measure of child care type that includes parental care (the reference category), informal home-based care, formal home-based care, and center-based care was constructed. At year 3, mothers were asked whether the focal child was currently being cared for by someone other than the mother or father and, if so, were asked to specify the primary arrangement, i.e., "where the child spends the most time." Care by family members was designated as informal home-based care; care by a "non-relative/family child care" as formal home-based care; and care at a "day care center" or "Head Start/Early Head Start" as formal center-based care.

Child behavioral outcomes. Children's internalizing behaviors were measured by the Anxious/Depressed and Withdrawn subscales of the Child Behavior Checklist

(CBCL) (Achenbach, 2004) administered to mothers at year 5 (α=0.77). Mothers provided scores for each of 23 items relating to children's anxious, depressed, and withdrawn behaviors. Children's externalizing problems were measured by the Aggressive and Destructive subscales of the CBCL, also administered to mothers at year 5 (α=0.85). Respondents provided scores for each of 29 items relating to children's aggressive and destructive behaviors, with individual item scores ranging from 0–2 (not true, somewhat/sometimes true, and very/often true). Based on clinical scoring guidelines and previous studies using FFCWS to examine child behavioral outcomes, the scores of all respective items were summed to measure children's IBP and EBP, respectively (Achenbach, 2004; Huang et al., 2010; Pilarz & Hill, 2017).

Covariates. A rich set of covariates that have been linked with IPV risk and children's internalizing and externalizing outcomes were used. Whenever possible, covariates were measured at the baseline wave, shortly following each child's birth. Mother characteristics measured at baseline included age, educational attainment (less than high school, high school or equivalent, some college or higher), self-reported race and ethnicity (white, black, Hispanic, other), immigration status, drug or alcohol use during pregnancy, and social support (0–3 scale). Mothers' depression, based on the Composite International Diagnostic Interview short form (CIDI-SF; Kessler et al., 1998), and parenting stress, derived from the Child Development Supplement of the Panel Study of Income Dynamics (PSID-CDS; Hofferth et al., 1997), were measured at year 1. Child characteristics measured at baseline were gender and low birth weight (under 2500g). Children's general health status (poor-fair, good-excellent) was measured at year 1.

Baseline household characteristics included household income, mother's relationship with the child's father (married or cohabitating, visiting, not romantically involved), and the number of children residing in the home.

Analytical Methods. Descriptive analyses were first conducted to examine the distribution of IPV occurrence, child care arrangements, children's IBP and EBP, and mother, child, and household characteristics. Next, Ordinary Least Squares regression (OLS) models were used to test the main effects of three measures of IPV and children's IBP and EBP, controlling for covariates. To examine whether child care arrangements modify the associations between IPV and child outcomes, interaction terms between the child care type (i.e., informal care, formal home-based care, and center-based care with parental care as a reference category) and the respective measure of IPV were included. The models examining IPV frequency included interaction terms between each child care type and level of IPV frequency (i.e., less frequent IPV and frequent IPV, with no IPV as a reference category). Analyses were conducted separately for each measure of IPV and each child outcome.

To understand the influences of IPV on behavioral problems for children in different primary care arrangements, and to further account for selection bias, subgroup analyses using inverse probability of treatment weighting (IPTW) were conducted. As OLS regression may be prone to biased estimates when there is inadequate covariate balance between treated and untreated groups, IPTW was used to be able to explicitly evaluate and obtain balance on each covariate, between children whose mothers who reported IPV and those whose mothers did not. Weighting subjects by the inverse

probability of treatment received and modifying the specification of the PS model to remove systematic differences between IPV and non-IPV exposed children in the sample created a synthetic sample in which IPV exposure was nearly independent of measured child, mother, and household characteristics (Austin & Stuart, 2015). Reflecting best practices for combining moderation analyses and PS methods (Green & Stuart, 2015), three separate IPTW models were estimated for children in parental care, home-based care, and center-based care. Because of relatively small sample sizes, formal and informal home-based care were combined into one category. Additionally, in the model examining physical IPV among children in home-based care, none of the 36 mothers identifying their race as "other" reported physical IPV. As this would have violated the overlap assumption, these 36 observations were omitted for this subgroup only. To evaluate and ensure accurate specifications of each model, and to correct observed differences in the characteristics between treatment (mothers with IPV) and control (mothers without IPV) groups in several models, conventional measures of balance were examined: weighted absolute standardized differences (these were nearly all below the standard of 0.1, and all below 0.2, in the final models) and the range of variance ratios for all continuous covariates (all were within the standard range of 0.75–1.25 in the final models) (Austin & Stuart, 2015).

In propensity score models, the inclusion of some variables associated with the outcome, in addition to potential confounders, can increase precision. For this reason, covariates representing children's gender and low birth weight were included in all IPTW analyses, and for the sake of consistency and interpretation, were also included in the

regression analyses. As a sensitivity test, OLS regression models that did not include children's gender or low birth weight were analyzed, and results were nearly identical. All analyses were conducted using Stata version 17 for Windows (StataCorp, College Station, TX).

Results

Table 2.1 presents mother, child and household characteristics of the full analytic sample (characteristics for the subgroups of children in parental, home-based, and center-based care can be found in Online Resource 1). At year 3, mothers of 900 (29.0%) children reported any IPV, 326 (10.5%) reported physical abuse, and 837 (26.9%) reported coercive abuse. Among those who experienced IPV, nearly 47% frequently experienced such abuse. With regard to primary child care arrangements at age 3, 39.9% of children were in their parents' care, 23.4% in informal care, 7.3% in formal home-based care, and 29.4% in center-based care. Mean child IBP and EBP scores at age 5 were 4.6 (*SD*=4.3) and 10.5 (*SD*=7.5), respectively.

There were significant main effects of each measure of IPV exposure, with the exception of less frequent IPV, compared with no IPV, on children's IBP and EBP (Table 2.2). As indicated by significant interaction terms, non-parental child care modified the respective associations between children's exposure to frequent, physical, and coercive IPV and their IBP scores. For children exposed to frequent IPV, all non-parental care types, compared with parental care, were significantly associated with decreased IBP scores. For children exposed to physical IPV, both informal and center-based care were significantly associated with decreased IBP scores (β=-1.4 [95% CI: -2.7, -0.1] and β=

-1.6 [95% CI: -2.8, -0.4], respectively), compared with parental care. Formal home-based care and center-based care significantly reduced the negative association between coercive IPV exposure and children's IBP scores (β=-1.8 [95% CI: -3.1, -0.4] and β=-1.0 [-1.8, -0.2], respectively).

There were also significant interaction effects between IPV and child care type, relating to children's EBP, were also found. For children exposed to frequent IPV, all non-parental care types, compared with parental care, were associated with decreased EBP scores. Center-based care, compared with parental care, was also significantly associated with decreased EBP scores for children exposed to physical IPV (β=-2.1 [95% CI: -4.1, 0.1]. For children exposed to coercive IPV, none of the non-parental care types were significantly associated with decreased EBP scores.

Subgroup analyses using IPTW (Table 2.3) confirmed the protective effects of home-based and, to a greater extent, center-based care. For children primarily in their parents' care, each measure of IPV, with the exception of less frequent IPV, was significantly associated with increased IBP and EBP scores. Among children in home-based care, only physical IPV was significantly associated with increased IBP, but exposure to less frequent (β =0.4 [95% CI: 0.4, 3.3]), physical (β =2.2 [95% CI: 0.8, 3.7]), and coercive (β =1.1 [95% CI: 0.1, 2.2]) IPV were significantly associated with increased EBP. For children in center-based care, exposure to IPV did not relate to any significant increases in either IBP or EBP.

Discussion

This study is the first to examine the influence of child care arrangements on the

relationships between early IPV exposure and children's behavioral outcomes. Consistent with previous research, these analyses find that early IPV exposure adversely affects children's behavioral development. Results also point to a protective influence of non-parental child care, particularly formal center-based care, during the preschool years. This study thus contributes to a growing literature that suggests non-parental child care can buffer some of the negative developmental effects of early high-risk contexts (Berry et al., 2016; Giles et al., 2011; Herba et al., 2013; Votruba-Drzal et al., 2004).

Findings supported the hypothesis that non-parental child care would modify the negative influences of IPV exposure on children's behavioral problems, particularly IBP. Both regression main effects and subgroup analyses indicated that for children who were primarily cared for by their parents, exposures to frequent, physical, and coercive IPV were significantly associated with increased internalizing and externalizing behavioral problems. However, non-parental care was shown to buffer some of these adverse influences of IPV exposure on children's subsequent behaviors. Notably, moderation analyses indicated that when IPV occurred frequently, all types of non-parental care significantly buffered the negative influences of children's exposure on both internalizing and externalizing behaviors. Approximately 45% of mothers experiencing frequent IPV reported both coercive and physical IPV victimization, compared with only 15% of mothers experiencing less frequent IPV. It is thus possible that the protective role of child care related to the interplay of IPV type and frequency that children witnessed. Overall, center-based care tended to provide the most expansive benefits for children exposed to IPV. Subgroup analyses using PS weights suggested that involvement in center-based

care was likely to shield children from the negative internalizing and externalizing behavioral effects of frequent, physical, and coercive IPV exposure. Home-based care, like center-based care, was found to attenuate the effects of IPV on IBP, and of frequent IPV on EBP, to the point of statistical non-significance.

Current findings may have bearing for survivor mothers as they make decisions about child care arrangements for their children and for advocates and agencies that work with families experiencing IPV. For instance, supporting survivor mothers' access to child care may be an important means to promote their children's well-being. In particular, high-quality child care settings that feature attributes such as sensitive caregiving, stability, consistent routines, and attention to young children's emotion regulation skills may critically support young children exposed to IPV. Center-based care has been linked with higher quality teacher-child interactions, compared with home-based care, possibly due to more stringent educational and training requirements for teachers and staff (Burchinal et al., 2002). However, home-based care settings might offer important benefits for children exposed to IPV, in addressing their possibly heightened needs for stable, responsive caregiving. At least two studies have found formal home-based care providers to have stronger attachment relationships with children in their care, compared with center-based providers (Ahnert et al., 2006; NICHD Early Child Care Research & Duncan, 2003). Children in home-based settings may also be less likely to experience instability caused by teacher and staff turnover, a more common feature of center-based settings. Although further studies are needed to understand the influences of informal home-based care, limited research suggests that relative caretakers

may impart a sense of family support and familiarity to the young children they care for (Lin & Wiley, 2017). Overall, it will be important to develop an understanding of the mechanisms by which different child care settings can protect children witnessing IPV.

Taken together, current findings lend support to the conceptualization of early child care settings as natural "systems of care"—environments with the potential to address multiple needs of trauma-exposed children and their families (Loomis, 2018). Recent years have seen the emergence of promising social-emotional curricula for early care settings, such as Paths (Domitrovich et al., 2007) and Incredible Years (Webster-Stratton et al., 2008), increasing use of trauma-informed professional development models for early childhood teachers, and the expansion of early childhood mental health consultation (ECMHC) (Bartlett & Smith, 2019). Child care centers in particular are poised to serve as a point of entry for identifying children's need for, and in some cases coordinating, trauma-responsive care and services (Osofsky & Lieberman, 2011). This role is perhaps more important in light of findings that, compared with their peers, young children of mothers with IPV histories are less likely to consistently attend pediatric visits where behavioral health screenings and referrals may take place (Bair-Merritt et al., 2008). In considering the indirect effects of IPV on children's well-being, supportive partnerships between child care providers and non-abusive parents may also support the needs of IPV exposed young children by promoting positive parenting behaviors and reducing parental stress (Klebanov & Brooks-Gunn, 2008; Mortensen & Barnett, 2016), and by connecting caregivers with parenting and other community-based resources to increase their well-being.

Findings should be interpreted in light of several limitations. First, the measure of children's exposure to IPV was based on mothers' reported experiences with IPV victimization and did not account for possible variations in children's direct exposure to abuse. Second, it is possible that mothers' experiences with IPV might have influenced their perceptions and reports of their children's IBP and EBP. Research has revealed that mothers' IPV related PTSD can interfere with reflective functioning—i.e., their ability to appraise their children's emotional expressions (Levendosky et al., 2012; Perizzolo Pointet et al., 2018). Although the FFCWS did not include information pertaining to maternal PTSD, I addressed this possibility by controlling for maternal depression and maternal parenting stress in all models. Third, care arrangements may also have influenced mothers' perceptions and reports of their children's behavioral outcomes, with mothers providing parental care likely spending more time observing and interacting with their children. Fourth, I addressed potential selection bias by including a comprehensive set of child, mother, and household related predictors in all regression models and by using IPTW models. However, it is still possible that these estimates are biased by unobserved confounders. Finally, while this study accounted for child care quality by differentiating among informal, formal home-based, and center-based care, it did not use established indices to measure the quality of child care settings or caregiver interactions.

Despite these limitations, this study has several important strengths. It used a rich, national dataset that includes detailed information pertaining to mothers' IPV experiences and child care use. This allowed me to measure IPV exposure in ways that accounted for different IPV types and levels of frequency. Additionally, I was able to differentiate the

modifying effects of various care types on relationships between early IPV exposure and children's behavioral problems. While an extensive literature has examined the benefits of center-based child care for children, few studies have explored the role of informal relative care or formal home-based care (Lin & Wiley, 2017). Last, employing PS techniques allowed me to evaluate and attend to systematic differences between IPV and non-IPV exposed children in the sample.

Conclusion

Experiences during early childhood have far-reaching consequences. This study suggests that utilization of non-parental child care, particularly center-based care, can mitigate the harmful influences of IPV exposure on young children's internalizing and externalizing behaviors. Findings align with previous studies that have found buffering effects of child care on the relationships between early adversity and children's developmental outcomes. In light of current findings that informal, formal home-based, and center-based care differentially interacted with IPV to predict children's behavioral outcomes, future research is needed to develop a more nuanced understanding of the mechanisms by which child care benefits children exposed to IPV—for instance, different dimensions of quality, and the dosage of non-parental child care use.

References

Achenbach, T. M. (2004). Manual for the child: Behavior checklist and revised child behavior profile. *Encyclopedia of Psychology, Vol. 2.*, *8*.

Adhia, A., Drolette, L. M., vander Stoep, A., Valencia, E. J., & Kernic, M. A. (2019). The impact of exposure to parental intimate partner violence on adolescent precocious transitions to adulthood. *Journal of Adolescence*, *77*. https://doi.org/10.1016/j.adolescence.2019.11.001

Ahnert, L., Pinquart, M., & Lamb, M. E. (2006). Security of children's relationships with nonparental care providers: A meta-analysis. *Child Development*, *77*(3), 664–679. https://doi.org/10.1111/j.1467-8624.2006.00896.x

Austin, A. E., Shanahan, M. E., Barrios, Y. v., & Macy, R. J. (2019). A Systematic Review of Interventions for Women Parenting in the Context of Intimate Partner Violence. *Trauma, Violence, and Abuse*, *20*(4), 498–519. https://doi.org/10.1177/1524838017719233

Austin, P. C., & Stuart, E. A. (2015). Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. *Statistics in Medicine*, *34*(28), 3661–3679. https://doi.org/10.1002/sim.6607

Bair-Merritt, M. H., Crowne, S. S., Burrell, L., Caldera, D., Cheng, T. L., & Dugqan, A. K. (2008). Impact of intimate partner violence on children's well-child care and medical home. *Pediatrics*, *121*(3). https://doi.org/10.1542/peds.2007-1671

Bair-Merritt, M. H., Johnson, S. B., Okelo, S., & Page, G. (2012). Intimate partner violence exposure, salivary cortisol, and childhood asthma. *Child Abuse and Neglect*, *36*(7–8). https://doi.org/10.1016/j.chiabu.2011.12.002

Bartlett, J. D., & Smith, S. (2019). The role of early care and education in addressing early childhood trauma. *American Journal of Community Psychology*, *64*(3–4). https://doi.org/10.1002/ajcp.12380

Beeble, M. L., Bybee, D., & Sullivan, C. M. (2007). Abusive men's use of children to control their partners and ex-partners. *European Psychologist*, *12*(1). https://doi.org/10.1027/1016-9040.12.1.54

Belsky, J., & Rovine, M. J. (1988). Nonmaternal care in the first year of life and the security of infant-parent attachment. *Child Development*, *59*(1). https://doi.org/10.1111/j.1467-8624.1988.tb03203.x

Berry, D., Blair, C., Willoughby, M., Garrett-Peters, P., Vernon-Feagans, L., Mills-Koonce, W. R., Cox, M., Burchinal, P., Burton, L., Crnic, K., Crouter, A., Greenberg, M., Lanza, S., & Werner, E. (2016). Household chaos and children's cognitive and socio-emotional development in early childhood: Does childcare play a buffering role? *Early Childhood Research Quarterly*, *34*, 115–127. https://doi.org/10.1016/j.ecresq.2015.09.003

Boeckel, M. G., Wagner, A., & Grassi-Oliveira, R. (2017). The Effects of Intimate Partner Violence Exposure on the Maternal Bond and PTSD Symptoms of Children. *Journal of Interpersonal Violence*, *32*(7). https://doi.org/10.1177/0886260515587667

Brandon, P. D. (2004). The child care arrangements of preschool-age children in immigrant families in the United States. *International Migration*, *42*(1). https://doi.org/10.1111/j.0020-7985.2004.00274.x

Burchinal, M., Howes, C., Pianta, R., Bryant, D., Early, D., Clifford, R., & Barbarin, O. (2008). Predicting child outcomes at the end of kindergarten from the quality of pre-kindergarten teacher-child interactions and instruction. *Applied Developmental Science*, *12*(3). https://doi.org/10.1080/10888690802199418

Burchinal, M. R., Cryer, D., Clifford, R. M., & Howes, C. (2002). Caregiver training and classroom quality in child care centers. *Applied Developmental Science*, *6*(1). https://doi.org/10.1207/S1532480XADS0601_01

Carpenter, G. L., & Stacks, A. M. (2009). Developmental effects of exposure to Intimate Partner Violence in early childhood: A review of the literature. *Children and Youth Services Review*, *31*(8), 831–839. https://doi.org/10.1016/j.childyouth.2009.03.005

Cater, Å., & Forssell, A. M. (2014). Descriptions of fathers' care by children exposed to intimate partner violence (IPV) - relative neglect and children's needs. *Child and Family Social Work*, *19*(2). https://doi.org/10.1111/j.1365-2206.2012.00892.x

Cipriano, E. A., Skowron, E. A., & Gatzke-Kopp, L. M. (2011). Preschool children's cardiac reactivity moderates relations between exposure to family violence and emotional adjustment. In *Child Maltreatment* (Vol. 16, Issue 3). https://doi.org/10.1177/1077559511408887

David, K. B., LeBlanc, M. M., & Self-Brown, S. (2015). Violence Exposure in Young Children: Child-Oriented Routines as a Protective Factor for School Readiness. *Journal of Family Violence*, *30*(3), 303–314. https://doi.org/10.1007/s10896-015-9676-z

DeJonghe, E. S., Bogat, G. A., Levendosky, A. A., Von Eye, A., & Davidson, W. S. (2005). Infant exposure to domestic violence predicts heightened sensitivity to adult

verbal conflict. *Infant Mental Health Journal*, *26*(3). https://doi.org/10.1002/imhj.20048

DeJonghe, E. S., von Eye, A., Bogat, G. A., & Levendosky, A. A. (2011). Does witnessing intimate partner violence contribute to toddlers' internalizing and externalizing behaviors? *Applied Developmental Science*, *15*(3), 129–139. https://doi.org/10.1080/10888691.2011.587713

de Young, A. C., Kenardy, J. A., & Cobham, V. E. (2011). Trauma in Early Childhood: A Neglected Population. *Clinical Child and Family Psychology Review*, *14*(3), 231–250. https://doi.org/10.1007/s10567-011-0094-3

Domitrovich, C. E., Cortes, R. C., & Greenberg, M. T. (2007). Improving young children's social and emotional competence: A randomized trial of the preschool "PATHS" curriculum. *Journal of Primary Prevention*, *28*(2). https://doi.org/10.1007/s10935-007-0081-0

Fantuzzo, J. W., & Fusco, R. A. (2007). Children's direct exposure to types of domestic violence crime: A population-based investigation. *Journal of Family Violence*, *22*(7), 543–552. https://doi.org/10.1007/s10896-007-9105-z

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of Childhood Exposure to Violence, Crime, and Abuse. *JAMA Pediatrics*, *169*(8). https://doi.org/10.1001/jamapediatrics.2015.0676

Garrido, E. F., Culhane, S. E., Petrenko, C. L. M., & Taussig, H. N. (2011). Psychosocial Consequences of Intimate Partner Violence (IPV) Exposure in Maltreated Adolescents: Assessing More than IPV Occurrence. *Journal of Family Violence*, *26*(7). https://doi.org/10.1007/s10896-011-9386-0

Geffner, R. A., Igelman, R. S., & Zellner, J. (2014). The effects of intimate partner violence on children. *The Effects of Intimate Partner Violence on Children*, 1–308. https://doi.org/10.4324/9781315044026

Giles, L. C., Davies, M. J., Whitrow, M. J., Warin, M. J., & Moore, V. (2011). Maternal depressive symptoms and child care during toddlerhood relate to child behavior at age 5 years. *Pediatrics*, *128*(1). https://doi.org/10.1542/peds.2010-3119

Graham-Bermann, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence*, *13*(1). https://doi.org/10.1177/088626098013001007

Grasso, D. J., Henry, D., Kestler, J., Nieto, R., Wakschlag, L. S., & Briggs-Gowan, M. J. (2016). Harsh Parenting As a Potential Mediator of the Association Between Intimate Partner Violence and Child Disruptive Behavior in Families With Young Children.

Journal of Interpersonal Violence, *31*(11). https://doi.org/10.1177/0886260515572472

Greene, C. A., Chan, G., McCarthy, K. J., Wakschlag, L. S., & Briggs-Gowan, M. J. (2018). Psychological and physical intimate partner violence and young children's mental health: The role of maternal posttraumatic stress symptoms and parenting behaviors. *Child Abuse and Neglect*, *77*. https://doi.org/10.1016/j.chiabu.2018.01.012

Green, K. M., & Stuart, E. A. (2015). *Examining Moderation Analyses in Propensity Score Methods: Application to Depression and Substance Use*. *82*(5), 773–783. https://doi.org/10.1037/a0036515.Examining

Grych, J. H., Jouriles, E. N., Swank, P. R., McDonald, R., & Norwood, W. D. (2000). Patterns of adjustment among children of battered women. *Journal of Consulting and Clinical Psychology*, *68*(1). https://doi.org/10.1037/0022-006X.68.1.84

Guille, L. (2004). Men who batter and their children: An integrated review. In *Aggression and Violent Behavior* (Vol. 9, Issue 2). https://doi.org/10.1016/S1359-1789(02)00119-2

Harding, H. G., Morelen, D., Thomassin, K., Bradbury, L., & Shaffer, A. (2013). Exposure to Maternal- and Paternal-Perpetrated Intimate Partner Violence, Emotion Regulation, and Child Outcomes. *Journal of Family Violence*, *28*(1). https://doi.org/10.1007/s10896-012-9487-4

Ha, Y., Ybarra, M., & Johnson, A. D. (2017). Variation in early cognitive development by maternal immigrant documentation status. *Early Childhood Research Quarterly*, *41*(August), 184–195. https://doi.org/10.1016/j.ecresq.2017.07.006

Herba, C. M., Tremblay, R. E., Boivin, M., Liu, X., Mongeau, C., Séguin, J. R., & Coté, S. M. (2013). Maternal depressive symptoms and children's emotional problems can early child care help children of depressed mothers? *JAMA Psychiatry*, *70*(8), 830–838. https://doi.org/10.1001/jamapsychiatry.2013.1361

Heru, A. M., Stuart, G. L., Rainey, S., Eyre, J., & Recupero, P. R. (2006). Prevalence and severity of intimate partner violence and associations with family functioning and alcohol abuse in psychiatric inpatients with suicidal intent. *Journal of Clinical Psychiatry*, *67*(1). https://doi.org/10.4088/JCP.v67n0104

Hibel, L. C., Granger, D. A., Blair, C., & Cox, M. J. (2011). Maternal sensitivity buffers the adrenocortical implications of intimate partner violence exposure during early childhood. *Development and Psychopathology*, *23*(2). https://doi.org/10.1017/S0954579411000010

Hofferth, S., Davis-Kean, P. E., Davis, J., & Finkelstein, J. (1997). The Child Development Supplement to the Panel Study of Income Dynamics: 1997 User Guide. *Survey Research Center, Institute for Social Research*.

Howell, K. H. (2011). Resilience and psychopathology in children exposed to family violence. *Aggression and Violent Behavior*, *16*(6), 562–569. https://doi.org/10.1016/j.avb.2011.09.001

Howell, K. H., & Graham-Bermann, S. A. (2011). The multiple impacts of intimate partner violence on preschool children. *How Intimate Partner Violence Affects Children: Developmental Research, Case Studies, and Evidence-Based Intervention.*, 87–107. https://doi.org/10.1037/12322-005

Huang, C. C., Vikse, J. H., Lu, S., & Yi, S. (2015). Children's Exposure to Intimate Partner Violence and Early Delinquency. *Journal of Family Violence*, *30*(8), 953–965. https://doi.org/10.1007/s10896-015-9727-5

Huang, C. C., Wang, L. R., & Warrener, C. (2010). Effects of domestic violence on behavior problems of preschool-aged children: Do maternal mental health and parenting mediate the effects? *Children and Youth Services Review*, *32*(10), 1317–1323. https://doi.org/10.1016/j.childyouth.2010.04.024

Hunter, E. C., & Graham-Bermann, S. A. (2013). Intimate Partner Violence and Child Adjustment: Moderation by Father Contact? *Journal of Family Violence*, *28*(5). https://doi.org/10.1007/s10896-013-9517-x

Johnson, A. D., Martin, A., & Brooks-Gunn, J. (2011). Who uses child care subsidies? Comparing recipients to eligible non-recipients on family background characteristics and child care preferences. *Children and Youth Services Review*, *33*(7), 1072–1083. https://doi.org/10.1016/j.childyouth.2011.01.014

Kendall-Tackett, K. A. (2007). Violence against women and the perinatal period: The impact of lifetime violence and abuse on pregnancy, postpartum, and breastfeeding. *Trauma, Violence, and Abuse*, *8*(3). https://doi.org/10.1177/1524838007304406

Kessler, R. C., Andrews, G., Mroczek, D., Ustun, B., & Wittchen, H.-U. (1998). The World Health Organization Composite International Diagnostic Interview short-form (CIDI-SF). *International Journal of Methods in Psychiatric Research*, *7*(4). https://doi.org/10.1002/mpr.47

Kita, S., Sato, I., Sakka, M., Soejima, T., & Kamibeppu, K. (2021). Does the Use of Childcare Services Reduce the Impact of Intimate Partner Violence on the Quality of Life of Children?: Multiple-Group Structural Equation Modeling. *Applied Research in Quality of Life*, *16*(5). https://doi.org/10.1007/s11482-020-09847-w

Klebanov, P. K., & Brooks-Gunn, J. (2008). Differential exposure to early childhood education services and mother-toddler interaction. *Early Childhood Research Quarterly*, *23*(2). https://doi.org/10.1016/j.ecresq.2007.12.001

Levendosky, A. A., Bogat, G. A., & Martinez-Torteya, C. (2013). PTSD Symptoms in Young Children Exposed to Intimate Partner Violence. *Violence Against Women*, *19*(2), 187–201. https://doi.org/10.1177/1077801213476458

Levendosky, A. A., Huth-Bocks, A. C., Semel, M. A., & Shapiro, D. L. (2002). Trauma Symptoms in Preschool-Age Children. *Children*, *17*(2), 150–164.

Levendosky, A. A., Huth-Bocks, A. C., Shapiro, D. L., & Semel, M. A. (2003). The Impact of Domestic Violence on the Maternal - Child Relationship and Preschool-Age Children's Functioning. *Journal of Family Psychology*, *17*(3). https://doi.org/10.1037/0893-3200.17.3.275

Levendosky, A. A., Lannert, B., & Yalch, M. (2012). The effects of intimate partner violence on women and child survivors: An attachment perspective. *Psychodynamic Psychiatry*, *40*(3), 397–434. https://doi.org/10.1521/pdps.2012.40.3.397

Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davidson, W. S., & Von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology*, *20*(4). https://doi.org/10.1037/0893-3200.20.4.544

Levendosky, A. A., Lynch, S. M., & Graham-Bermann, S. A. (2000). Mothers' perceptions of the impact of woman abuse on their parenting. *Violence Against Woman*, *6*(3). https://doi.org/10.1177/10778010022181831

Lieberman, A. F. (2007). Ghosts and angels: Intergenerational patterns in the transmission and treatment of the traumatic sequelae of domestic violence. *Infant Mental Health Journal*, *28*(4), 422–439. https://doi.org/10.1002/imhj.20145

Lin, C. H., & Wiley, A. R. (2017). The relationship of relative child care and parenting behaviors in fragile families. *Children and Youth Services Review*, *82*(July), 130–138. https://doi.org/10.1016/j.childyouth.2017.09.022

Lloyd, S. (2014). Physical Aggression, Distress, and Everyday Marital Interaction. In *Family Violence from a Communication Perspective*. https://doi.org/10.4135/9781483327556.n9

Loeb, S., Bridges, M., Bassok, D., Fuller, B., & Rumberger, R. W. (2007). How much is too much? The influence of preschool centers on children's social and cognitive development. *Economics of Education Review*, *26*(1), 52–66. https://doi.org/10.1016/j.econedurev.2005.11.005

Loomis, A. M. (2018). The Role of Preschool as a Point of Intervention and Prevention for Trauma-Exposed Children: Recommendations for Practice, Policy, and Research. *Topics in Early Childhood Special Education*, *38*(3), 134–145. https://doi.org/10.1177/0271121418789254

Lopez-Duran, N. L., Olson, S. L., Hajal, N. J., Felt, B. T., & Vazquez, D. M. (2009). Hypothalamic pituitary adrenal axis functioning in reactive and proactive aggression in children. *Journal of Abnormal Child Psychology*, *37*(2). https://doi.org/10.1007/s10802-008-9263-3

Love, J. M., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., Brooks-Gunn, J., Chazan-Cohen, R., Tarullo, L. B., Brady-Smith, C., Fuligni, A. S., Schochet, P. Z., Paulsell, D., & Vogel, C. (2005). The Effectiveness of Early Head Start for 3-Year-Old Children and Their Parents: Lessons for Policy and Programs. *Developmental Psychology*, *41*(6). https://doi.org/10.1037/0012-1649.41.6.88

Masten, A. S., & Cicchetti, D. (2010). Developmental cascades. In *Development and Psychopathology* (Vol. 22, Issue 3). https://doi.org/10.1017/S0954579410000222

McCartney, K., Dearing, E., Taylor, B. A., & Bub, K. L. (2007). Quality child care supports the achievement of low-income children: Direct and indirect pathways through caregiving and the home environment. *Journal of Applied Developmental Psychology*, *28*(5–6), 411–426. https://doi.org/10.1016/j.appdev.2007.06.010

McDonald, R., Jouriles, E. N., Briggs-Gowan, M. J., Rosenfield, D., & Carter, A. S. (2007). Violence Toward a Family Member, Angry Adult Conflict, and Child Adjustment Difficulties: Relations in Families With 1- to 3-Year-Old Children. *Journal of Family Psychology*, *21*(2). https://doi.org/10.1037/0893-3200.21.2.176

McDonald, R., Jouriles, E. N., & Minze, L. C. (2011). Interventions for young children exposed to intimate partner violence. *How Intimate Partner Violence Affects Children: Developmental Research, Case Studies, and Evidence-Based Intervention.*, 109–131. https://doi.org/10.1037/12322-006

Mortensen, J. A., & Barnett, M. A. (2016). The role of child care in supporting the emotion regulatory needs of maltreated infants and toddlers. *Children and Youth Services Review*, *64*, 73–81. https://doi.org/10.1016/j.childyouth.2016.03.004

NICHD Early Child Care Research. (1998). Early Child Care and Self-Control, Compliance, and Problem Behavior at Twenty-Four and Thirty-Six Months: The NICHD Early Child Care Research Network. *Child Development*, *69*(4), 1145–1170. https://doi.org/10.1111/j.1467-8624.1998.tb06165.x

NICHD Early Child Care Research, & Duncan, G. (2003). Modeling the Impacts of Child Care Quality on Children's Preschool Cognitive Development. *Child Development*, *74*(5), 1454–1475. https://doi.org/10.1111/1467-8624.00617

Osofsky, J. D., & Lieberman, A. F. (2011). A call for integrating a mental health perspective into systems of care for abused and neglected infants and young children. *American Psychologist*, *66*(2). https://doi.org/10.1037/a0021630

Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Culkin, M. L., Howes, C., Kagan, S. L., & Yazejian, N. (2001). The relation of preschool child-care quality to children's cognitive and social developmental trajectories through second grade. *Child Development*, *72*(5). https://doi.org/10.1111/1467-8624.00364

Perizzolo Pointet, V. C., Moser, D. A., Suardi, F., Rothenberg, M., Serpa, S. R., & Schechter, D. S. (2018). *Maternal Trauma and Related Psychopathology: Consequences to Parental Brain Functioning Associated with Caregiving*. https://doi.org/10.1007/978-3-319-65724-0_7

Phillips, D., McCartney, K., & Scarr, S. (1987). Child-Care Quality and Children's Social Development. *Developmental Psychology*, *23*(4). https://doi.org/10.1037/0012-1649.23.4.537

Pico-Alfonso, Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúúa, E., & Martinez, M. (2006). The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide. *Journal of Women's Health*, *15*(5), 599–611. https://doi.org/10.1089/jwh.2006.15.599

Pilarz, A. R., & Hill, H. D. (2017). Child-Care Instability and Behavior Problems: Does Parenting Stress Mediate the Relationship? *Journal of Marriage and Family*, *79*(5), 1353–1368. https://doi.org/10.1111/jomf.12420

Postmus, J. L., Huang, C. C., & Mathisen-Stylianou, A. (2012). The impact of physical and economic abuse on maternal mental health and parenting. *Children and Youth Services Review*, *34*(9). https://doi.org/10.1016/j.childyouth.2012.06.005

Raver, C. C., Blair, C., Garrett-Peters, P., Vernon-Feagans, L., Greenberg, M., Cox, M., Burchinal, P., Willoughby, M., Mills-Koonce, R., & Ittig, M. (2015). Poverty, household chaos, and interparental aggression predict children's ability to recognize and modulate negative emotions. *Development and Psychopathology*, *27*(3). https://doi.org/10.1017/S0954579414000935

Reichman, N. E., Teitler, J. O., Garfinkel, I., & McLanahan, S. S. (2001). Fragile Families: Sample and Design. *Children and Youth Services Review*, *23*(4–5). https://doi.org/10.1016/S0190-7409(01)00141-4

Renner, L. M., & Boel-Studt, S. (2017). Physical family violence and externalizing and internalizing behaviors among children and adolescents. *American Journal of Orthopsychiatry*, *87*(4). https://doi.org/10.1037/ort0000260

Smith, S. G., Chen, J., Basile, K. C., et al. (2017). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010–2012 State Report*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Spilsbury, J. C., Kahana, S., Drotar, D., Creeden, R., Flannery, D. J., & Friedman, S. (2008). Profiles of behavioral problems in children who witness domestic violence. *Violence and Victims*, *23*(1). https://doi.org/10.1891/0886-6708.23.1.3

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised conflict tactics scales (CTS2) development and preliminary psychometric data. *Journal of Family Issues*, *17*(3). https://doi.org/10.1177/019251396017003001

Sturge-Apple, M. L., Davies, P. T., Cicchetti, D., & Manning, L. G. (2010). Mothers' Parenting Practices as Explanatory Mechanisms in Associations Between Interparental Violence and Child Adjustment. *Partner Abuse*, *1*(1). https://doi.org/10.1891/1946-6560.1.1.45

Tabb, K. M., Huang, H., Valdovinos, M., Toor, R., Ostler, T., Vanderwater, E., Wang, Y., Menezes, P. R., & Faisal-Cury, A. (2018). Intimate Partner Violence Is Associated with Suicidality among Low-Income Postpartum Women. *Journal of Women's Health*, *27*(2). https://doi.org/10.1089/jwh.2016.6077

Tajima, E. A., Herrenkohl, T. I., Moylan, C. A., & Derr, A. S. (2011). Moderating the effects of childhood exposure to intimate partner violence: The roles of parenting characteristics and adolescent peer support. *Journal of Research on Adolescence*, *21*(2). https://doi.org/10.1111/j.1532-7795.2010.00676.x

U.S. Census Bureau. (2013). *Who's Minding the Kids? Child Care Arrangements: Spring 2011* (P70-135). Retrieved from https://www.census.gov/library/publications/2013/demo/p70-135.html

Votruba-Drzal, E., Coley, R. L., & Chase-Lansdale, P. L. (2004). Child Care and Low-Income Children's Development: Direct and Moderated Effects. *Child Development*, *75*(1), 296–312. https://doi.org/10.1111/j.1467-8624.2004.00670.x

Webster-Stratton, C., Jamila Reid, M., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years Teacher and Child Training Programs in high-risk schools. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *49*(5). https://doi.org/10.1111/j.1469-7610.2007.01861.x

Yamauchi, C., & Leigh, A. (2011). Which children benefit from non-parental care? *Economics of Education Review*, *30*(6), 1468–1490. https://doi.org/10.1016/j.econedurev.2011.07.012

Ybarra, G. J., Wilkens, S. L., & Lieberman, A. F. (2007). The influence of domestic violence on preschooler behavior and functioning. *Journal of Family Violence*, *22*(1). https://doi.org/10.1007/s10896-006-9054-y

Table 2.1: Sample Characteristics, N=3,108

	n	%
Intimate Partner Violence (IPV) (Year 3)		
IPV Frequency		
Never	2,208	71.0
Less Frequent	479	15.4
Frequent	421	13.6
Physical IPV	326	10.5
Slapped or kicked you	234	7.5
Hit you with fist or object	183	5.9
Made you have sex or do sexual things against your will	172	5.5
Coercive IPV	837	26.9
Keeps you from seeing friends/family	580	18.7
Prevents you from going to work/school	314	10.1
Withholds money, makes you ask for money, takes money	455	14.6
Child care arrangement (Year 3)		
Parental care	1,240	39.9
Informal home-based care	726	23.4
Formal home-based care	228	7.3
Center-based care	914	29.4
Child internalizing score (Year 5), mean (SD)	4.6 (4.3)	
Child externalizing score (Year 5), mean (SD)	10.5 (7.5)	
Mother characteristics (Baseline)		
Age, mean (SD)	25.1 (6.0)	
Education		
Less than high school	976	31.4
High school or equivalent	967	31.1
Some college or higher	1,165	37.5
Race/Ethnicity		
White	708	22.8
Black	1,540	50.0
Hispanic	754	24.3
Other	106	3.4
Country of Origin		
U.S. born	2,703	87.0
Foreign born	405	13.0
Mother social support (0-3 scale), mean (SD)	2.8 (0.7)	
Drug or alcohol use during pregnancy	369	11.9
Mother meets depression diagnostic criteria (Year 1)	485	15.6
Parental stress (Year 1)		
Low	1,527	49.1
High	1,581	50.9
Child characteristics (Baseline)		
Sex, n		
Female	1,497	48.2
Male	1,611	51.8
First born, n	1,207	38.8

Low birth weight, n	290	9.3
General health status (Year 1)		
Poor-fair	369	11.9
Good-excellent	2,739	88.1
Household characteristics (Baseline)		
Mother's relationship with biological father		
Married/cohabitating	1,894	60.9
Visiting	837	26.9
Not romantically involved	377	12.1
Number of children in the household, mean (SD)	1.3 (1.3)	
Household income, mean (SD)	33,779.7 (32,257.2)	

Table 2.2: Moderating Role of Child Care on the Relationship between Exposure to IPV and Child Behavioral Outcomes

	Internalizing Behavioral Problems (IBP)		Externalizing Behavioral Problems (EBP)	
	B	95% CI	B	95% CI
Model 1. Exposure to IPV				
Main effects:				
IPV frequency (vs. no IPV)				
Less frequent IPV (vs. no IPV)	0.5	[-0.2, 1.2]	0.7	[-0.5, 1.8]
Frequent IPV (vs. no IPV)	1.6***	[0.9, 2.4]	2.8***	[1.6, 4.1]
Child care type (vs. parental care)				
Informal care	-0.1	[-0.6, 0.4]	-0.1	[-0.9, 0.7]
Formal home-based care	0.2	[-0.5, 0.9]	0.9	[-0.3, 2.1]
Center-based care	-0.2	[-0.7, 0.2]	0.6	[-0.2, 1.3]
Interaction effects				
Less frequent IPV x Informal care	0.4	[-0.7, 1.5]	1.3	[-0.6, 3.2]
Less frequent IPV x Formal home-based care	-0.5	[-2.2, 1.2]	-0.6	[-3.6, 2.4]
Less frequent IPV x Center-based care	-0.1	[-1.1, 0.9]	0.2	[-1.5, 2.0]
Frequent IPV x Informal care	-1.8**	[-2.9, -0.6]	-2.0*	[-4.0, -0.1]
Frequent IPV x Formal home-based care	-2.8**	[-4.6, -1.0]	-3.8*	[-6.9, -0.7]
Frequent IPV x Center-based care	-1.9***	[-2.9, -0.8]	-1.9*	[-3.7, -0.1]
Model 2. Exposure to Physical IPV				
Main effects:				
Physical IPV (vs. no physical IPV)	1.5***	[0.7, 2.3]	2.7***	[1.3, 4.1]
Child care type (vs. parental care)				
Informal care	-0.1	[-0.5, 0.3]	0.0	[-0.7, 0.7]
Formal home-based care	-0.2	[-0.8, 0.5]	-0.6	[-0.5, 1.7]
Center-based care	-0.3	[-0.7, 0.1]	0.7	[-0.0, 1.3]
Interaction effects				
Physical IPV x Informal care	-1.4*	[-2.7, -0.1]	-1.0	[-3.1, 1.2]
Physical IPV x Formal home-based care	-0.6	[-2.5, 1.3]	-2.3	[-5.6, 0.9]
Physical IPV x Center-based care	-1.6**	[-2.8, -0.4]	-2.1*	[-4.1, -0.1]
Model 3. Exposure to Coercive IPV				
Main effects:				
Coercive IPV (vs. no coercive IPV)	1.0***	[0.4, 1.5]	1.4**	[0.5, 2.3]
Child care type (vs. parental care)				
Informal care	-0.1	[-0.5, 0.4]	0.0	[-0.8, 0.8]
Formal home-based care	0.2	[-0.5, 0.9]	0.9	[-0.3, 2.1]
Center-based care	-0.2	[-0.7, 0.2]	0.6	[-0.2, 1.3]
Interaction effects:				
Coercive IPV x Informal care	-0.7	[-1.5, 0.2]	-0.5	[-2.0, 1.0]
Coercive IPV x Formal home-based care	-1.8*	[-3.1, -0.4]	-2.1	[-4.5, 0.3]
Coercive IPV x Center-based care	-1.0*	[-1.8, -0.2]	-0.7	[-2.1, 0.7]

Note. IPV = intimate partner violence.
*** p<0.001, ** p<0.01, * p<0.05

Table 2.3: Average Treatment Effects of IPV by Child Care Type Using IPTW

	Parental Care		Home-based Care		Center-based Care	
	IBP	EBP	IBP	EBP	IBP	EBP
	B [95% CI]	B [95% CI]	B [95% CI]	B [95% CI]	B [95% CI]	B [95% CI]
IPV Frequency (vs. no IPV):						
Low frequency IPV	0.6 [-0.2, 1.3]	0.7 [-0.5, 1.9]	0.6 [-0.2, 1.4]	1.8* [0.4, 3.3]	0.3 [-0.4, 1.0]	0.8 [-0.5, 2.0]
High frequency IPV	1.2* [0.3, 2.1]	2.6** [1.0, 4.2]	-0.0 [-0.7, 0.7]	0.8 [-0.4, 2.0]	-0.2 [-0.8, 0.5]	1.3 [-0.4, 2.9]
Physical IPV (vs. no physical IPV)[a]	1.5** [0.6, 2.3]	3.8*** [2.1, 5.5]	0.6 [-0.1, 1.3]	2.2** [0.8, 3.7]	-0.0 [-0.7, 0.7]	0.5 [-0.8, 1.8]
Coercive IPV (vs. no coercive IPV)	0.8** [0.2, 1.4]	1.4** [0.4, 2.5]	0.2 [-0.5, 0.8]	1.1* [0.1, 2.2]	0.1 [-0.4, 0.7]	0.7 [-0.4, 1.9]

Notes. IPV = intimate partner violence. IPTW = inverse probability of treatment weighting.
[a] Model examining home-based care subgroup excludes 36 observations that violate the overlap assumption.
*** p<0.001, ** p<0.01, * p<0.05

Table 2.4: Sample Characteristics by Child Care Arrangement Type

	Parental Care (N=1,240)		*Home-Based Care (N=954)*		*Center-Based Care (N=914)*	
	n	%	n	%	n	%
Intimate Partner Violence (IPV) (Year 3)						
IPV Frequency						
Never	909	73.3	676	70.6	626	68.5
Less Frequent	182	14.7	149	15.6	148	16.2
Frequent	149	12.0	132	13.8	140	15.3
Physical IPV	117	9.4	106	11.1	103	11.3
Coercive IPV	313	25.2	256	26.8	268	29.3
Child internalizing score (Year 5), mean (SD)	4.9 (4.7)		4.6 (4.1)		4.2 (4.1)	
Child externalizing score (Year 5), mean (SD)	10.5 (7.6)		10.4 (7.1)		10.7 (7.7)	
Mother characteristics (Baseline)						
Age, mean (SD)	25.3 (6.2)		25.0 (6.0)		25.1 (6.0)	
Education						
Less than high school	512	41.3	277	29.0	187	20.5
High school or equivalent	370	29.8	306	32.1	291	31.8
Some college or higher	358	28.9	371	38.9	436	47.7
Race/Ethnicity						
White	295	23.8	228	23.9	185	20.2
Black	545	44.0	426	44.7	569	62.3
Hispanic	356	28.7	264	27.7	134	14.7
Other	44	3.6	36	3.8	26	2.8
Country of Origin						
U.S. born	1,046	84.4	826	86.6	831	90.9
Foreign born	194	15.7	128	13.4	83	9.1
Mother social support (0–3 scale), mean (SD)	2.7 (0.7)		2.8 (0.6)		2.8 (0.6)	
Drug or alcohol use during pregnancy	162	13.1	110	11.5	97	10.6
Mother meets depression diagnostic criteria (Year 1)	177	14.3	151	15.8	157	17.2
Parental stress (Year 1)						
Low	609	49.1	487	51.1	431	47.2
High	631	50.9	467	49.0	483	52.8

Child characteristics (Baseline)						
Sex						
Female	606	48.9	464	48.6	427	46.7
Male	634	51.1	490	51.4	487	53.3
First born	408	32.9	414	43.4	385	42.1
Low birth weight	120	9.7	90	9.4	80	8.8
General health status (Year 1)						
Poor-fair	160	12.9	106	11.1	103	11.3
Good-excellent	1,080	87.1	848	88.9	811	88.7
Household characteristics (Baseline)						
Mother's relationship with biological father						
Married/cohabitating	828	66.8	551	57.8	515	56.4
Visiting	298	24.0	269	28.2	270	29.5
Not romantically involved	114	9.2	134	14.1	129	14.1
Number of children in the household, mean (SD)	1.4 (1.4)		1.2 (1.3)		1.1 (1.1)	
Household income, mean (SD)	30,230.6 (30,388.8)		35,446.9 (32,719.5)		36,854.5 (33,776.1)	

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CHAPTER THREE

"EVERYTHING HAD TO GO THROUGH HIM": IPV SURVIVOR MOTHERS' CHILD CARE DECISION MAKING

Introduction

Findings from Chapter 2 highlight the potentially protective influences of non-parental child care for young children exposed to intimate partner violence (IPV). In addition, several previous studies indicate that child care and child care subsidies can be important resources for promoting IPV survivors' safety and economic self-sufficiency (Dichter & Rhodes, 2011; Hendy et al., 2003; Postmus et al., 2009). Despite the significant roles of child care and child care subsidies for survivor mothers and their children, little is known about survivor mothers' child care decisions, or the contextual factors that influence these decisions. To address this gap in our knowledge, the current qualitative study explores the perspectives of 17 survivor mothers of young children.

Parents' Child Care Decisions

The U.S. child care market is mixed, featuring a wide range of public and private options comprising center-based care, formal (i.e., licensed) home-based care, informal (i.e., non-licensed) home-based care by non-relatives, and informal care by friends and family. According to nationally representative data from the 2019 Early Childhood Program Participation (ECPP) Survey, among the 60% of U.S. children aged 5 or younger receiving regular weekly care from a non-parental caregiver, 62% attended center-based programs, 20% received home-based care from non-relatives, and 38%

received informal care from relatives (Tekin, 2021). Child care arrangements tend to vary by household income, with lower income parents more likely to use parental care and relative care, compared with more socioeconomically advantaged families, who are more likely to use center-based arrangements (Carlin et al., 2019).

Parents' choices about child care are multifaceted and complex, based on child and parent needs, personal and sociocultural preferences, household resources, family dynamics, and broader contextual factors. Thus, it is unsurprising that research findings on parents' most important child care considerations are mixed. Among the factors that matter most to parents generally as they make decisions about child arrangements are structural features of child care, including staff qualifications and child: adult ratios, and process-oriented features such as health, safety, structured activities, and positive parent-provider relationships (Cui & Natzke, 2020; Forry et al., 2013; Rose & Elicker, 2008, 2010). In addition, parents' knowledge of child care options, sociocultural perceptions of non-parental care, ideologies about family, and children's ages and developmental needs are known to play important roles in parents' choices (Early & Burchinal, 2001; Hofferth & Wissoker, 1992; Kuhlthau & Mason, 1996; Rose & Elicker, 2008, 2010).

Some studies suggest that lower-income families' child care decisions may focus primarily on practical considerations, such as cost, convenience, and reliability, likely due to the intensified complexity of arranging care with limited social and financial resources (Gordon et al., 2021; Herbst et al., 2020; Sandstrom & Chaudry, 2012). Systemic barriers, including child care deserts (i.e., areas with too few licensed child care slots to serve the families needing care) and volatile child care markets,

disproportionately affect working families with lower incomes. For low-income mothers in particular, child care arrangements are known to frequently change, due in part to their less predictable work schedules, nonstandard hours, and inflexible work policies (Chaudry, 2006; Ha et al., 2012; Sandstrom & Chaudry, 2012).

Intimate Partner Violence and Child Care Decisions

The sizeable literature on parental child care decision making in the general population and among low-income families provides important insights that may be relevant to survivor mothers of young children, particularly given that low income is a risk factor for both IPV perpetration and victimization. However, determinants of child care decisions that relate to parents' experiences with trauma and violence, including IPV, are vastly under-researched. Only two known qualitative studies have reported findings pertaining to survivors' child care decisions. One study with 45 mothers receiving TANF, including some who had experienced IPV, found that participants with personal trauma histories cited a strong distrust of strangers in formal child care settings (Zippay & Rangarajan, 2007). In addition, within a recent qualitative sample of 18 IPV survivor mothers receiving community-based counseling services, participants emphasized the difficulty of meeting formal child care requirements for drop-off and pick-up and consequently faced difficult decisions between conflicting work and child care schedules (Showalter et al., 2022).

Perpetrators of IPV commonly engage in patterns of coercive, controlling behaviors, including intimidation, humiliation, and isolation of their victims, to reinforce relationship dominance (Stark & Hester, 2019). These patterns of behaviors may be

punctuated by severe acts of physical, sexual, or psychological aggression or credible threats of violence that serve to uphold perpetrators' control over their partners. Conceptually, as child care underpins survivor parents' ability to pursue work and education and thereby achieve self-sufficiency, it is a likely target of coercive control. However, there is yet very little empirical evidence of IPV perpetrators' influences on child care decisions or on survivors' child care decisions. Existing knowledge comes from several qualitative studies within the body of scholarship on economic abuse. These findings indicate that abusers may interfere with survivors' work or school by not showing up for child care, refusing to provide child care, or lying about children's health or safety while caring for children (Sanders, 2015; Showalter et al., 2022; Voth Schrag & Edmond, 2017). Additionally, in their qualitative study of domestic violence and employment, Swanberg and Logan found that women feared leaving children home alone with abusive partners (2005).

More broadly, survivors' help-seeking decisions are shaped by individual, interpersonal, and sociocultural factors, as well as by prior help-seeking experiences—whether from friends and family, or formal supports that may have trivialized, stereotyped, and disempowered them (Liang et al., 2005). Abuse has been shown to undermine survivors' non-intimate relationships and isolate survivors from friends and family who might otherwise provide child care support (Katerndahl et al., 2012; Levendosky et al., 2000; Postmus et al., 2012). Survivors may also have cause to distrust formal child care providers and early education systems due to the potentially punitive consequences of disclosing abuse and concerns about mandatory reporting and child

removal (Liang et al., 2005; Lippy et al., 2020; Overstreet & Quinn, 2013). Further, the costs of seeking formal supports such as child care subsidies, including the loss of privacy and stigmatization, may supersede other considerations. Research relating to the needs and help-seeking behaviors of racially and ethnically diverse survivors, including immigrant and undocumented survivors, has identified personal and institutional barriers such as lack of non-English language and culturally appropriate services, deportation threats and risks, and systemic racism and oppression resulting in system mistrust (DeVoe & Smith, 2002; Peled & Gil, 2011; Rizo et al., 2011).

Policy Context

In the U.S., Northeastern states have among the highest average child care costs in the nation (Economic Policy Institute, 2019). Child care subsidies funded by the Child Care and Development Fund (CCDF) are available to low-income families, but many state subsidy systems feature long waitlists and complex application and reauthorization processes. During the Covid-19 pandemic, a number of states used emergency funds allocated by The Coronavirus Aid, Relief, and Economic Security (CARES) Act to mitigate the effects of the pandemic on child care providers and working families. States used these funds to provide emergency care for children of essential workers, continue paying subsidized providers during periods of low attendance or closure, and waiving or covering portions of families' child care tuition (Bedrick & Daily, 2020). However, many of these temporary policy changes have since expired.

Unlike other risk groups (i.e., families experiencing homelessness, children with special needs, and families with very low income) that are prioritized by CCDF

regulations, families experiencing IPV are not typically granted priority status. Currently, only five states—California, Georgia, New York, Pennsylvania, and Rhode Island—have adopted child care subsidy policies that explicitly support IPV survivors and their children. These policies, all recently implemented between 2016 and 2022, grant survivors and their children priority status for subsidy receipt, temporary exemption from verification documentation requirements, or waived co-payments.

Current Study

Taken together, research on survivors' help-seeking decisions, our limited empirical knowledge of IPV perpetrators' influences on child care, and survivors' potentially heightened vulnerability to child care policy- and market-related barriers, indicate that survivor mothers' child care decisions merit special consideration. Despite these indications and evidence that child care and child care subsidies can play vital roles for survivor mothers of young children, no studies to date have explored survivors' child care and child care subsidy decisions in depth. The current study focuses on (a) survivor mothers' considerations and decisions about child care and child care subsidies, and (b) the influences of IPV on survivor mothers' child care decision-making processes and arrangements. To do so, it draws on interview data from 17 survivor mothers of young children, aged 5 or younger.

Methods

Data, Sampling, and Analysis

Data for this analysis came from 17 in-depth, semi-structured interviews (Seidman, 1991) with IPV survivors with at least one young child aged five or younger,

who indicated that they had needed and/or used child care at any point during their child(ren)'s lifetime. Participants were recruited between April 2022 and April 2023 across three New England states. Recruitment materials were distributed through domestic violence agencies, social service agencies, homeless shelters, and Facebook groups. This convenience sampling strategy was based on participant safety, feasibility, and access considerations.

Procedures

Prior to each interview, informed consent was obtained, brief demographic surveys were administered, and gift cards in the amounts of US$50 were offered. A semi-structured interview guide was used to ensure that the interviewer addressed all topic areas of interest, while also allowing the flexibility to tailor prompts and follow-up questions to each participant. This interview guide was developed based on a literature review as well as two focus groups with domestic violence advocates and community-based case managers with experience working with survivor mothers of young children. Relevant to this chapter, domains covered in the interview guide included: (1) participants' household and employment characteristics; (2) histories of needing and/or using child care and child care subsidies; (3) child care and child care subsidy considerations and decisions; and (4) IPV perpetrators' influences on their child care decisions and arrangements.

Interviews ranged from 41 to 59 minutes in length and took place by phone (n = 15) or Zoom video conference (n = 2), depending on participant preference. Participants were additionally offered the option of meeting in person, e.g., on agency premises or in

a safe community location, but none preferred this mode. Interviews were conducted by a researcher who was a trained social worker and had experience in IPV services. A trauma-informed approach was utilized to prioritize participants' safety and well-being. This entailed advance communication about safe methods and times for direct outreach, and conducting interviews with sensitivity to distress (e.g., including reminders that interviewees can discontinue at any time, take breaks, or choose not to answer specific questions). Fourteen interviews were audio-recorded and transcribed verbatim. In response to participant preference, three interviews were not audio-recorded; instead, the interviewer took detailed notes during these interviews, including some verbatim notes, and refined these directly afterward. Transcripts and interview notes were de-identified, and transcripts were verified to ensure accuracy.

Data Analysis

Data-driven thematic analysis (Braun & Clarke, 2014) was conducted with all interviews. Thematic analysis followed an inductive approach to identifying themes, given the relatively small body of research and limited theory relating to survivor mothers' child care decisions. Following initial read-throughs of all interview transcripts in their entirety, a codebook was developed, which reflected the topics covered in the semi-structured interview guide and the study's aims. This codebook was reevaluated and revised as needed throughout the coding process. Each transcript was coded thematically using NVivo software. The resulting set of initial themes was further refined and developed through the construction of conceptually-clustered matrices (Miles & Huberman, 1994) of the coded interview data. Themes were refined according to the dual

criteria of internal homogeneity, i.e., how well data within each theme cohere together meaningfully; and external heterogeneity, i.e., having clear and identifiable distinctions among themes (Patton, 2002). Based on this analysis, and ongoing discussions with faculty advisors, a final set of themes was constructed. In the last stage of analysis, compelling examples of each theme were extracted from the data.

Findings

Sample characteristics

The final sample of survivor mother participants included 17 women aged 21–42 years. Nearly all had left their abusive partners at the time of participation, some within the past year (n = 10) and some over a year ago (n = 7). Only one participant described herself as currently in a relationship with an abuser. One other participant identified her children's father, an ex-partner, as her abuser, but acknowledged that her current partner had also physically assaulted and intimidated her. Sample characteristics can be found in Table 3.1.

Survivor mothers' child care needs and utilization followed four general trajectories. First, several mothers had cared for their children full time while in abusive relationships, as their partners had controlled or obstructed their employment or education, but after leaving those relationships needed child care to be able to achieve self-sufficiency (n = 5). For those following the second trajectory, their abusers had provided parental care, and after leaving these partners, they needed non-parental child care to be able to continue working or attending school (n = 4). Third, some chose to care for their children full time, or balance full-time care and work from home, during and

following their abusive relationships (n = 4). Last, several participants had consistently worked and predominantly used non-parental child care during and following their abusive relationships (n = 3). At the time of interviews, almost half of participants (n = 8) primarily cared for their children, most as full-time parents, one as a home-based child care provider, and several others by working opposite shifts with current partners or balancing care and work from home. Just over half of participants (n = 9) primarily used center-based care at the time of interviews, including kindergarten, public preschool, private centers, and Head Start programs. Every participant had used multiple types of care during their children's lifetimes. The majority of participants had regularly used informal child care provided by friends or family members (n = 14), and several had used other non-licensed, home-based child care (n = 4). None discussed using licensed home-based care.

Among participants who had used center-based or other non-relative care, most discussed learning about child care supply through informal peer networks, online reviews, and regional "child care Facebook groups." Other participants utilized formal supports. For example, one mother worked in a building that also housed the local Head Start office, and her manager played an instrumental role in connecting her with those staff who helped guide her through the process of applying for that program. Another participant worked with a community-based nonprofit organization that helped her find child care and apply for a child care subsidy. Among the 10 participants who reported using domestic violence services, two discussed the supportive role of domestic violence advocates in helping them identify and obtain child care services and child care subsidies.

IPV Influences

All mothers in this sample described their child care decisions as having been influenced by the IPV perpetrated by former or current partners, and most described child care as one of the domains through which their abusers exerted coercive control. Perpetrators' tactics, as described by current participants, comprised restraint of mothers' use of child care, refusal to provide care or provision of inadequate and dangerous care, and interference with survivors' child care arrangements.

Thwarting mothers' child care utilization

In some cases, IPV perpetrators outright prevented mothers' use of non-parental child care. They used jealousy and coercive tactics to ensure mothers cared for their children full-time; isolated survivors from friends and family who otherwise may have provided child care; and disallowed mothers' use of informal care through verbal abuse, intimidation, and threats.

Insistence on maternal care.

Perpetrators employed gender-based stereotypes (e.g., that "good" mothers care for their own children) and structural inequalities (e.g., male control over household finances) to dictate family decisions and achieve desired ends. Five mothers related that their children's fathers had either outright prevented them from working outside of the home or successfully sabotaged their employment. These women's abusers insisted on them caring for their children full-time.

> I tried bringing up the fact that I wanted to work outside the home a bit more, like something part-time, and that was just shut down immediately. So, we didn't even

really get to the child care aspect of it.

Several participants described their abusive partners' use of ostensible concerns about non-parental child care use, or child care costs, to justify these tactics of economic abuse.

> I met him when I was 18 and he was 30. There was already a really big power shift, not a good power dynamic. And then as I started to mature and get older—I had my son when I was 21—I wanted to get out of the house and get into the workforce. … He moved me to the sticks and then was like, 'Well, there's no work here. And if you work, you're going to pay for child care.'

Despite these purported concerns, all participants inferred that abusers' central motivation was the desire to isolate and control them. One mother explained that her ex-husband's attempts to control child care "had nothing to do with the kids":

> I tried to get child care down the road, but unfortunately, I wasn't able to because my ex didn't like it. Then I tried to work and that was a mess too because he wouldn't allow me to drive or get my license. So, I was basically jailed in my own house. I couldn't go work because he thought I was cheating on him and all this other stuff. I did try to get child care, but he wouldn't like the place or there was always some type of excuse. … He'd be like, 'No, it's not good enough for my son. They're not going to take care of him the way you would, so just stay home.'

Referring to her two abusive ex-boyfriends, another mother similarly recounted:

> They didn't want [their respective children] in daycare. Just because they didn't want me working, they didn't want me out of the house. Just because they always thought that I was not being faithful or because they were very controlling.

Isolation from social supports. A majority of women described their abusers' systematic efforts to isolate them from friends and family, which in many cases limited their access to informal caregiving support. Specific tactics included physically moving their families to rural areas, far from family or friends; intentionally causing division between their partners and their support systems; using intense jealousy, verbal harassment, and intimidation to prevent their partners from spending time with others or working outside the home; and in one case, controlling a partner's access to a phone. These behaviors were perceived by mothers to be rooted in power and control. For instance, one participant shared that partner had prevented her from seeing friends because "He knew that if I hung around them that I would maybe be close to leaving, or they would try to help me to leave, and he didn't want that." These tactics of abusive isolation often influenced survivors' child care options and decisions. Another participant described her ex-boyfriend's persistent efforts to sabotage her relationship with her mother—her only close family and primary source of child care—by lying about things the participant hadn't done or said. During another mother's previous marriage, she didn't have anyone she felt comfortable leaving her son with because her relationships with friends and family had "dwindled away." She explained this alienation was the result of her ex-husband regularly disrespecting her in their presence as well as his general aggression and antagonism. Abusive isolation typically took extreme forms, involving multiple tactics and escalating over time:

> He had us really isolated, so I didn't have any friends or anything and I didn't feel comfortable even accepting a job and leaving [our child], especially with him.

> I have zero [support system]. I have no family and I have no friends. The isolation was absolutely complete in my last relationship. … I'm starting over from scratch. It's just me and the kids, that's it.

Limiting use of child care. When mothers did have access to informal care, perpetrators coercively prevented mothers from utilizing it. One had refused to allow his wife's use of child care services during church services, which prevented her from taking part in worship and her faith community. Several others reported being pressured or prevented from allowing a friend or family member to provide care, based on abusers' insistence that their supports were hostile, unsafe, or untrustworthy:

> I couldn't allow friends to watch him, or he wouldn't allow my mom to watch him because he didn't trust my mom.

> Everything had to go through him. But even now when I gave birth to my last daughter. He has a problem with my family members watching her. It was a fight to even let her be around my dad or my sister, anything like that. … He goes back and forth with me about how it's not good for her and, basically, he just thinks that all of my family is bad people and they're not good for her to be around.

Failure to Provide Care

Some mothers, particularly those experiencing socioeconomic disadvantage, relied on fathers' care of children to be able to work or attend school. However, with only two exceptions, perpetrators were described as failing to provide consistent or appropriate care. Some didn't show up to care for their children; others fabricated or used child care

concerns to harass survivors at work or at school. In several cases they had engaged in dangerous or abusive behaviors while caring for children.

Refusal to provide care. Participants described their abusive partners' unwillingness to consistently care for their children while mothers worked or attended school, or their refusal to care for their children at all. Survivors attributed this lack of parental engagement to their abusers' "narcissism," substance use, sense of entitlement, or parenting attitudes rooted in male privilege. Several abusive fathers were reportedly uninterested and uninvolved in caring for their children, or in selecting or arranging child care. This was reflected in mothers' statements such as, "As long as he didn't have to do it, he didn't care," and "He didn't care; he cared about himself and that was it." Two other participants respectively explained that their former abusers "can't even handle the kids for 5 minutes," and viewed caring for their own children as "babysitting." But some participants, experiencing financial strain, relied on their abusers' care in order to work or attend school as a survival strategy. One mother who did so for a period of time described her ex-partner as doing "the bare minimum" to care for their son, which caused her tremendous stress while at work. Two others shared similar experiences:

> Even when I would have to leave him with the kids, which I tried to do as rarely as possible, but he would demand that they be—I couldn't leave until they were in bed. … And on a very rare occasion, I had to leave before then, and I would have to either have had dinner made, already fed or everything ready to go. ... And yeah, so it was like walking on thin ice, I had to do everything or make sure that they were sleeping so that nothing happened. And even if he had the kids, he

> would blow up my phone and constantly text or harass me and whatever, to come home.

> I needed child care so I could work, and he just couldn't be bothered. I would go to work. He'd call me 20 minutes in my shift to say I—because we had split up because of things he was doing—and he'd call me 20 minutes into my shift saying, 'I can't handle him, come get him.'

The latter participant further explained that during her subsequent period of incarceration, her toddler was primarily cared for by her mother, not his father, and that his father eventually stopped visiting and responding to them altogether.

Inadequate and dangerous caregiving. Some mothers shared that they had only left their children in the care of their abusive partners infrequently (e.g., for occasional appointments), and for as little time as possible, due to their abusers' "harshness" towards their children, substance use, or neglect. One participant explained that her husband's problem drinking not only exacerbated his abusive behavior towards her, but also underpinned his unreliability as a parent and caregiver:

> He's not reliable. I can't call him and say, 'Hey, I need a sitter for this day. [Our son] doesn't have school.' He'll say, 'Yeah, I can watch him, no problem.' But then when the day rolls around, I can't find him. … He's been an absentee father. He comes around when he wants to come around. I can't rely on him for anything.

Other survivors described learning that their former or current partners were overtly dangerous caregivers:

> If I was working at the restaurant or something, he would bring my son—because we lived in the basement—he would bring my son upstairs, leave him in the playpen with my grandfather, and my grandfather was sleeping because he was up drinking all night, and he would just leave my son up there and either take off or go downstairs and play video games and smoke weed, which, you know, I didn't find out until later.

> When he was sober—he was sober for a few years—I had no problem leaving the kids with him because he is a really good dad. Since he started drinking again, I am terrified to leave them with him because like I said, when he drinks, he gets stupid. I wouldn't put it past him to drink and drive with the kids in the car or to pass out because he was so drunk, and the kids are on their own.

Several abusers had physically harmed their children—in several cases directing abuse towards a male child, more so than his sister(s)—or assaulted participants in front of their children. As a result, at least nine participants' families were involved with Child Protective Services (CPS). In two cases this directly undermined mothers' child care decision-making control. One mother who left her abuser and thereby retained custody of her children described feeling pressured by her child welfare caseworker to utilize a center-based program more than 40 minutes away from the emergency shelter where she resided, despite not having a car. Another participant's children were temporarily placed in non-kinship foster care due to her ex-husband's assault of their son:

> And then I left again… when DCYF removed the kids. And I was just totally done… And then March 17th, the world shut down* (due to the pandemic). So, my housing that I had set up went out the window. And [the child welfare agency] said, 'Well, if you don't have a place to take the kids, then they need to remain in foster care.' Yeah. So, they were in foster care until [a few months later] when the world opened back up and I was able to get immediately into a housing place, completed all of the stuff that [the child welfare agency] wanted me to complete.

Her children's placement effectively disrupted her control over their care: they were immediately removed from their child care center and placed in a new setting.

Interference with child care arrangements

Abusers' tactics of interference included threatening and harassing informal and formal child care providers to sabotage arrangements; threatening or trying to pick up children from child care against survivors' wishes or in violation of active protection orders; sabotaging survivors' employment to influence child care arrangements; and, after relationships ended, using formal systems such as courts and child protective services to control mothers' use of child care.

Sabotage of child care arrangements. Abusers directly attempted to undermine and interfere with the child care arrangements mothers were using. One participant regularly brought her children to a friend's home, so that both mothers could work from home while their children played. However, her husband's recent opposition to this child care arrangement presented a difficult decision:

> I actually ended up telling my older daughter, ‘Okay, we're not going to mention to daddy that we went to [our friends’ home] today,’ which is crazy. It's so unhealthy to do something like that to a child, to even say that. But if I didn't say that and she said, ‘Oh, I played with [my friend] today,’ then he would get upset, and I would end up paying for that later and be berated.

Abusers’ coercion in some cases extended to their own family member caregivers:

> So, he had decided that he didn't want his father in their life anymore, and he was going to try to stop that. He tried to stop the same with his brother and sister-in-law as well. And they were like, ‘Nope, not happening.’ But when it came to my friends, that wasn't necessarily his family and he tried to say, ‘No, I don't want them with your friends. Your friends are crap. Your friends are shit.’ … So, he would try to stop me, and have all these crazy excuses because he didn't want me to go do whatever it was I was trying to do.

This coercion at times involved direct harassment and intimidation of caregivers. A participant described her abuser’s openly contemptuous treatment of her sister when she cared for their daughter. Another participant’s ex-husband threatened and intimidated his own mother, effectively preventing her from providing child care:

> Then, he got into some disagreement with [his mother]. He freaked her out, and he found out that she was coming and visiting me with my daughter and scared the shit out of her and told my daughter that she wasn't allowed to see her anymore. Now we have to go around basically in secret and hide that she's even coming to my house. … Being babysat is out of the question.

One mother reported that soon after she obtained a protection order against her ex-boyfriend, following a dangerous assault in their son's presence, he called their son's daycare center and requested to pick him up. (Staff refused his request.) Another mother's abusive ex-partner had harassed her at work in order to sabotage her employment as well as her utilization of non-parental child care, which he opposed.

Use of formal systems.

Even after survivors left their abusive relationships, they faced ongoing efforts by their ex-partners to control access to child care using formal levers, including courts and the child welfare system. These tactics sometimes entailed empty threats, but in other cases ex-boyfriends and ex-husbands took formal steps to restrain or interfere with survivors' use of care.

> It's incredibly difficult. I have a friend who I've been friends with since I was a kid. And in an emergency situation she had my daughter for a couple hours, and it was an absolute nightmare. She did it for me for free and he was not pleased. That was a big issue. … He threatened to bring me back to court and to call DCYF and report me for neglect.

> He said he filed a restraining order against me and said that my daughter's not safe around my family. He's always not liked my family. So yeah, he said that. I don't think he knows that they do take care of her at times for me, but yeah, obviously that's not true.

As part of divorce proceedings, two participants' ex-husbands insisted on limiting the number of consecutive hours of non-parental child care participants could use, which these women viewed as intentional efforts to undermine their ability to work, and consequently inflict financial harm. In addition, abusers used threats to coercively control their ex-partners' child care decisions:

> I have friends who I trust, who I would love to utilize as child care, but he makes a big point that he has 50/50 decision making and that if I leave the kids in the care of somebody that he doesn't feel is fit, which is almost everybody, that he's going to bring me to court and he's going to petition for custody.

Systemic Barriers and Survival

Nearly all participants described encountering systemic challenges relating to child care affordability, availability, and transportation, that substantially narrowed their child care options and thereby influenced their decisions.

Affordability

One participant, for whom subsidized child care had made it possible to leave an abusive partner and maintain self-sufficiency, explained that the most critical child care need for IPV survivor mothers was "to be able to afford it." However, for almost all of the mothers in this sample, quality child care was financially out of reach, either consistently so, or during periods of their young children's lives. Several mothers with employed current partners or supportive parents or extended families chose to care for their children full time, based on personal preference and trust considerations. However, four participants explained that their choice to stay at home with their children was

primarily based on a lack of affordable child care. One mother related, “I looked into child care, but I would be paying more than I'd be making.” Another mother planned to return to work following her recent maternity leave but couldn’t afford child care. Describing her mental health struggles since leaving the workforce indefinitely, she stated, “I don’t know who I am anymore.”

Among mothers in this sample who used center-based care, most found ways to do so affordably: taking advantage of free public preschool programs, enrolling children in Head Start programs, or using child care subsidies. On the other hand, a participant who did not qualify for child care subsidies temporarily paid out of pocket for a quality center where her children thrived, but the arrangement wasn’t sustainable. She explained that her daughter “made a lot of little friends and she wanted to go back, but we just couldn't afford it the next year.”

Although half of the mothers in this sample were utilizing center-based care at the time of their interviews, predominantly for preschool- or kindergarten-aged children, the majority of participants expressed needing to rely on more affordable informal caregivers throughout much of their children’s lifetimes, particularly during infancy and toddlerhood. Even in cases when participants could afford their primary child care arrangements, they additionally needed to use back-up care during emergencies, when children were sick, when child care fell through, or when child care hours didn’t align with their work hours. In these situations, survivors turned to friends and family whenever possible. When survivors had limited support nearby, often due to their abusers’ isolation, affording back-up care was very difficult. One mother, whose younger

child attended the Head Start center where she worked, described her job as "being on the line" following her children's two-week illness, during which she spent all of her income on child care:

> And I finally found [a babysitter] and then I blew all my savings that one week. I spent $400 to have her stay at home all week while I went to work. That's more than I made that week. … She was willing to work for $15 an hour, which is what I get paid. The average going rate on [care.com] I've found so far is about $24 and up.

Subsidized Child Care

Nine participants recalled using subsidized child care or were currently using subsidized care, and most described it as an important resource. One mother, who had applied for and used a child care subsidy shortly after leaving her abusive partner, explained that she would not otherwise have been able to afford daycare. As she lacked a support system nearby, in part due to her abuser's control, the subsidy effectively enabled her to work and support her toddler son. Another participant recounted that her child care subsidy had enabled her to complete nursing school and begin a career, which in turn "changed her life": she had since purchased a home and a car and could afford a better quality of life for her child.

Participants also described several barriers to accessing or using subsidized care, including long periods of "phone tag" with program staff, waitlists for income-eligible families, complications following interstate moves, and challenges finding affordable providers that had availability and accepted subsidies. One mother qualified for but didn't

use the subsidy, because the only subsidized child care center she could find with availability “was astronomically priced.” Another shared:

> I ended up finding a lady through a friend who has a home daycare, but then all of a sudden, I had to figure out how to pay her because she doesn't go through child subsidy. So that was a struggle.

A recently separated mother described a challenge she had encountered, relating to documentation. At the time of her interview, she was renting a room in an apartment while her abuser was incarcerated for domestic assault. She explained:

> It's hard me to prove that he's not with me, even though I have court orders saying that we're not together, that I have the full and sole propriety guardianship of my son, that I'm his caregiver. I don't remember how it's worded, but I have court orders. I have a bunch of letters saying that we do not live with each other and when I am reapplying for [the child care subsidy] that's something that holds me back from being like, okay, you're all set, you don't have to worry about him or us or his reapplication or anything. They still tell me, ‘Oh, you need something with his address on it.’ And I tell them, I'm like, ‘I asked him for it, and he doesn't get it to me quick,’ or ‘I can't get it. He doesn't work with me.’ I can't. There's nothing I can do. I don't know what else to do.

Two participants described financially struggling but making too much to qualify for child care subsidies based on their household income:

> My husband worked, but we were just making ends meet; I couldn't afford to pay a daycare center. That's why I was going to work—because we couldn't afford to

> live, so I was going to take a part-time job. And I couldn't qualify for the [subsidy] for her, and I also didn't even qualify for food stamps to help us get by, because he just made a little too much money.

Another mother experienced some difficulties obtaining the required eligibility letters from her school and an unapproachable employer, and overall discomfort with a process that "forces you to make private things public." Proving eligibility was described as particularly challenging by mothers who worked multiple part-time jobs while attending school. In cases when participants' families qualified for subsidized care, they weren't always able to afford the "gap," or difference between providers' fees and what the subsidies covered[1]:

> For a while the subsidy was paying the parent portion, and I was good at that point, but they stopped paying the parent portion recently. I never got notification of it, and all of a sudden, I started getting an invoice saying that I owe child care. Ever since having to start to pay that I am struggling. [My abuser] doesn't pay child support, he doesn't help out financially at all.

This problem deterred two mothers from applying, despite qualifying. One shared that after seeing how much she would have to pay after the subsidy, she became depressed and "kind of just gave up." The other mother explained:

> I still would've had to pay more than half of my paycheck to cover my end every week, and I was like, 'I can't afford that.'

[1] Federal law grants states discretion about allowing child care providers to charge families additional amounts above required co-payments when providers' fees exceed subsidy payments.

Survivors generally described their abusers as contributing little, if at all, to child care expenses. For instance, one mother bemoaned that her ex-husband "makes really good money, but he spends it all on alcohol, weed, cigarettes, bowling."

Accessibility

Other systemic challenges facing participants, particularly those residing in rural regions, were a lack of available child care, and transportation. As previously discussed, a number of survivors were intentionally isolated from friends and family by their abusers and therefore unable to access the support of informal caregivers. Three participants found it difficult to find formal child care arrangements due to their nonstandard work hours, or over the summer when preschools and kindergartens closed. Several mothers described few, if any, licensed child care providers in their respective regions with available spots, and two participants explained that few local providers accepted child care subsidies, which they needed in order to afford care. Five participants described very long (in some cases, years-long) waitlists for local child care centers and licensed home-based programs.

Transportation was often cited as an important consideration, and in some cases, a barrier affecting mothers' use of their preferred child care arrangements. Four mothers described driving long distances so that their children could attend preschool programs, but in each case, this ultimately proved unsustainable. One mother regretfully recalled needing to pull her daughter out of a center she had enjoyed, in part because of the long distance. Traveling long distances for child care was not only inconvenient, but also costly, and presented challenges for work and school scheduling. However, in some cases

it was necessary. Many of the participants' "in a pinch" caregivers, most of them friends and family, lived far from their homes, which required time and coordination. In some cases, lack of affordable, available child care led participants to form arrangements that were much further away than they would have preferred:

> I ended up having to go out of my way by half an hour every day to put him in an in-home childcare with a complete stranger, which took away time from my other kids. Because now I have to go an hour in the morning and an hour in the evening, completely out of my way, just to get child care that I could afford because she was in-home.

Another mother explained that the only specialized preschool program with availability for her son, who had special needs, was "completely out of the way," and transportation was only available for several days each week. She explained, "It's just not feasible for me. I'd be working four hours a day, and I need the full-time. I'm a single mom."

Protecting Children at All Costs

Even in the face of abusers' coercion and structural barriers to accessing quality child care, survivor mothers prioritized the safety and well-being of their children above all else. Survivors' key child care considerations included children's needs, trust, and safety.

Child Needs

Most participants identified their children as presenting with at least mild internalizing or externalizing behavioral problems, which most attributed to IPV exposure. In response, mothers sought child care providers—whether trusted family and

friends, acquaintances, or trained center-based providers—who would treat their children with empathy, provide "extra" support and care, and not judge their families' circumstances or their children's behavioral challenges. With formal providers, mothers described assessing these qualities based on peers' recommendations, online reviews, and through initial meetings.

Nearly all mothers discussed their children's developmental needs as a central reason for choosing their respective child care arrangements. Perspectives on children's most important needs varied, depending on the extent of their trauma exposure, their personalities, and special needs. Some mothers indicated openness to either home-based or center-based care, as long as caregivers were responsive to children's needs:

> I think it doesn't matter where it is as long as the caregivers are tuned in to the kids and know about their past experiences so that they can be able to help them if they're feeling big emotions about it or if something's resurfacing for them. Yeah. Just having caregivers that are aware and able to help.

Others prioritized one-on-one attention and loving care, and expressed concern about high child: adult ratios in center-based and home-based settings, especially given their children's trauma exposure:

> I think that if they had a place that they could go to and they were comfortable and they could handle certain behaviors and understand when things are trauma responses and be helpful… But when you have one staff member to 15 kids, and you have a kid who's having a breakdown as a trauma response because they're

> triggered by something that another kid is doing it's- how are you going to fix that?
>
> I think in-home up here is licensed for six kids per one provider. And I think that's too many for one person. You know what I mean? Unless it's your own kids, like six kids in one household is fine if it's your own kids, but if you're trying to watch somebody else's and they all have individual needs, especially special needs children, you can't do that.

In these cases, informal care by friends and family was typically preferred. One participant, who had recently fled her abuser in another state, had interviewed for a full-time job the previous day and, if successful, planned to use her mother and stepfather as her primary source of child care. She relished the opportunity for her daughter to bond with family, following years of isolation by her abusive partner. Several mothers preferred care by family or friends because of these caregivers' knowledge of the family's background, and their perceived ability to understand and empathize with children whose IPV exposure had influenced their behavior:

> I needed somebody that I knew, who knew and understood children and understood the situation, so that my kids could get the care that they needed, and somebody that wasn't just going to be like, 'Well they're just naughty or misbehaved.'

Alternatively, some participants were primarily concerned about specific developmental setbacks, most commonly speech delays; interested in fostering children's

social development (particularly in the wake of the Covid-19 pandemic); or sought specialized services for children's diagnosed disorders (e.g., ADHD, autism). In these cases, participants tended to prioritize center-based care, and several found centers where children could receive services within the child care setting. At the time of interviews, six participants reported having used (n = 4) or were seeking (n = 2) center-based care that provided services for children's special needs. However, one participant with a special needs child discussed the difficulties of finding consistent center-based or informal care for her son, due to his behavioral challenges:

> He was in the Boys & Girls Club briefly, but he has pretty severe ADHD and was asked to stop coming a couple times. … He's a kindergartner now. He does go to an after-school program, which is offered through the school and at the school district level. But again, his behavioral stuff has been really hard because he has really bad ADHD and he's only allowed to go two days a week. Every other time I've had to get an extra person to provide child care, like a very close family friend. And then one or two times I tried other babysitters, but they asked to not babysit him again.

Trust and Safety

Mothers consistently prioritized their children's safety and avoided using child care they perceived to be low quality or unsafe. A mother explained, "Especially when your home life isn't great, you want to make sure your kid is in a safe place." One participant decided to transition out of the workforce and care for her infant daughter full-time, due to COVID-19 related health concerns. Other mothers chose to care for their

children full-time when quality child care was unaffordable, or during their abusive relationships when their abusers' care was untrustworthy. One participant stated that she would only consider returning to work if she found a well-reviewed, high-quality center that accepted child care subsidies, as she would "rather just sit at home and have my daughter be with me and be safe." Other participants shared:

> I know how much money you make is what the quality of whatever you're getting, or that's how I feel. I was definitely concerned that because I don't make a lot of money and I would be scraping the bottom of anything, that she wasn't going to get the quality care that she needed, or that I felt like she deserved.

> I called every school [daycare center] and went to a lot of schools, but all the schools that had openings were just dirty or too small for the number of kids, or I wasn't comfortable in any of them.

Two participants cited the strong support from their parents, or their current partners' parents, as enabling them to affordably stay home with children. In most cases, however, the decision to care for children full-time required participants to forgo employment or education opportunities.

Several participants expressed concerns about the "unknowns" associated specifically with non-relative home-based child care. One mother had relied on an affordable provider for some time, whom she had found through a Facebook group. One day she dropped her son off at a much later time than normal and realized there were many more children in the home than the provider had claimed- "to the point where she

literally couldn't reach over the kids to get [my son] in order to watch him." She reported the provider to the state and had not utilized a home-based provider since.

Another common theme was the primary reliance on parental care, or reliance on trusted family caregivers, due to participants' own trauma histories and associated safety concerns. One participant expressed strong concerns about child care providers using physical discipline, based on her childhood abuse history and IPV victimization. Several mothers explained that it would be difficult to trust their young children to strangers, whether in a home-based or center-based setting, due to their own experiences:

> I'm nervous to just have someone watch my child for a little bit and not have her with me all the time. I feel like it's just because in the past, I've seen my mom be abused by men, and I was sexually assaulted when I was a child by men. So, I have trust issues in that aspect of anyone watching my daughter.

> I was abused as a child, so having very safe space- I didn't worry about who was watching her or anything like that. I knew [my mother in law's] character, so it wasn't- I felt much safer with her watching her.

> I feel totally comfortable with my mom watching [my son]. I don't worry, I don't think anything's going to happen. So, I totally trust her.

Counterintuitively, several mothers in this sample described trusting their parents as primary or secondary caregivers, despite having experienced abuse or neglect as children. When asked about this, participants explained they had noticed marked changes

in their parents' behaviors over time, and that their parents treated their grandchildren with much more care and affection than they had provided their children.

> It wasn't even always like that when I was a child. But I think being a grandparent, you get the second go-around and see what's really important.

> It's funny because everybody realizes, you see how your parents raise you and then you see how they act towards their grandchildren because they get guilt.

For another, it was a difficult choice. While incarcerated, she chose to leave her then three-year-old son in the care of her mother. Although her mother's husband perpetrated IPV against her, the participant's abusive ex-husband was an even less safe, and unwilling, alternative.

On the other hand, participants could not always trust their friends and family to provide quality care. Eight participants made statements indicating they could not fully trust or rely on a specific close friend or family member for child care, due to substance use, cognitive decline, family conflict, lack of familiarity with young children, unreliability, or irresponsibility.

Participants who preferred or had used center-based care sought providers that used security cameras, regularly sent photo and written updates (e.g., through a phone application), and agreed to maintain close contact with mothers about any attempts made by abusive fathers to see or pick up children. Alternatively, a mother who had recently become a non-licensed home-based child care provider shared her own preference for home-based care, given the relative lack of "red tape":

> I guess the bottom line is that [centers have] laws and rules and all that, that may make it a little- would make it uneasy for me as someone coming from domestic violence, putting my kids in a center, knowing that there may have been a chance that they would've just had to let them go [to their fathers]. Versus, I'm a mama bear. So, if you're going to tell *me* that, even if there's nothing in court, I'm going to be like, 'Hell no, you're not taking this kid. Get off my property.' … I feel like it's comforting to the families to know that you're willing to treat their children and protect their children like you would your own. You're not necessarily going to find that in a center.

Relatedly, children's ages influenced mothers' safety considerations. Mothers of infants were more likely to choose parental care due to trust and safety concerns, in addition to their personal desire to provide care. Three mothers with older children, aged 3–5, expressed that their children's ability to talk made them feel more comfortable enrolling them in center-based care. Another mother stated, "I don't trust anybody," due to her posttraumatic stress, but still enrolled her preschool age daughter in a Head Start program for its perceived developmental benefits.

Rising to the Challenge

Participants' child care decisions commonly reflected a determination and ability to survive through the intense challenges of IPV and systemic barriers towards protecting and supporting their children. Many participants argued or fought back, in various capacities, against their partners' attempts to coercively control child care. Some mothers used child care from close relatives, or enrolled their children in center-based care,

despite their partners' intense resistance and harassment. Others pursued a strategy of tactical compliance with abusers' child care demands to mitigate risks to themselves and to their children. Mothers whose partners were unsafe or unreliable caregivers mobilized strategies to manage their children's safety, by providing care themselves, alerting non-parental caregivers to the risks abusers posed to their children, and involving formal systems to respond to and prevent child abuse. Nearly all survivor mother participants in this study waited for opportunities to leave relationships or left when abuse against them and their children escalated; many subsequently used child care arrangements their ex-partners had disallowed.

To respond to challenges related to affordability and accessibility while prioritizing children's safety and well-being, mothers employed resourceful strategies. Most common was reliance on friends or family who offered free care, whether for brief or extended periods of coverage. Two participants found providers who were flexible about payments. One mother described with relief that her children's center allowed them to consistently attend, even during periods when she couldn't afford to pay her share of the cost (after the subsidy). Another mother used Facebook groups to find a home-based provider who allowed her to pay whatever she could afford, which at times involved paying her in food. At times mothers relied on employers' flexibility:

> [My son's] dad used to stay home with him while I went off to work. This was at an old job, but when we had ended things and I took my son and we had left, I would have to work from home. They arranged it for me that I would be able to work from home just because they knew I had nobody to watch my son at all.

Mothers' strategies also included working opposite shifts as their partners (n = 3), assembling coverage from multiple providers, working cash-in-hand jobs (to influence eligibility for child care subsidies and other benefits), trading babysitting services with friends, finding jobs that allowed bringing a young child, and establishing a small business that enabled work from home while children were napping and sleeping. In addition, two mothers shared that they had considered providing child care. One participant mused, "It might be worth it to just take a couple weeks off at my work and just provide child care for other people; I would make more money." Two participants did so: one mother established her own (non-licensed) home-based child care program, and another obtained employment at a Head Start center that offered free early education training and tuition.

Some of these approaches offered short-term relief, or were only utilized in emergencies (e.g., relying on an aging parent with physical or cognitive limitations). A single mother, who worked multiple jobs from home while caring for her children full time, traded babysitting services with friends but described the limited scope of this strategy:

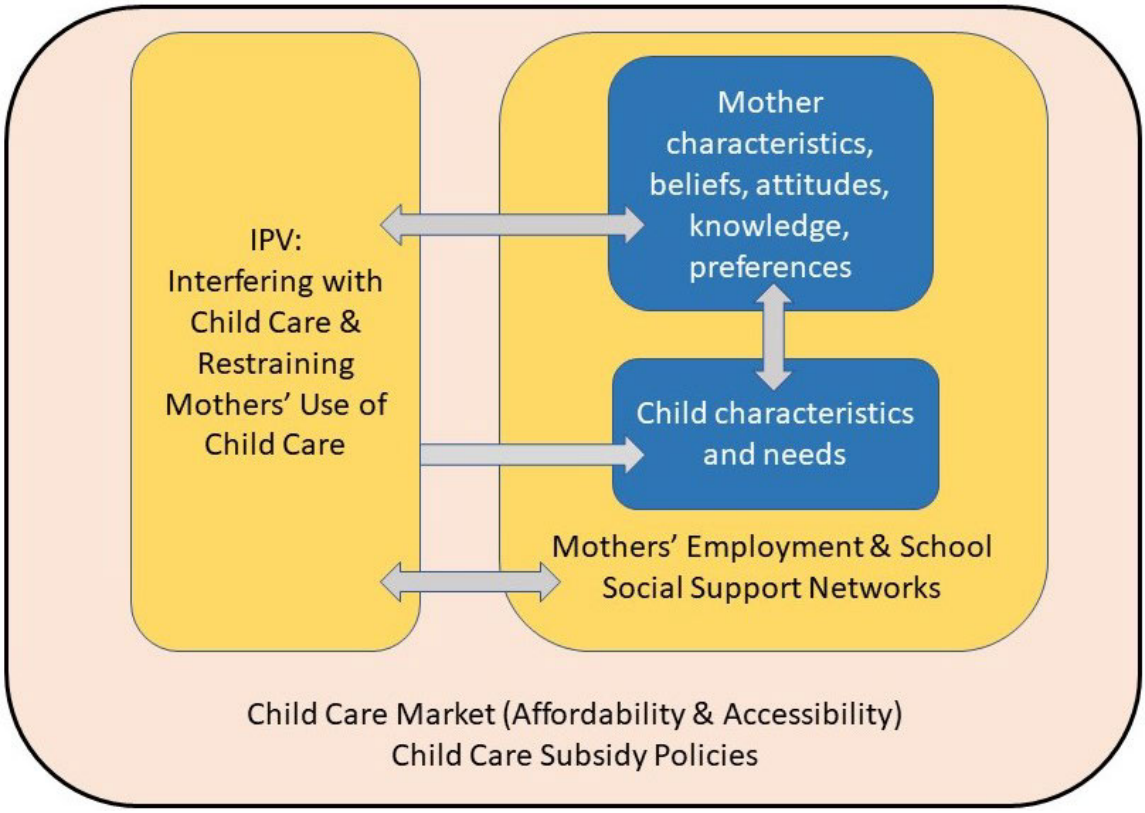
> It would be nice to be able to afford just one day a week of solid child care that I didn't have to worry about, that I could just use to work. But other than that, the 'in a pinch' stuff, I think I'm pretty well-supported. But I can't ask my friends to take my kids all day just so I can work.

Notably, when child care solutions became unsustainable, whether due to IPV or systemic barriers, mothers quickly adapted and identified new survival strategies. One

participant chose to work as a home care provider for an ailing family member, as she could bring along her young son. After the family member passed away, she sought child care support from her mother in the interim, and eventually found a child care center that accepted her subsidy. Another participant initially tried to work opposite shifts with her abusive husband, due to financial strain and exorbitant child care costs. However, he got her fired from multiple night shift jobs by harassing her to return home to care for their children. She accordingly found two jobs that allowed her to bring her infant with her while her older children attended school, but her husband sabotaged the first, and the second proved unfeasible with a baby. Finally, after leaving her husband, she started her own home-based child care program and achieved self-sufficiency.

Discussion

Fig. 3.1 Model of Survivor Mothers' Child Care Decision Making



The present study contributes to our knowledge of survivor mothers' child care decisions and the individual, interpersonal, and contextual factors that influence them. Figure 3.1 presents a model of survivor mothers' child care and child care subsidy decision making, based on current study findings. At the individual level, survivors' child care decisions were driven by their perceptions of children's needs and characteristics; beliefs about family and mothering; knowledge of child care resources and financial assistance; and attitudes about various types of child care arrangements, particularly with respect to safety and trust. These components generally align with extant research on

parental child care decision-making. However, given participants' IPV and childhood trauma histories, they prioritized safety and trust to a much greater extent than is reflected in previous studies with parents seeking ECE. IPV also played more direct roles in shaping mothers' decisions. In addition to the direct physical and psychological harm that perpetrators inflicted on mothers and children, which in some cases influenced their child care needs, perpetrators also restrained and interfered with mothers' child care options and arrangements, isolated them from their support systems (including informal caregivers), and made efforts to sabotage mothers' employment and education. At the same time, many perpetrators refused to care for their children, and when they did, typically provided inadequate or even dangerous care.

Social and structural factors also importantly influenced mothers' decisions. Survivors with trusted friends and family residing nearby could sometimes rely on these supports for informal care, particularly during children's infancy and early toddler years. While this was typically on a part-time basis, it allowed survivors greater flexibility in making decisions about child care, employment, and school. Child care market factors (e.g., child care deserts, lack of subsidized providers, prohibitively high out-of-pocket costs for subsidized care, and formal providers' limited hours of availability) also heavily influenced survivors' decisions about child care arrangements, and about applying for and using child care subsidies. These structural factors also affected some mothers' decisions about employment and education. For instance, some mothers ultimately chose to stay home with children rather than use affordable child care they perceived to be low

quality, while other mothers worked fewer hours, worked part-time from home, or dropped out of school due to child care unaffordability and inaccessibility.

Faced with the formidable tasks of providing and arranging child care for young children while contending with IPV, survivor mothers exhibited agency, tenacity, and resilience. As depicted by double arrows in Figure 3.1, all mothers in this sample engaged in resistance: they resisted perpetrators' efforts to use and harm their children, to harm them, to prevent or sabotage their employment and schooling, to isolate them from their support systems, and to interfere with and restrain their child care options and decisions. Consistent with previous research (Rajah & Osborn, 2022), current participants' resistance took different forms, including active opposition, tactical avoidance and compliance, and help-seeking (e.g., seeking domestic violence services, child protective services, and court orders), and, ultimately, the decision to leave the relationship.

Notably, this study helped uncover a distinct set of IPV tactics related to child care. Mothers in this sample perceived their abusers as being primarily motivated by the desire to control, isolate, and harm them. It is also conceivable, based on previous research on batterer-parents and participants' narratives, that some perpetrators may have been driven by jealousy of mother-child bonds and mothers' attentiveness to their children's needs. Survivors' strong connections with anyone other than the perpetrator, including their own children, fundamentally challenge his control (Bancroft et al., 2012; Katz, 2022). In broader sociocultural terms, these fathers may also have sought to weaken mothers' authority within the family. Child care remains a highly gendered domain in the

U.S., with much of the responsibility for parental caregiving and for arranging and managing non-parental care shouldered by mothers. Perpetrators' efforts to interfere with and restrain child care may therefore reflect, at least in part, an attempt to control a household sphere in which mothers are perceived to have disproportionate agency and power.

Many of the IPV tactics revealed by this study lay at the intersection of economic abuse and the use of children (UOC). Economic abuse is a pattern of economic control, financial exploitation, and employment sabotage within intimate relationships that undermines survivors' economic self-sufficiency (Postmus et al., 2012). The UOC, still a very under-researched phenomenon, can involve interference in a survivor's relationship with her children, threats to harm or kidnap children, or use of children as pawns to manipulate the survivor (Beeble et al., 2007; Clements et al., 2022). According to mothers in this sample, child care related IPV not only undermined their economic self-sufficiency but also caused them stress and fear as they sought to ensure their children's safety and well-being. Some of the specific IPV tactics discussed by survivors in this sample, such as abusers' failure to show up for child care commitments, refusal to provide child care, or use of child care to interfere with survivors' work and school, align with the few child care related findings that exist within the economic abuse literature (Sanders, 2015; Showalter et al., 2022; Voth Schrag et al., 2020). Current participants' concerns about leaving their children home with abusive partners, their distrust of strangers in formal child care settings, and their difficulty navigating conflicting work and child care schedules were also consistent with prior research (Swanberg & Logan,

2005; Showalter et al., 2022; Zippay & Rangarajan, 2007). That current participants identified a more expansive set of tactics, beyond those previously identified, indicates that child care-related IPV merits in-depth examination. In addition, perpetrators' prevalent use of child care to undermine survivors' economic self-sufficiency, and to manipulate mothers' ability to parent during and following relationships, suggests that research on economic abuse of mothers of young children, the use of young children as an abusive tactic, and mothering young children in the context of IPV should account for child care related IPV.

Extensive research has documented the systemic challenges, including those discussed by current participants, who face low-income U.S. families as they arrange care for their young children. However, for mothers in this sample experiencing both IPV and low income, those challenges were greatly magnified. Given the potential for high quality, affordable child care and child care subsidies to enhance their safety, self-sufficiency, and children's developmental trajectories, state policymakers should consider engaging in targeted outreach and utilizing existing policy levers to increase child care affordability and accessibility for this population. Mothers' experiences highlight the importance of trauma-responsive policymaking that does not compel mothers to engage in outreach to former abusive partners, which can severely compromise their own and their children's safety. Further research will be needed to understand how recent child care subsidy policies pertaining to families experiencing IPV in California, Georgia, New York, Pennsylvania, and Rhode Island have influenced survivors' child care decisions and arrangements.

This study also provides practical implications for health and human service providers working with survivor mothers of young children. Mothers in this sample discussed how their partners' coercive control, including gaslighting tactics, manipulated their child care perceptions and realities. Given this, empowering survivor mothers of young children with knowledge of these prevalent tactics and other survivors' responsive strategies may decrease their feelings of isolation and support their child care decision making and safety planning efforts amidst considerable stress. Findings also underscore the importance of domestic violence service providers' knowledge sharing and advocacy around child care and suggest that state CCDF agencies should consider efforts to support and collaborate with community-based domestic violence programs toward supporting this population. Finally, enhanced knowledge of child care related tactics of IPV, as well as the systemic challenges facing survivor mothers of young children as they make child care decisions, may help to inform efforts by non-DV service providers (e.g., pediatric and mental health professionals) who work with this population.

Several limitations may affect the interpretation of this study's results. First, the small, regional sample limits the generalizability of findings. In addition, convenience sampling methods may have resulted in sampling bias, with survivor mothers of young children who were better-resourced, and whose safety and well-being were more firmly established, conceivably more likely to participate. Although survivor mother participants had all experienced IPV within the past five years, only one participant was currently in an abusive relationship at the time of her interview. Therefore, findings were predominantly based on mothers' retrospective accounts, and may therefore be

influenced by recall bias. Finally, it is possible that video and phone interview formats differently influenced participation and results. During phone conversations, for example, the interviewer was unable to identify and interpret participants' body language and facial expressions.

Conclusion

Understanding the child care needs and decisions of IPV survivor mothers of young children is essential for informing policies and services aimed at supporting their self-sufficiency and their children's well-being. This study is the first to centrally examine IPV survivors' decisions about child care and child care subsidies, and the influences of IPV on child care. Present findings identify some of the key individual, interpersonal, and systemic factors influencing survivors' child care decisions, and illustrate survivor mothers' resilience and strategic approaches to arranging safe care for their children. This study also highlights the potentially important role that child care subsidies can play in supporting survivors' and their children's safety and economic security. Current findings indicate the need for quantitative examination of survivors' child care and child care subsidy considerations and decisions, drawing on population-based samples. In addition, further qualitative research is needed to understand the influences of child care related IPV on various dimensions of survivors' and their children's well-being.

References

Bancroft, L., Silverman, J. G., & Ritchie, D. (2012). The batterer as parent: Addressing the impact of domestic violence on family dynamics. In *The Batterer as Parent: Addressing the Impact of Domestic Violence on Family Dynamics*. https://doi.org/10.4135/9781452240480

Bedrick, E., & Daily, S. (2020). *States are using the CARES Act to improve child care access during COVID-19*. Child Trends.

Beeble, M. L., Bybee, D., & Sullivan, C. M. (2007). Abusive men's use of children to control their partners and ex-partners. *European Psychologist*, *12*(1). https://doi.org/10.1027/1016-9040.12.1.54

Braun, V., & Clarke, V. (2014). Using thematic analysis in psychology Using thematic analysis in psychology. *Psychiatric Quarterly*, *0887*(1), 37–41. https://doi.org/10.1111/j.1460-2466.1978.tb01621.x

Carlin, C., Davis, E. E., Krafft, C., & Tout, K. (2019). Parental preferences and patterns of child care use among low-income families: A Bayesian analysis. *Children and Youth Services Review*, *99*. https://doi.org/10.1016/j.childyouth.2019.02.006

Chaudry, A. (2006). Putting children first: How low-wage working mothers manage child care. In *Putting children first: How low-wage working mothers manage child care*. https://doi.org/10.1177/009430610503400615

Clements, K. A. V., Sprecher, M., Modica, S., Terrones, M., Gregory, K., & Sullivan, C. M. (2022). The Use of Children as a Tactic of Intimate Partner Violence and its Relationship to Survivors' Mental Health. *Journal of Family Violence*, *37*(7). https://doi.org/10.1007/s10896-021-00330-0

Cui, J., & Natzke, L. (2020). Early Childhood Program Participation: 2019. First Look--Summary. NCES 2020-075. *National Center for Education Statistics*.

DeVoe, E. R., & Smith, E. L. (2002). The impact of domestic violence on urban preschool children battered mothers' perspectives. *Journal of Interpersonal Violence*, *17*(10), 1075–1101. https://doi.org/10.1177/088626002236661

Dichter, M. E., & Rhodes, K. V. (2011). Intimate Partner Violence Survivors' Unmet Social Service Needs. *Journal of Social Service Research*, *37*(5), 481–489. https://doi.org/10.1080/01488376.2011.587747

Early, D. M., & Burchinal, M. R. (2001). Early childhood care: Relations with family characteristics and preferred care characteristics. *Early Childhood Research Quarterly*, *16*(4). https://doi.org/10.1016/S0885-2006(01)00120-X

Economic Policy Institute (2019). *The cost of child care in the United States*.

Forry, N. D., Simkin, S., Wheeler, E. J., & Bock, A. (2013) 'You know how it makes you feel': Low-income parents' childcare priorities and definitions of ideal high-quality childcare, *Journal of Children and Poverty*, *19*:2, 107-126.

Gordon, J. A., Herbst, C. M., & Tekin, E. (2021). Who's minding the kids? Experimental evidence on the demand for child care quality. *Economics of Education Review*, *80*. https://doi.org/10.1016/j.econedurev.2020.102076

Ha, Y., Magnuson, K., & Ybarra, M. (2012). Patterns of child care subsidy receipt and the stability of child care. *Children and Youth Services Review*, *34*(9). https://doi.org/10.1016/j.childyouth.2012.05.016

Hendy, H. M., Eggen, D., Gustitus, C., McLeod, K. C., & Ng, P. (2003). Decision to leave scale: Perceived reasons to stay in or leave violent relationships. *Psychology of Women Quarterly*, *27*(2), 162–173. https://doi.org/10.1111/1471-6402.00096

Herbst, C. M., Desouza, K. C., Al-Ashri, S., Srivatsav Kandala, S., Khullar, M., & Bajaj, V. (2020). What do parents value in a child care provider? Evidence from Yelp consumer reviews. *Early Childhood Research Quarterly*, *51*. https://doi.org/10.1016/j.ecresq.2019.12.008

Hofferth, S. L., & Wissoker, D. A. (1992). Price, Quality, and Income in Child Care Choice. *The Journal of Human Resources*, *27*(1). https://doi.org/10.2307/145913

Katerndahl, D. A., Burge, S. K., Ferrer, R. L., Becho, J., & Wood, R. C. (2012). Understanding intimate partner violence dynamics using mixed methods. *Families, Systems and Health*, *30*(2). https://doi.org/10.1037/a0028603

Katz, E. (2022). Coercive control in children's and mothers' lives. In *Coercive Control in Children's and Mothers' Lives*. https://doi.org/10.1093/oso/9780190922214.001.0001

Kuhlthau, K., & Mason, K. O. (1996). Market child care versus care by relatives: Choices made by employed and nonemployed mothers. *Journal of Family Issues*, *17*(4). https://doi.org/10.1177/019251396017004007

Levendosky, A. A., Lynch, S. M., & Graham-Bermann, S. A. (2000). Mothers' perceptions of the impact of woman abuse on their parenting. *Violence Against Woman*, *6*(3). https://doi.org/10.1177/10778010022181831

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *American Journal of Community Psychology*, *36*(1–2), 71–84. https://doi.org/10.1007/s10464-005-6233-6

Lippy, C., Jumarali, S. N., Nnawulezi, N. A., Williams, E. P., & Burk, C. (2020). The Impact of Mandatory Reporting Laws on Survivors of Intimate Partner Violence: Intersectionality, Help-Seeking and the Need for Change. *Journal of Family Violence*, *35*(3), 255–267. https://doi.org/10.1007/s10896-019-00103-w

Miles, Huberman, A. M., & Huberman, A. M. (1994). *Qualitative data analysis: an expanded sourcebook (2nd ed.).* Sage Publications.

Overstreet, N. M., & Quinn, D. M. (2013). The Intimate Partner Violence Stigmatization Model and Barriers to Help Seeking. *Basic and Applied Social Psychology*, *35*(1), 109–122. https://doi.org/10.1080/01973533.2012.746599

Patton, M. Q. (2002). *Qualitative evaluation and research methods (2nd ed.).* Sage Publications.

Peled, E., & Gil, I. B. (2011). The mothering perceptions of women abused by their partner. *Violence Against Women*, *17*(4). https://doi.org/10.1177/1077801211404676

Postmus, J. L., Plummer, S. B., McMahon, S., Murshid, N. S., & Kim, M. S. (2012). Understanding Economic Abuse in the Lives of Survivors. *Journal of Interpersonal Violence*, *27*(3), 411–430. https://doi.org/10.1177/0886260511421669

Postmus, J. L., Severson, M., Berry, M., & Yoo, J. A. (2009). Women's experiences of violence and seeking help. *Violence Against Women*, *15*(7), 852–868. https://doi.org/10.1177/1077801209334445

Rajah, V., & Osborn, M. (2022). Understanding Women's Resistance to Intimate Partner Violence: A Scoping Review. *Trauma, Violence, and Abuse*, *23*(5). https://doi.org/10.1177/1524838019897345

Rizo, C. F., Macy, R. J., Ermentrout, D. M., & Johns, N. B. (2011). A review of family interventions for intimate partner violence with a child focus or child component. *Aggression and Violent Behavior*, *16*(2), 144–166. https://doi.org/10.1016/j.avb.2011.02.004

Rose, K. K., & Elicker, J. (2008). Parental decision making about child care. *Journal of Family Issues*, *29*(9). https://doi.org/10.1177/0192513X07312103

Rose, K. K., & Elicker, J. (2010). Maternal child care preferences for infants, toddlers, and preschoolers: The disconnect between policy and preference in the USA. *Community, Work and Family*, *13*(2). https://doi.org/10.1080/13668800903314366

Sanders, C. K. (2015). Economic Abuse in the Lives of Women Abused by an Intimate Partner: A Qualitative Study. *Violence Against Women*, *21*(1). https://doi.org/10.1177/1077801214564167

Sandstrom, H., & Chaudry, A. (2012). "You have to choose your childcare to fit your work": Childcare decision-making among low-income working families. *Journal of Children and Poverty*, *18*(2). https://doi.org/10.1080/10796126.2012.710480

Seidman. (1991). *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences.* Teachers College Press.

Showalter, K., Maguire-Jack, K., & McCloskey, R. (2022). Mothers' Resilience: Experiences of Intimate Partner Violence Survivors at Work. *Children*, *9*(3). https://doi.org/10.3390/children9030373

Stark, E., & Hester, M. (2019). Coercive Control: Update and Review. *Violence Against Women*, *25*(1). https://doi.org/10.1177/1077801218816191

Swanberg, J. E., & Logan, T. K. (2005). Domestic violence and employment: A qualitative study. *Journal of Occupational Health Psychology*, *10*(1). https://doi.org/10.1037/1076-8998.10.1.3

Tekin, E. (2021). An overview of the child care market in the United States [White paper]. National Bureau of Economic Research. https://www.nber.org/sites/default/files/2021-10/White%20Paper-Tekin-101.06.21_revised.pdf

Voth Schrag, R. J., & Edmond, T. (2017). School Sabotage as a Form of Intimate Partner Violence: Provider Perspectives. *Affilia - Journal of Women and Social Work*, *32*(2), 171–187. https://doi.org/10.1177/0886109916689785

Zippay, A., & Rangarajan, A. (2007). Child care "packaging" among TANF recipients: Implications for social work. *Child and Adolescent Social Work Journal*, *24*(2), 153–172. https://doi.org/10.1007/s10560-006-0073-6

Table 3.1 Sample Characteristics

	n	%
IPV Survivor Mothers (*n* = 17)		
Age (average)	29.4	
Relationship with IPV perpetrator		
Currently together	1	5.9
Left within past year	7	41.2
Left >1 year ago	7	41.2
Race/ethnicity		
Non-White Hispanic	3	17.6
Black, American Indian and Alaska Native	1	5.9
White	13	76.5
Focal child's age (*n* = 26)		
0–1 years	6	23
2–3 years	10	38.5
4–5 years	10	38.5
Focal child's gender (*n* = 26)		
Boy	12	46.2
Girl	14	53.8
Focal children's formal diagnoses (*n* = 26)		
Speech delay	5	19.2
Attention deficit and hyperactive disorder	3	11.5
ASD	2	7.7
Attachment Disorder	1	3.8

Notes. IPV = intimate partner violence; ECE = early care and education.

CHAPTER 4

"THEY NEED NURTURANCE; THEY NEED TO BE SEEN": PROMOTING RESILIENCE FOR CHILDREN EXPOSED TO INTIMATE PARTNER VIOLENCE THROUGH EARLY CARE AND EDUCATION

Introduction

An estimated 16–25% of all children in the U.S. are exposed to intimate partner violence (IPV) during their childhoods (Finkelhor et al., 2015; McDonald et al., 2006). While some children are indirectly exposed (e.g., they overhear a parent perpetrate IPV), approximately 90% directly witness the violence (Hamby et al., 2011). It is also common for IPV to escalate over time, which places children at risk for chronic exposure (Fantuzzo & Fusco, 2007). Very young children are more likely than older children to be at home when IPV occurs and often maintain close physical proximity to their mothers. This places them at higher risk for direct IPV exposure and injury (Finkelhor et al., 2015).

Early childhood is a critical period of development and one of heightened vulnerability to threat and stress (Shonkoff & Phillips, 2000). Trauma during early childhood, including IPV exposure, can hinder social and emotional development and lead to enduring negative effects on children's well-being (Perry & Conners-Burrow, 2016). Studies have found that early exposure to IPV is associated with emotion dysregulation, sleep disturbance, depression, anxiety, high levels of stress in response to inter-adult conflict, and aggressive, destructive, and antisocial behaviors (Alessi & Hearn,

1984; (Camacho et al., 2012; DeJonghe et al., 2005, 2011; Huang et al., 2015; Levendosky et al., 2006; McDonald et al., 2007). Early IPV exposure has also been shown to co-occur frequently with child maltreatment, which may cause more severe internalizing and externalizing effects than IPV exposure alone (Bidarra et al., 2016; Hamby et al., 2010; Sternberg et al., 2006).

In the U.S., more than 60% of children aged 5 or younger receive regular, weekly care by non-parental caregivers (Tekin, 2021). Several recent studies point to early care and education (ECE), an existing and widely used resource within all children's communities, as a promising means to support and address the needs of young children experiencing trauma (Loomis, 2018; Mortensen & Barnett, 2016; Osofsky & Lieberman, 2011). In fact, there is emerging evidence that non-parental child care can respectively buffer the negative influences of IPV on young children's quality of life and internalizing and externalizing behavioral problems (Kita et al., 2021; Nicholson & Ha, 2022). Yet, little is known about the mechanisms by which ECE might influence this population. To develop an understanding of the ECE needs and experiences of young children exposed to IPV, and the protective factors within ECE environments that may promote their resilience and challenges in doing so, the current study draws on data from 17 interviews with IPV survivor mothers of young children, and 6 interviews with professional ECE stakeholders with experience working with children exposed to IPV.

Resilience for Young Children Exposed to IPV

Resilience in early childhood is characterized by competence, i.e., positive function and development, in the face of significant adversity. Resilience is a dynamic

process involving complex interactions among young children and their changing family, community, and social environments (Dubowitz et al., 2016; Howell, 2011; Masten, 2001). Researchers have proposed that for IPV exposed children, strong caregiver bonds, emotion regulation, and prosocial skills are particularly important domains of competence (Gewirtz & Edleson, 2007; Howell, 2011). These skills are closely linked: caregiver bonds can facilitate the development of emotion regulation, which in turn can support children's development of empathy, positive peer relationships, and social skills.

Young children have been found to exhibit a wide variability in functioning following early IPV exposure, with only 20–37% exhibiting emotional-behavioral resilience (Graham-Bermann et al., 2009; Howell et al., 2014; Kitzmann et al., 2003). Studies have examined some of the key factors linked with their resilience, with a strong focus on factors within children's home environments (Fogarty et al., 2020). These include less frequent or severe violence exposure; safe, stable relationships with non-abusive parents; effective and engaged parenting; child characteristics, such as emotion regulation skills and self-esteem; mother characteristics, including warmth, physical and mental health, socioeconomic advantage, knowledge of child development, and attunement to children's emotional experiences; parent-child attachment; and peer and family support (Graham-Bermann et al., 2009; Grip et al., 2014; Johnson & Lieberman, 2007; Manning et al., 2014; Spearman et al., 2023). Much less is known about the factors outside children's home environments that can prevent IPV exposure or mitigate its negative influences. A recent systematic review of factors promoting resilience for children exposed to IPV (Fogarty et al., 2019) identified only one study that had

investigated a community-level protective factor, i.e., not being involved in a judicial process (Georgsson et al., 2011), for school-aged children.

Survivor mothers' understanding of their young children's needs and their perspectives on ways to promote children's resilience are of critical importance. Yet, few studies have elicited survivor mothers' knowledge about key protective factors for their young children. Fogarty and colleagues (2019) interviewed nine IPV survivor mothers about strategies they had used to promote resilience of their children, aged 10 and older. These included role modeling; stable, consistent parenting; trying to reduce children's direct exposure to IPV; facilitating children's continued relationships with their fathers; fostering engagement in interests, hobbies, and sports; and ensuring their own emotional well-being. Qualitative studies that have relatedly explored IPV survivor mothers' efforts to safeguard and support their children provide implicit evidence of what mothers perceive to be the key factors to promote children's resilience. Participants in these studies protected children from physical harm by removing them from the home environment (e.g., sending them to stay with a neighbor or relative), seeking protection orders, and attempting to prevent IPV by appeasing or avoiding their partners (Haight et al., 2007; Hardesty et al., 2008; Kelly, 2009; Nixon et al., 2017; Peled & Gil, 2011). They also sought to enhance children's well-being by offering reassurance and emotional support, allowing children to discuss their IPV experiences, expressing positivity, and educating children on healthy relationships (Haight et al., 2007; Hardesty et al., 2008; Kelly, 2009; Nixon et al., 2017; Peled & Gil, 2011).

Protective Influences of ECE

In recent years, researchers have increasingly examined the benefits of high quality ECE for children experiencing early childhood trauma, particularly child abuse and neglect (Klein et al., 2018; Lee & Ludington, 2016; Loomis, 2018; Maguire-Jack et al., 2022; Mortensen & Barnett, 2016). High quality ECE environments are typically characterized by several key structural process quality features, such as well-trained staff and low child: adult ratios, and process quality features such as developmentally supportive activities and positive interactions between children and their caregivers (NICHD Early Child Care Research Network, 2002). Programs that feature these high-quality components have been shown to be important developmental contexts for young children (Burchinal et al., 2008; Peisner-Feinberg et al., 2001; Vandell et al., 2010). Numerous studies have documented the benefits of high quality ECE for young children generally, including increased child emotional engagement, social competence and development, and lower risk for later behavior problems (Burchinal et al., 2008; Love et al., 2005; Mortensen & Barnett, 2015; Peisner-Feinberg et al., 2001).

At-risk young children may experience especially strong benefits. Overall, the literature shows that children from less adequate home environments (based on observational measurements of the home learning environment and maternal sensitivity), who are socioeconomically disadvantaged, and whose parents have low levels of education experience greater gains from attending high quality child care, compared with their more advantaged peers (Peisner-Feinberg et al., 2001; Votruba-Drzal et al., 2010; Watamura et al., 2011). Other studies find that non-parental child care can buffer the

risks of household chaos and maternal depression on young children (Berry et al., 2016; Giles et al., 2011; Herba et al., 2013). On the other hand, when at-risk children experience low-quality ECE, their social and behavioral outcomes can markedly suffer (Mortensen & Barnett, 2016; Watamura et al., 2011). These findings suggest the critical importance of high quality ECE settings for at-risk children to avoid exacerbating the negative effects of adversity and trauma.

Very few studies to date have explored the role of ECE in promoting resilience for children exposed to family violence. One recent study found that Head Start enrollment was associated with better social and emotional outcomes for children generally but had greater impact on those who had ever experienced violence or crime (Lee & Ludington, 2016). Several others have found positive behavioral and social impacts of center-based ECE, including Head Start, on children experiencing parental maltreatment and children residing in non-parental foster care settings (Klein et al., 2018; Lipscomb et al., 2013; Pears et al., 2013). Nonetheless, research suggests that in order to thrive, maltreated children may need more targeted, therapeutic care than high quality ECE settings traditionally provide (Lipscomb et al., 2014; Mortensen & Barnett, 2016). In their rapid review of the literature on ECE policies and family violence, Macguire-Jack and colleagues concluded that the few studies examining these relationships offered promising evidence to support some ECE policies and programs (e.g., child care subsidies and Head Start) as means to prevent family violence (2022). Only two studies to date have focused on ECE for children exposed to IPV. Kita and colleagues (2021) found that use of non-parental child care services was likely to buffer the negative impact

of parents' IPV risk—measured based on parents' self-reported relationship tension and difficulty—on Japanese children's health-related quality of life. Nicholson and Ha (2022) found that informal, formal home-based, and center-based ECE all significantly modified associations between U.S. children's exposure to IPV at age 3 and their internalizing and/or externalizing behavioral problems at age 5, with center-based care found to have the most expansive benefits.

Taken together, this research points to ECE as a promising area for promoting resilience of children exposed to IPV. However, no studies to date have examined the mechanisms within ECE settings that explain its protective influences for children exposed to IPV or explored parents' or ECE providers' perspectives. In addition, research on ECE for at-risk children has focused predominantly on formal center-based care; relatively little is known about protective factors within informal or formal home-based care. The current study seeks to address these knowledge gaps by examining IPV survivor mothers' and professional ECE stakeholders' perspectives on the key influences of ECE—including informal care by family and friends, family child care (FCC), and center-based child care—on young children exposed to IPV.

Methods

Data and Sampling

Data for this analysis came from 17 in-depth, semi-structured interviews (Seidman, 1991) with IPV survivors with at least one young child aged five or younger. These participants were interviewed for a broader dissertation study, and data from these interviews were additionally examined for a qualitative study exploring IPV survivor

mothers' ECE decisions (i.e., Chapter 3). In addition, the present study drew on data from 6 ECE professionals with expertise relating to children exposed to IPV within ECE settings, as well as direct experience working with children and families experiencing IPV. This study recognizes that IPV survivors are the experts on their own and their children's experiences and circumstances; ECE professionals were also interviewed toward developing a more holistic understanding of how children exposed to IPV interact with their child care providers and environments, and to understand ECE professionals' perceptions and approaches to working with children exposed to IPV.

Due to safety concerns about conducting phone and virtual interviews with IPV survivors during the Covid-19 pandemic, ECE professional participants were first recruited and interviewed. Between the summers of 2021 and 2022, 6 ECE professionals were selected and recruited to reflect a diversity of perspectives and roles and based on the alignment between their professional expertise and the study research questions. In addition to direct emails to ECE center administrators, outreach materials were also shared with local FCC associations to reach licensed home-based child care providers. To ensure that ECE professionals' perspectives were relevant to survivor mothers' and their children's ECE experiences, all were recruited from the three New England states from which prospective survivor mother participants would be recruited. Mother participants were recruited between April 2022 and April 2023. A brief screening instrument was used to assess whether mothers met the criteria for study inclusion. Eligibility criteria required that participants were aged 18 or older, that they were the primary caretaker for at least one child aged 0–5, and that they had experienced IPV (i.e., physical abuse,

sexual abuse, emotional abuse, threats, and/or extremely controlling or jealous behavior) by a current and/or former partner during their child's lifetime. Recruitment materials were distributed through domestic violence (DV) agencies, social service agencies, homeless shelters, and Facebook groups. This convenience sampling strategy was based on participant safety, feasibility, and access considerations.

Procedures

Prior to each interview, informed consent was obtained, brief demographic surveys were administered, and gift cards in the amounts of $50 for mother participants and $30 for ECE professional participants were offered. The demographic surveys for ECE professionals additionally included questions about participants' areas of expertise, and whether their previous and/or current roles had involved direct work with IPV survivors and their children. Semi-structured interview guides were used to ensure that the interviewer addressed all topic areas of interest, while also allowing the flexibility to tailor prompts and follow-up questions to each participant. These interview guides were developed based on literature review as well as two focus groups with DV advocates and community-based case managers who worked with survivor mothers and their young children. Relevant to this study, domains covered in the mother interview guide included (1) children's IPV exposure, (2) children's needs from non-parental ECE (including informal care by friends or family, formal home-based care, and center-based care, preschool, and pre-K), and (3) the influences of ECE and/or lack of ECE on children's well-being. Two mother participants worked full-time as child care providers, one as a non-licensed FCC provider and the other as a Head Start assistant teacher. Although

neither was aware of any children in their care who had experienced IPV specifically, their groups included children with trauma histories. Therefore, during these interviews their perspectives and experiences as ECE providers were additionally explored. ECE professional interview guides were developed based on literature reviews relating to each respective professional orientation and its relation to study research questions. Common to all interview guides were domains relating to the ECE needs and experiences of young children exposed to IPV.

Mother interviews ranged from 41 to 59 minutes in length and took place by phone (n = 15) or Zoom video conference (n = 2), depending on participant preference. Professional stakeholder interviews ranged from 37 to 48 minutes in length, and all took place by Zoom video conference (n = 6). Mother participants were additionally offered the option of meeting in person, e.g., on agency premises or in a safe community location, but none preferred this mode. Interviews were conducted by a researcher who was a trained social worker and had experience in providing IPV services. A trauma-informed approach was utilized to prioritize mother participants' safety and well-being, which entailed advance communication about safe methods and times for direct outreach, and conducting interviews with sensitivity to distress (e.g., including reminders that interviewees can discontinue at any time, take breaks, or choose not to answer specific questions). Twenty-four interviews were audio-recorded and transcribed verbatim. In response to participant preference, three mothers' interviews were not audio-recorded; instead, the interviewer took detailed notes during these interviews, including some verbatim notes, and refined these directly afterward. Transcripts and interview notes were

de-identified, and transcripts were verified to ensure accuracy.

Data Analysis

Interviews were analyzed using data-driven thematic analysis (Braun & Clarke, 2014). Thematic analysis followed an inductive approach to identifying themes, given the relatively small body of research relating to the influences of child care on young children exposed to IPV. Mother interviews were analyzed first, followed by ECE professional interviews as a separate group. Following initial read-throughs of all mother interview transcripts in their entirety, a codebook was developed, which reflected the topics covered in the semi-structured interview guides and the study's aims. This codebook was reevaluated and revised as needed throughout the coding process. Each transcript was coded thematically using NVivo software. The resulting set of initial themes was further refined and developed through the construction of conceptually-clustered matrices (Miles & Huberman, 1994) of the coded interview data. Themes were refined according to the dual criteria of internal homogeneity, i.e., how well data within each theme cohere together meaningfully; and external heterogeneity, i.e., having clear and identifiable distinctions among themes (Patton, 2002). Interviews with ECE professionals were coded next, following the same approach and a distinct codebook. Based on this analysis, and ongoing discussions among the first three authors, a final set of themes was constructed. In the last stage of analysis, compelling examples of each theme were extracted from the data.

Following analysis, final themes relating to protective factors within ECE settings were organized according to the three domains of Masten and Coatsworth's classification

of competence-promoting strategies for children facing early adversity: (a) risk-focused mechanisms, which reduced, eliminated, or prevented exposure to IPV and associated risks; (b) resource-focused mechanisms that attenuated or counter-balanced the negative impacts of IPV exposure; and (c) process-focused mechanisms that tapped into the adaptational systems promoting children's positive functioning (Masten & Coatsworth, 1998). Within the resilience literature, this classification is often utilized to frame prevention and/or intervention approaches and techniques to promote children's resilience in diverse settings.

Findings

IPV Survivor Mothers

The current sample included 17 IPV survivor mothers, aged 21–42 years, whose characteristics are detailed in Table 4.1. Thirteen (76.5%) identified as white, three (17.6%) as non-white Hispanic, and one (5.9%) as Black/American Indian and Alaska Native. Most had left their abusive partners at the time of participation, some within the past year (n = 9) and some over a year ago (n = 7). Only one participant described herself as currently in a relationship with an IPV perpetrator. At the time of interviews, eight mothers primarily cared for their children and nine primarily used center-based care, including kindergarten, public preschool, private centers, and Head Start programs. Each had used multiple types of care during their children's lifetimes. Almost all participants had regularly used informal child care provided by friends or family members (n = 14) during periods or throughout their young children's lifetimes, and several had regularly used other non-licensed, home-based child care (n = 4).

These participants had a total of 37 children, 26 of them aged 0–5. Table 4.1 also presents characteristics of these 26 children, on whom mothers' interviews focused. Six children were aged 0–1; the remaining 20 children were equally split between 2–3 year olds and 4–5 year olds. Just over half (54%) were girls. Eight mothers had young children with diagnosed disorders or developmental delays, which several mothers attributed to children's IPV exposure or to fathers' direct child maltreatment. These children had been diagnosed with speech delays (n = 5); attention deficit and hyperactive disorder (ADHD, n = 2), autism spectrum disorder (ASD, n = 1), ASD and ADHD (n = 1), and ADHD and attachment disorder (n = 1). Other mothers described their toddler children, too young to be formally diagnosed, as exhibiting symptoms of ADHD (n = 2) or of ADHD and ASD (n = 1). All five children with diagnosed or suspected ADHD and/or ASD were boys.

ECE Professionals

The demographics of ECE professionals are also included in Table 4.1. Two participants did not complete demographic surveys; among the four who did, their mean age was 45 and all identified as white. These participants (not including the two mothers who worked in ECE) included six professionals who worked as ECE providers, or as consultants to ECE providers and systems: (1) an owner and director of two child care centers and a Court Appointed Special Advocate (CASA) volunteer (i.e., trained court advocate for children experiencing abuse and neglect), (2) an Early Childhood Mental Health Consultant (i.e., mental health professional who consults with ECE providers in a problem-solving, capacity-building relationship) and former pre-K teacher, (3) a licensed FCC provider, (4) a children's services director for two YWCA child care centers and

former ECE teacher, (5) a child care center teacher who had recently transitioned into a "jack of all trades" role involving part-time teaching, liaising with families, and training staff, and (6) a trauma trainer and consultant to ECE systems and clinical psychologist specializing in Child-Parent Psychotherapy (CPP; an evidence-based practice model for trauma-exposed children aged 0–6 and their caregivers). Child care teachers and administrators had worked, on average, 24.8 years with children and families in ECE settings. Other ECE professionals had also worked directly with children exposed to IPV, one in a current role and the other in a previous ECE provider role.

Perceived Influences of IPV on Young Children

Among children in this sample, direct exposure to IPV varied. All mothers reported that their children had witnessed a physical assault, psychological abuse, or intimidation (e.g., tearing a door off its hinges or punching holes in walls), and/or overheard fighting, intermittently or consistently during their abusive relationships. Approximately half of participants reported that their partners' abuse had escalated during and since the Covid-19 pandemic, further threatening their children's safety. Perpetrators also influenced children's well-being through their harsh, abusive parenting behaviors. Three mothers characterized their abusive ex-partners as good fathers whom their children enjoyed time with—although one was a neglectful and dangerous caregiver while intoxicated. These exceptions aside, perpetrators were generally described by mothers to be absent, harsh fathers, and 6 were reported to have physically abused their children. Among the majority of children whose parents had split (all but 3), most had ongoing relationships with their fathers. These children's mothers expressed strong

concerns about their ex-partners' parenting behaviors. Fathers had "said very inappropriate things" to children on the phone or while providing care, attempted to alienate children from their mothers, berated their current partners in front of children, or barely interacted with children during their time together. Other children's fathers had either stopped seeing them or were prohibited from doing so at the time of interviews due to active protection orders, child abuse investigations, or terminated parental rights.

Many of the children described by participants had suffered tremendous upheaval and loss as a result of IPV. Seven mothers experienced periods of homelessness with their young children, after which they had temporarily resided in emergency DV shelters, transitional housing, and/or with friends or family members. Perpetrators had systematically isolated their families or threatened or intimidated mothers' supports, which limited children's access to beloved friends and family—for some, long-term. Some children experienced non-kinship foster care placement due to IPV. Others lost contact with fathers whom they loved. Another mother's vindictive former abuser won custody of their son after her recent abusive partner reportedly strangled him; her son had not seen her in four years.

All mothers perceived at least one of their children to have been negatively influenced by IPV, to varying degrees. They described specific child characteristics, behaviors, and symptoms they perceived as being related to fathers' IPV perpetration and harsh or neglectful parenting. Severe separation anxiety, particularly within child care settings, was a common challenge:

> He didn't want to get on the bus [to preschool], he didn't want to leave, because in his mind he thought I wasn't going to be there. And because, with his dad gone, he thought I was going to be gone too.

Other internalizing symptoms described by mothers included generalized anxiety, depression, bedwetting, disordered eating, refusal to sleep over friends' or family members' homes, being easily startled and upset by loud sounds, rumination about past IPV, and fear of men:

> [She was] very clingy to me. And always like kind of scared when her dad would come around. She'd always say that she'll always be afraid and constantly asking when he is going to be here, if we have to go- if we'd end up in a domestic violence shelter.

Externalizing symptoms included smashing and throwing things, punching, hitting, kicking, and biting. Most children were thought to love their fathers, but they also feared them or feared for their mothers. This resulted in confusion, anxiety, and "not knowing who is safe to trust," as one toddler's mother explained. Several mothers also reported that perpetrators had harmed their children indirectly by undermining their own mental health and parenting; one perceived the "biggest impact" her partner's abuse had on her children to be its effects on her emotional state. Echoing these depictions, ECE professionals described ways that children's IPV exposure had behaviorally manifested within ECE settings: severe separation anxiety during drop-offs, lack of emotion regulation, aggression towards other children, violent threats, sadness, and aloofness. A provider described one child's externalizing behaviors:

> He was running out of the classroom constantly, acting out, punching his teachers, and saying that's what daddy does to mommy.

ECE Providers' Awareness of IPV

A cross-cutting theme across mother and professional stakeholder interviews was the importance of ECE providers having awareness of children's IPV exposure, as well as an understanding of IPV. Mothers emphasized that providers needed to know about children's traumatic experiences, to be poised to effectively support them. Three trauma specialists pointed out that without an understanding of IPV dynamics, child care providers may be prone to judge mothers' parenting, or build better rapport with abusive parents, who often present socially as charismatic and sympathetic. ECE providers in this sample had rarely learned definitively whether children in their care had been exposed to IPV. They generally gained awareness of IPV through children's involvement in the child welfare system (e.g., when one or both parents were no longer allowed to pick up or drop off, or when children placed in foster care were removed from their ECE settings), when survivor mothers shared protection orders with them, when mothers exhibited signs of physical abuse, or when children referenced IPV during care. A former preschool teacher and an FCC provider recalled singular incidents in which survivor parents had disclosed IPV. For the FCC provider, this only occurred after the mother's children had been placed in foster care:

> I said, 'You don't need to be embarrassed. You can share anything with me.' She goes, 'I knew that, but I was embarrassed to tell you.' I said, 'I wouldn't have thought any differently about you. I would've gotten you help.'

All mothers who used friend or relative care had disclosed IPV to these caregivers and had generally felt comfortable doing so. Among the 11 mothers who had used home-based or center-based ECE, all but one disclosed IPV despite strong concerns about privacy and mandated reporting. They did so to ensure that providers would prevent fathers from picking up children, understand and sensitively respond to children's challenging behaviors, meet children's heightened needs, and not associate children's challenges with mothers' parenting. Five mothers chose to share limited or vague information about their children's trauma exposure with ECE providers. The one mother who chose not to disclose IPV at all explained that her decision was based on her current child welfare system involvement. Some mothers were willing to disclose their IPV experiences right away, whereas several needed to build trusting relationships with child care providers first.

Protective Influences of ECE

Mothers and ECE professionals discussed their perceptions of the most important risk-focused, resource-focused, and process-focused ways in which ECE providers and settings had, and can potentially, promote resilience of young children exposed to IPV. Within each of these domains, mothers' and ECE professionals' perspectives were largely consistent. However, mothers' interviews in particular revealed the varying extent to which children exposed to IPV could access these protective features of ECE, due to IPV perpetrators' influence, as well as systemic barriers related to child care markets and socioeconomic disadvantage. These factors are examined in Chapter 3.

Risk-focused Mechanisms

Current participants, but predominantly mothers, described risk-focused protective mechanisms for children within ECE as fundamentally important. These included reduced exposure to IPV, reduced exposure to fathers' harsh parenting and maternal stress and anxiety caused by IPV, ECE providers' enforcement of protection orders and other efforts to prevent abusive fathers' unsafe contact with children, and their mandated reporting of child maltreatment.

Reducing IPV exposure. Perhaps most critically, ECE reduced direct exposure to IPV for children whose abusive fathers still resided with them. Several mothers expressed relief that their children were able to spend time in a "safe haven" away from their fathers' abusive influence, whether a child care center, FCC setting, or the home of a friend or family member. An ECMHC additionally emphasized the importance of children comprehending their safety within child care environments. "If they're not feeling safe," she explained, their ability to learn or process anything else "is out the window." Conversely, a lack or loss of child care could compromise children's safety. One mother recalled her intense concern for her children's exposure to severe IPV by their father during the COVID-19 pandemic. It had "created more of an upper hand for him" as she was unable to find emergency or transitional housing, and his abuse escalated, eventually resulting in their children's temporary foster care placement:

> I'm really grateful that my kids were in foster care during that time because they would not have been in school; they would've been home with him or with us together if we had been together. And I feel like where, [child care] teachers are

> an extra layer of accountability, I fear for what would've happened if they were stuck at home, because they wouldn't have been in child care.

Reducing exposure to IPV-related stressors. In addition to physical safety, ECE helped distance children from the stressors resulting from IPV. A mother who still lived with her abusive husband shared that the tension caused by IPV "makes for a very negative environment." Given this stressful context, mothers appreciated their children having opportunities to spend time with other children in positive environments, play outside, and "just be a kid." Since leaving a DV emergency shelter, one mother lived with her sister, whose outside porch contained lead paint. She typically kept her daughter inside for fear of lead poisoning and was grateful her daughter could safely play outside at daycare. ECE was also described as providing children distance and distraction amidst changing household structure, homelessness, loss of contact with their fathers, and exposure to their mothers' stress and fear:

> [Preschool] definitely helped. … Because I cried a lot, and I didn't want [my son] to see that of course. I was just worried, and I was worried my ex was trying to get out of jail and I was trying to deal with all that. So, it was good the way that he was in school, and he wasn't able to see me stressed out, or see me nervous, or see me looking out the windows and being all nervous and paranoid. So that was good that he was able to be with his friends and just be okay.

Another mother described wanting child care for similar reasons, following her recent separation from her abusive husband:

> I could have used some child care just to deal with all of this court stuff. I've had to go to the courthouse and bring the kids with me, and I had a meeting with the DV advocate today and I had to bring the kids to that, which- it's just crappy having to have them around that, especially the older one, because she can understand what's going on.

Preventing abusers' interference and harm. Even for children whose mothers had left abusive relationships, safety was an ongoing, central concern. As described in Chapter 3, after relationships ended, IPV perpetrators continued to threaten and control mothers. This included threats to "take children away" and to pick up children from child care in violation of protection orders. Some mothers reasonably feared their ex-partners would hurt them or their children after they left the relationship, or when perpetrators were released from prison (at least two had been incarcerated for domestic assault). Amidst these concerns, child care was viewed by mothers as a safe space, particularly when providers were aware of the risks that perpetrators posed to children.

Eight mothers had sought an enhanced level of safety within child care settings by providing caregivers or administrators copies of protection orders, DV agency documents, or child welfare caseworkers' contact information to prove perpetrators could not have contact with children. These mothers described providers as generally responsive to and supportive of these requests. Three perpetrators had tried to take their children from child care centers, but providers had turned them away based on the formal documentation mothers had provided. One mother explained with relief that "He showed up once or twice, but they don't let him anywhere near [my daughter]." A children's

services director also described her experiences refusing to allow abusive parents to pick up children based on active protection orders or child welfare system involvement:

> Nine times out of ten they do just walk out the building, but there are times that I've had to call the police, and they have come and talked to them and removed them and so forth.

This participant acknowledged that in rare cases, abusers' harassment had escalated to the point of threatening other families' safety, which prompted staff to terminate those children from the program. Establishing safeguards against abusive fathers was also more difficult when survivors lacked documentation and abusive fathers still retained parental rights, particularly when utilizing center-based care.

Reporting child maltreatment. Finally, participants discussed child care providers' role as mandatory reporters of child maltreatment. Here, ECE professionals' and mothers' perspectives conflicted. Only one participant, a former preschool teacher, related an experience reporting IPV-related child abuse with the support of a survivor mother who had disclosed her children's severe IPV exposure. This teacher first approached the mother about her plan to report before actually doing so, and believed her action to have upheld the children's safety and supported the family as a whole. In contrast, two mothers indignantly discussed their child care providers' reporting. One described a previous center-based provider's report as undermining her trust in subsequent providers. The other mother shared that her center-based provider made a report furtively, instead of speaking with her first; she abruptly pulled her child out of the center and explained she "wouldn't ever feel comfortable sharing about abuse after that

situation."

Resource-focused Mechanisms

Resource-focused mechanisms within ECE, discussed by all participants, included nurturance and affection, enriching activities, stability and structured routines, consistent but flexible responses to children's dynamic needs, and referrals or on-site provision of therapies and mental health services. These components of ECE were described as counteracting children's IPV exposure and improving their access to extant resources—particularly important for children who had been exposed to severe IPV and for those with special needs. These themes were common to mothers and ECE professionals, with one exception: only mothers focused on ECE as an important point of entry for therapeutic services.

Nurturance. In addition to physical safety and distance from the trauma of IPV, mothers and ECE professionals described nurturance—caregivers' provision of affectionate attention, encouragement, and emotional and physical nourishment—as one of the most critical protective features of child care. One mother, who worked as a Head Start teacher, shared:

> They say you only need one good adult to overcome a mentally cycling situation. And if Head Start has been—and any babysitter—just, if you can be that one adult, then that makes the whole difference in the world.

Nurturing caregiver relationships were especially important for children who were experiencing parental separation due to foster care placement, suffering from severe separation anxiety as a result of IPV, and/or affected by their abusive fathers' imposed

isolation.

Most participants discussed helpful nurturance as taking the form of individual care and attention by family caregivers, daycare center staff, and early childhood educators. Most mothers discussed wanting or appreciating caregivers' efforts to provide individual love and affection, hold and physically comfort their children, reassure them, pay attention to their cues ("to be able to say, 'Hey, there's something going on here'"), and help them cope with "big feelings" and challenging circumstances at home. One mother shared her specific hope for her young daughter's prospective teacher:

> I think sometimes I'm too attached to the situation, so it's hard for me to look at it from- but I would say that [her teacher] being able to comfort her and say, 'You know what, no matter what, it's going to be okay. You don't have to worry about it. We're the adults. We're going to take care of it for you. You don't have to worry about it. You're safe.'

Several other mothers described their children as having a favorite center-based teacher who had provided particularly nurturing support.

ECE providers all acknowledged children's need for nurturance and shared their experiences providing extra support to children affected by IPV. For most, this involved physical affection and attention. A home-based provider encapsulated her approach as "Lots of love, lots of hugs." A former preschool teacher explained that she employed her love language of touch (i.e., her preferred way to receive and express affection; Chapman, 1992) to soothe visibly anxious children in her care. All described the importance of building relationships with children exposed to IPV, even when that took

time, and described their efforts to provide individual care whenever possible:

> My instinct is generally to give them a little extra love, or just take them for a little walk and give them some private time to just talk to you.

Even for mothers who primarily cared for their children, nurturance from non-parental caregivers was discussed as an important protective factor. Most mothers had relied on informal care by friends and family members, and these individuals, most commonly participants' mothers, were generally reported to have developed close, positive relationships with children. In the short term, caregivers' patient nurturance was observed to have helped reduce or fully alleviate some of the perceived symptoms of IPV exposure:

> Especially around men, around my dad and my brothers, it really took her a long time with them. Now she's just blossomed. I mean, as soon as she sees everybody, she's so excited and it's been really great to watch that change over time.

Nurturing family caregiver relationships were also perceived to have positive long-term implications, especially by mothers with childhood trauma histories or few family connections:

> I think it's really important just to have a family connection overall because your family who is going to be who's there for you when everything is going the end of the world for you, or it feels that way, at least. I just feel like them being there for her at such a young age now will give her the opportunity when she's older to go up to them and say, 'Hey. This is going on in my life right now. I need some help.'

Enriching activities. Particularly mothers whose children attended daycare centers or preschool programs expressed appreciation for the enrichment activities, whether structured or unstructured, that children engaged in. These included mindfulness groups facilitated by a school social worker, for children with known trauma histories; art projects; yoga, sports, and other types of movement; sensory activities; and outdoor play. A mother fondly recalled of her infant's daycare center, "They did lots of stuff with the kids, and she really thrived there." An FCC provider described the key needs of children in her care who had experienced IPV as being play-related:

> They definitely loved to be able to explore and play and laugh and have fun with everybody. That's what made their day, coming back to have fun.

Since leaving a domestic violence emergency shelter, one mother lived with her sister, whose outside porch contained lead paint. She typically kept her daughter inside for fear of lead poisoning, and was grateful for her daughter's daycare center programming:

> As long as it's not raining, she goes outside, and they get to play on the playground and in the sand. They go for walks in the woods. They go for walks just around the block. She gets to actually be a kid and be outside.

Stability. Most mothers, and all ECE professionals, discussed stability and consistency within child care settings as highly beneficial for children exposed to IPV. While these terms were sometimes used interchangeably, participants typically discussed stability in terms of child care arrangements and teacher constellations and consistency in terms of caregiver behaviors, expectations, and routines. For children experiencing IPV, and in some cases homelessness or foster care placement, stability was perceived to be an

essential attribute of child care. Mothers generally reported positive outcomes for children whose child care settings remained stable, and who consequently were able to develop nurturing bonds with caregivers. Two ECE providers also discussed their efforts to promote children's stability at home. An FCC provider helped a mother obtain food, resources, and child care subsidies after she left an abusive partner. A children's services director similarly related efforts to collaborate with DV and other social services to support families' stability.

Despite the importance of stability, participants' experiences indicated that children exhibiting aggressive behaviors as a result of IPV exposure may be at risk for experiencing child care disruption. Several mothers described their children being occasionally or frequently sent home from their child care settings due to aggressive behavior. Two shared that their young sons, diagnosed with ADHD and ADHD/autism, respectively, had been expelled from their preschool settings. From the perspective of center-based providers, when children exposed to IPV needed extra support, they sought to engage adults within the building whom children were closest with or responded best to. This approach, however, hinged on staff stability. Unfortunately, several mothers had used centers that suffered from high turnover or described their children's teachers as insufficiently unengaged or supportive.

Consistency and flexibility. In addition to stability, consistency within child care settings was also viewed by mothers and ECE professionals as promoting children's well-being amidst the stressors of IPV. ECE providers and consultants explained that consistent expectations (e.g., for activities, transitions, and discipline) and daily routines

helped alleviate children's stress and provided a sense of security. Most important to mothers, as it related to consistency, was the importance of consistent, patient discipline to compensate for fathers' harsh and erratic parenting. One mother, for instance, shared that her ex-husband had responded severely to their children's age-appropriate tantrums. Since leaving that relationship, she wanted child care providers to exhibit understanding and "address those things appropriately." Another mother highlighted the importance of caregivers' consistency:

> [My daughter] is quick to anger sometimes. And so, I've noticed that [her relative caregivers] can really just sit with it and be patient and just try to work through whatever it is at the moment with her, which I really appreciate all of them being able to do that.

Echoing this ideal of consistent discipline and care, an ECMHC discussed the need for child care providers to have consistent tools in place for when children's behaviors escalated—thus conveying to children, "This is what you can expect from me constantly."

Relatedly, structure and routines were frequently cited protective factors. One mother shared that her son's severe separation anxiety, which became amplified during his father's incarceration, diminished after a period of time due to his consistent drop-off routine. Several mothers pointed to relative caregivers' or center-based providers' consistent routines as bringing children peace and reducing challenging behaviors. Notably, all ECE provider participants discussed their work with young children exposed to IPV as involving a balance between structure and flexibility. Providers tried to closely

observe children's cues and respond flexibly, which involved making exceptions to rules, deviating from routines, or adjusting disciplinary norms:

> When we know something's going on, any kind of trauma, it's giving them- not allowing misbehavior, but giving them a little bit of leeway when they're acting up.

A center-based director described specific accommodations to help comfort children exposed to IPV and other trauma, such as allowing them to use a pacifier in a "no-pacifier classroom" or to bring in a "snuggle item" from home. An FCC provider and IPV survivor mother stated her preference for home-based care, explaining that it provided "enough" structure, but that she "can flip the switch and do whatever the kids need that day."

Entry point for services. Mothers in particular discussed ECE as a valuable entry point for needed services as well as a reference point to help them understand their children's developmental progress and needs. Six mothers had used (n = 4) or were seeking (n = 2) center-based care that provided services for children's special needs. One of these participants explained that her son's daycare involvement allowed her to see and understand his peers' development, which prompted her to identify and seek services for what she realized was an early speech delay. Children had received speech therapy, physical therapy, occupational therapy, counseling, and trauma-responsive mindfulness groups within their respective ECE settings. One center-based program also had a child advocate and social worker on staff. Access to these resources instilled one mother with hope for her son's well-being:

> He's so sensitive and I think it will be really good for him to be able to resolve everything that he's been through instead of just holding it in.

Services provided within children's daycare, preschool, or pre-K programs were described as ideal, as they did not disrupt children's routines or cost parents time and transportation. One mother explained that as a single parent, attending school full-time and transporting her son to his multiple services was very challenging. She felt like she was "trying to do it all," and emphasized that services provided in children's daycare settings would be very helpful to anyone, but especially to single parents. She added: "There's only so many hours in the day, but it's important that kids receive the services they need." Another mother discussed similar challenges:

> We actually had to travel to [a distant town] to get him into counseling and it was really hard to work around his preschool schedule. ... So, I actually ended up discontinuing [counseling] because it was just too much for [him].

By some mothers' accounts, individual teachers and providers were instrumental in helping parents coordinate services for their children. One mother praised her son's preschool teacher as "on top of it"; she "knew everything," and arranged all necessary meetings and evaluations for him to obtain services.

Process-focused Mechanisms

Last, participants discussed process-focused mechanisms that restored children's adaptational systems and thereby aided their positive development following IPV exposure. These comprised emotion regulation support, including help identifying and processing emotions resulting from trauma; and decreased isolation and scaffolded

opportunities to develop social skills. ECE professionals with clinical expertise and ECE administrators tended to focus on the former. Mothers also discussed ECE providers' support of children's emotion regulation, but those who had experienced isolation by abusive partners tended to emphasize their children's decreased isolation and social skill development.

Emotion regulation. Interviews highlighted ECE providers' multiple roles in supporting children's emotion regulation, particularly in center-based settings: designing and maintaining trauma-responsive spaces, supporting individual children's emotion regulation while ensuring group safety, and planning and implementing trauma-responsive programming. Mothers and ECE providers all discussed practical strategies that child care providers employed to support children's emotion regulation. In addition to nurturance and consistency, they included designing and maintaining positive environments with designated "calm spaces"; helping children self-sooth with sensory and fidget toys; taking children for brief walks outside the classroom; modeling calm; using breathing techniques; incorporating yoga, movement, and art; spending ample time outside; and utilizing team-based approaches to help children having emotional outbursts or engaging in dangerous behavior. ECE center administrators and consultants addressed all of these approaches, while the two FCC providers (including an IPV survivor mother who provided home-based care) focused on helping children regulate emotions through nurturing, individual care and consistency.

Emotion regulation support also importantly involved helping children identify and process their feelings, including those related to IPV and other trauma. An ECE

consultant and clinical psychologist stated, “They need to be nurtured; they need to be seen. They need to have an opportunity to share what happened.” Focusing on young children’s negative behaviors, she argued, “is just as damaging in many cases as the original exposure they had.” Mothers’ and ECE providers’ perspectives all reflected a dedication to helping children identify and discuss emotions in developmentally appropriate ways. An FCC provider described having regular conversations with two young children in her care to help them process the trauma of IPV and recent separation from their mother during their non-kinship foster care placement. After providing them space to share their experiences, she was able to provide reassurance: ‘Mommy loves you, and it will all get better.’ Several mothers favorably described similar practices employed by their children’s child care providers, which they regarded as empowering of their children. Some mothers reported that their children generally felt more comfortable opening up to non-parental caregivers or felt the need to protect their mothers, in which cases, child care providers’ ability to connect and listen was extremely valuable. Mothers recalled ECE providers helping children talk through the pain of missing their fathers, their IPV-related anxieties, and their foster care experiences.

Social development. Families’ isolation, imposed by abusive partners in conjunction with social distancing during the pandemic, prompted mothers to feel concerned about children’s social development. Several children were born during the pandemic, and mothers who were interviewed in early 2022 still described very few local playgroups or opportunities to meet other families. ECE was thus perceived to offer children critical opportunities to socialize with peers and develop social skills. One

participant shared how her daughter's Head Start involvement had fostered her social development and overall well-being:

> Just the socialization- I mean, she's been in Head Start since she turned three. It's been phenomenal for her. It's helped her be more even. She doesn't cry as much.

Another shared that her son had experienced some bullying throughout his years in daycare, but despite this she perceived that social interaction had benefitted him tremendously. For one child with diagnosed ADHD, however, the high child: adult ratios in his preschool center gave rise to social challenges:

> He really struggled because he was only used to ever spending time with his sister. … And then his classmates are all little people with the same little emotions, and it was really hard for him. He struggled. And that's why he had to be sent home so frequently.

Two mothers discussed the importance of socialization as an unmet need. One had primarily used her mother for child care but wondered if center-based care would have improved his social development, as "children learn best from other children." The second had cared for her child until he attended preschool on her abuser's insistence. At the time, however, she wished she could send him to daycare to break the social isolation imposed by his father and help him form friendships in anticipation of preschool.

Discussion

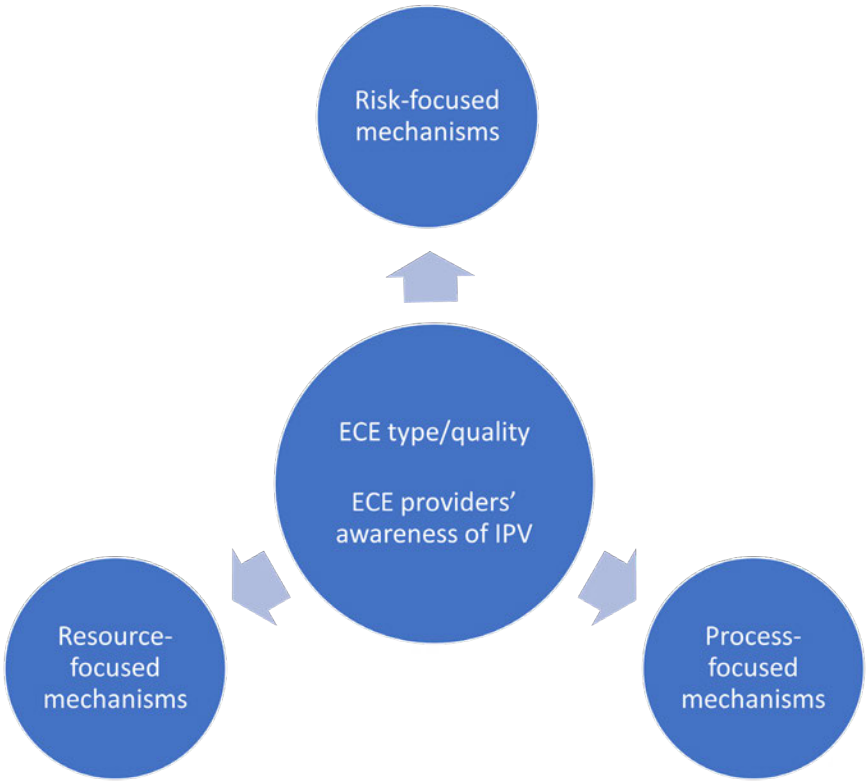
The current study explored IPV survivor mothers' and ECE professionals' perceptions of young children's needs from ECE and the ways they perceived ECE to have promoted children's positive functioning, i.e., resilience, during and following IPV

exposure. Risk-focused mechanisms were deemed a critical first line of defense for children, particularly by mothers. They included reduced exposure to IPV, reduced exposure to fathers' harsh parenting and maternal stress and anxiety caused by IPV, and prevention of abusive fathers' unsafe contact with children within ECE settings. ECE providers' mandated reporting of child maltreatment was viewed as a protective factor by an ECMHC but was not perceived positively by mothers. Safety within ECE was especially critical while perpetrators resided with children, and immediately after mothers left abusive relationships, when risk of harm (including intimate partner homicide) often increases. These findings highlight the potential role of ECE in preventing childhood IPV exposure. Participants' discussion predominantly addressed resource-focused mechanisms within ECE, viewed as mitigating the negative influences of IPV exposure on children's well-being. These included nurturance, enriching activities, stability, a balance of consistency and flexibility, and facilitated access to therapeutic services. Resource-focused mechanisms were especially important for children who had been exposed to severe IPV and for those with special needs. Consistent with previous research, the prevalence of ADHD, ASD, and speech delays were much higher in this sample, compared with young children generally (Rizo et al., 2020). Finally, process-focused mechanisms that restored children's adaptational systems comprised support of emotion regulation and social development. The latter was especially important for children whose fathers had systematically isolated their families, thereby limiting children's opportunities to make friends and develop social skills.

Generally, multi-level interventions that combine multiple or all three types of

these mechanisms are deemed the most effective for supporting young children experiencing adversity (Yates et al., 2015). Current findings therefore illustrate the promising nature of high quality ECE, which may feature risk-focused, resource-focused, and process-focused mechanisms, as a resilience intervention for children exposed to IPV. Notably, however, within each category of resilience-promoting mechanisms, the effectiveness of support depended, to a meaningful extent, on caregivers' awareness of children's traumatic experiences and the perceived quality of care. These relationships are depicted in Figure 4.1. Importantly, while mothers in this sample overwhelmingly favored disclosing IPV to ECE providers toward enhancing the care their children received, this may not be a safe option for many survivors in states considering children's exposure to IPV to comprise child abuse and neglect. Mandated reporting and other formal child welfare policies relating to children's exposure to IPV vary across the U.S., with some states classifying IPV exposure as a form of child maltreatment and others classifying exposure as maltreatment only if it has harmed children (Child Welfare Information Gateway, 2016). Even in states relying on the latter standard, there may be significant risks for survivor mothers who disclose IPV to ECE providers. One recent study examined substantiated referrals to one such state-level child welfare agency, and found that 20% were IPV-related, and that a plurality had named both a male and a female perpetrator (Victor et al., 2019). Findings such as these suggest that it is not uncommon for IPV survivor mothers to be substantiated for child maltreatment based on their partners' IPV perpetration, even in states where IPV exposure itself does not constitute abuse or neglect.

Figure 4.1 ECE Features Promoting Resilience for Children Exposed to IPV



The four ECE providers in this sample, as well as the two survivor mothers who worked as ECE providers, were generally knowledgeable about IPV and its influences on young children and displayed high levels of empathy for families affected by IPV. While most described children's behavioral challenges in their respective settings, they did so sensitively and perceived these behaviors to be signaling children's heightened needs for nurturance and support. On the other hand, mothers' perceptions of their ECE providers varied, with most describing a mix of positive and negative experiences. Two children with diagnosed disorders experienced expulsion from their respective centers. A non-licensed home-based provider and two center-based settings were described as

insufficiently supportive of children's needs, which mothers attributed to high child: adult ratios and teacher burnout. Overall, however, children reportedly had positive ECE experiences and greatly benefitted from the risk-focused, resource-focused, and process-focused mechanisms within these settings.

Findings suggest that informal, formal home-based, and center-based ECE arrangements may each provide important benefits for this population. Benefits of informal care for children included the development of strong, long-term bonds and consistent individual attention. Grandmothers' care was generally viewed as most beneficial, compared with other friends' and relatives' care. With the exception of one mother, who described overcrowded conditions and poor care by a non-licensed home-based provider she had once used, FCC providers were highly valued by mothers due to their smaller group sizes and balance of structure and flexibility. The home-based providers who were interviewed—one licensed, the other unlicensed and an IPV survivor mother—both described their early childhood and trauma-related training and exhibited strong commitment to nurturing and providing trauma-responsive care to children who had experienced IPV and other adversity.

Much of mothers' and ECE professional participants' discussion about protective features of ECE focused on center-based settings. According to participants, the benefits of center-based care for children exposed to IPV hinged on child: adult ratios and training: providers who lacked understanding of trauma and IPV, or who worked in understaffed settings, tended to inadequately support children's needs. Conversely, center-based care typically offered more opportunities for social development, structured

routines, enriching activities, and access to therapeutic services, which greatly benefited many children. Among the most effective center-based settings discussed were those delivered within facilities that consolidated other family services, and those offering a suite of on-site services and specialized staff, such as family liaisons and social workers.

Limitations of this study are as follows. First, the quality of ECE discussed by participants was unknown, making it difficult to ascertain how various quality features had influenced children. This study highlights the need for quantitative examinations of the ECE characteristics that most importantly influence this population. Second, some children in this sample were not only exposed to IPV, but also were maltreated by their fathers; future research is needed to understand how ECE might influence children exposed to IPV only vs. those with "dual exposure" to IPV and child maltreatment, given evidence of their disparate trauma symptomology (Showalter et al., 2020). Third, findings may have been influenced by selection bias; for instance, ECE professionals with greater attunement to or interest in supporting children exposed to IPV were potentially more likely to participate in the study. While the perspectives of informal caregivers were not included in this study, findings indicate the important caregiving role they play for this population and suggest the need for additional research to understand their perspectives.

Conclusion

Despite these limitations, current study findings lay important groundwork for understanding how ECE may protect and promote resilience among children exposed to IPV. Previous researchers have highlighted children's early years as an important time to

prevent and mitigate the negative influences of IPV exposure, as children "form much of their worldview and socioemotional response to life during these years" (Howell & Graham-Bermann, 2011; 100). Especially given the very low rates of mental health service uptake among young children in need of trauma-related support, ECE can potentially play a significant role in promoting their resilience (Loomis, 2018). This study contributes to a growing literature elucidating the protective influences of ECE for children exposed to trauma and adversity and lends support to a conceptualization of resilience that accounts for not only children's individual and family characteristics, but also their extrafamilial contexts. Current findings suggest that integrating knowledge of trauma into ECE policies, procedures, and practices may increase support to children experiencing IPV, maltreatment, and other trauma.

References

Alessi, J. J., and Hearn, K. (1984). Group treatment of children in shelters for battered women. In A. R. Roberts (Ed.), *Battered women and their families: Intervention strategies and treatment programs (pp. 49–62).* New York: Springer.

Berry, D., Blair, C., Willoughby, M., Garrett-Peters, P., Vernon-Feagans, L., Mills-Koonce, W. R., Cox, M., Burchinal, P., Burton, L., Crnic, K., Crouter, A., Greenberg, M., Lanza, S., & Werner, E. (2016). Household chaos and children's cognitive and socio-emotional development in early childhood: Does childcare play a buffering role? *Early Childhood Research Quarterly*, *34*, 115–127. https://doi.org/10.1016/j.ecresq.2015.09.003

Bidarra, Z. S., Lessard, G., & Dumont, A. (2016). Co-occurrence of intimate partner violence and child sexual abuse: Prevalence, risk factors and related issues. *Child Abuse and Neglect*, *55*. https://doi.org/10.1016/j.chiabu.2016.03.007

Braun, V., & Clarke, V. (2014). Using thematic analysis in psychology Using thematic analysis in psychology. *Psychiatric Quarterly*, *0887*(1), 37–41. https://doi.org/10.1111/j.1460-2466.1978.tb01621.x

Burchinal, M., Howes, C., Pianta, R., Bryant, D., Early, D., Clifford, R., & Barbarin, O. (2008). Predicting child outcomes at the end of kindergarten from the quality of pre-kindergarten teacher-child interactions and instruction. *Applied Developmental Science*, *12*(3). https://doi.org/10.1080/10888690802199418

Camacho, K., Ehrensaft, M. K., & Cohen, P. (2012). Exposure to intimate partner violence, peer relations, and risk for internalizing behaviors: A prospective longitudinal study. *Journal of Interpersonal Violence*, *27*(1), 125–141. https://doi.org/10.1177/0886260511416474

DeJonghe, E. S., Bogat, G. A., Levendosky, A. A., Von Eye, A., & Davidson, W. S. (2005). Infant exposure to domestic violence predicts heightened sensitivity to adult verbal conflict. *Infant Mental Health Journal*, *26*(3). https://doi.org/10.1002/imhj.20048

DeJonghe, E. S., von Eye, A., Bogat, G. A., & Levendosky, A. A. (2011). Does witnessing intimate partner violence contribute to toddlers' internalizing and externalizing behaviors? *Applied Developmental Science*, *15*(3), 129–139. https://doi.org/10.1080/10888691.2011.587713

Dubowitz, H., Thompson, R., Proctor, L., Metzger, R., Black, M. M., English, D., Poole, G., & Magder, L. (2016). Adversity, Maltreatment, and Resilience in Young Children. *Academic Pediatrics*, *16*(3). https://doi.org/10.1016/j.acap.2015.12.005

Fantuzzo, J. W., & Fusco, R. A. (2007). Children's direct exposure to types of domestic violence crime: A population-based investigation. *Journal of Family Violence*, *22*(7), 543–552. https://doi.org/10.1007/s10896-007-9105-z

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of Childhood Exposure to Violence, Crime, and Abuse. *JAMA Pediatrics*, *169*(8). https://doi.org/10.1001/jamapediatrics.2015.0676

Fogarty, A., Giallo, R., Wood, C., Kaufman, J., & Brown, S. (2020). Emotional-behavioral resilience and competence in preschool children exposed and not exposed to intimate partner violence in early life. *International Journal of Behavioral Development*, *44*(2). https://doi.org/10.1177/0165025419830241

Georgsson, A., Almqvist, K., & Broberg, A. G. (2011). Dissimilarity in vulnerability: Self-reported symptoms among children with experiences of intimate partner violence. *Child Psychiatry and Human Development*, *42*(5). https://doi.org/10.1007/s10578-011-0231-8

Gewirtz, A. H., & Edleson, J. L. (2007). Young children's exposure to intimate partner violence: Towards a developmental risk and resilience framework for research and intervention. *Journal of Family Violence*, *22*(3), 151–163. https://doi.org/10.1007/s10896-007-9065-3

Giles, L. C., Davies, M. J., Whitrow, M. J., Warin, M. J., & Moore, V. (2011). Maternal depressive symptoms and child care during toddlerhood relate to child behavior at age 5 years. *Pediatrics*, *128*(1). https://doi.org/10.1542/peds.2010-3119

Graham-Bermann, S. A., Gruber, G., Howell, K. H., & Girz, L. (2009). Factors discriminating among profiles of resilience and psychopathology in children exposed to intimate partner violence (IPV). *Child Abuse and Neglect*, *33*(9). https://doi.org/10.1016/j.chiabu.2009.01.002

Grip, K. K., Almqvist, K., Axberg, U., & Broberg, A. G. (2014). Perceived Quality of Life and Health Complaints in Children Exposed to Intimate Partner Violence. *Journal of Family Violence*, *29*(6). https://doi.org/10.1007/s10896-014-9622-5

Haight, W. L., Shim, W. S., Linn, L. M., & Swinford, L. (2007). Mothers' strategies for protecting children from batterers: The perspectives of battered women involved in child protective services. *Child Welfare*, *86*(4).

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse and Neglect*, *34*(10). https://doi.org/10.1016/j.chiabu.2010.03.001

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). Children's exposure to intimate partner violence and other family violence. *Juvenile Justice Bulletin*.

Hardesty, J. L., Oswald, R. F., Khaw, L., Fonseca, C., & Chung, G. (2008). Lesbian mothering in the context of intimate partner violence. *Journal of Lesbian Studies*, *12*(2–3). https://doi.org/10.1080/10894160802161364

Herba, C. M., Tremblay, R. E., Boivin, M., Liu, X., Mongeau, C., Séguin, J. R., & Coté, S. M. (2013). Maternal depressive symptoms and children's emotional problems can early child care help children of depressed mothers? *JAMA Psychiatry*, *70*(8), 830–838. https://doi.org/10.1001/jamapsychiatry.2013.1361

Howell, K. H. (2011). Resilience and psychopathology in children exposed to family violence. *Aggression and Violent Behavior*, *16*(6), 562–569. https://doi.org/10.1016/j.avb.2011.09.001

Howell, K. H., Barnes, S. E., Miller, L. E., & Graham-Bermann, S. A. (2014). Developmental variations in the impact of intimate partner violence exposure during childhood. *Journal of Injury and Violence Research*, *8*(1), 43–57. https://doi.org/10.5249/jivr.v8i1.663

Howell, K. H., & Graham-Bermann, S. A. (2011). The multiple impacts of intimate partner violence on preschool children. *How Intimate Partner Violence Affects Children: Developmental Research, Case Studies, and Evidence-Based Intervention.*, 87–107. https://doi.org/10.1037/12322-005

Huang, C. C., Vikse, J. H., Lu, S., & Yi, S. (2015). Children's Exposure to Intimate Partner Violence and Early Delinquency. *Journal of Family Violence*, *30*(8), 953–965. https://doi.org/10.1007/s10896-015-9727-5

Johnson, V. K., & Lieberman, A. F. (2007). Variations in behavior problems of preschoolers exposed to domestic violence: The role of mothers' attunement to children's emotional experiences. *Journal of Family Violence*, *22*(5). https://doi.org/10.1007/s10896-007-9083-1

Kelly, U. A. (2009). "I'm a mother first": The influence of mothering in the decision-making processes of battered immigrant Latino women. *Research in Nursing and Health*, *32*(3). https://doi.org/10.1002/nur.20327

Kita, S., Sato, I., Sakka, M., Soejima, T., & Kamibeppu, K. (2021). Does the Use of Childcare Services Reduce the Impact of Intimate Partner Violence on the Quality of Life of Children?: Multiple-Group Structural Equation Modeling. *Applied Research in Quality of Life*, *16*(5). https://doi.org/10.1007/s11482-020-09847-w

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*(2). https://doi.org/10.1037/0022-006X.71.2.339

Klein, S., Mihalec-Adkins, B., Benson, S., & Lee, S. Y. (2018). The benefits of early care and education for child welfare-involved children: Perspectives from the field. *Child Abuse and Neglect*, *79*. https://doi.org/10.1016/j.chiabu.2018.02.015

Lee, K., & Ludington, B. (2016). Head Start's Impact on Socio-Emotional Outcomes for Children Who Have Experienced Violence or Neighborhood Crime. *Journal of Family Violence*, *31*(4). https://doi.org/10.1007/s10896-015-9790-y

Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davidson, W. S., & Von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology*, *20*(4). https://doi.org/10.1037/0893-3200.20.4.544

Lipscomb, S. T., Pratt, M. E., Schmitt, S. A., Pears, K. C., & Kim, H. K. (2013). School readiness in children living in non-parental care: Impacts of Head Start. *Journal of Applied Developmental Psychology*, *34*(1). https://doi.org/10.1016/j.appdev.2012.09.001

Loomis, A. M. (2018). The Role of Preschool as a Point of Intervention and Prevention for Trauma-Exposed Children: Recommendations for Practice, Policy, and Research. *Topics in Early Childhood Special Education*, *38*(3), 134–145. https://doi.org/10.1177/0271121418789254

Love, J. M., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., Brooks-Gunn, J., Chazan-Cohen, R., Tarullo, L. B., Brady-Smith, C., Fuligni, A. S., Schochet, P. Z., Paulsell, D., & Vogel, C. (2005). The Effectiveness of Early Head Start for 3-Year-Old Children and Their Parents: Lessons for Policy and Programs. *Developmental Psychology*, *41*(6). https://doi.org/10.1037/0012-1649.41.6.88

Maguire-Jack, K., Hardi, F., Stormer, B., Lee, J. Y., Feely, M., Rostad, W., Ford, D. C., Merrick, M. T., Murphy, C. A., & Bart. Klika, J. (2022). Early childhood education and care policies in the U.S. And their impact on family violence. *Children and Youth Services Review*, *142*. https://doi.org/10.1016/j.childyouth.2022.106653

Manning, L. G., Davies, P. T., & Cicchetti, D. (2014). Interparental Violence and Childhood Adjustment: How and Why Maternal Sensitivity Is a Protective Factor. *Child Development*, *85*(6). https://doi.org/10.1111/cdev.12279

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3). https://doi.org/10.1037/0003-066X.56.3.227

Masten, A. S., & Coatsworth, J. D. (1998). The Development of Competence in Favorable and Unfavorable Environments: Lessons from Research on Successful Children. *American Psychologist*, *53*(2). https://doi.org/10.1037/0003-066X.53.2.205

McDonald, R., Jouriles, E. N., Briggs-Gowan, M. J., Rosenfield, D., & Carter, A. S. (2007). Violence Toward a Family Member, Angry Adult Conflict, and Child Adjustment Difficulties: Relations in Families With 1- to 3-Year-Old Children. *Journal of Family Psychology*, *21*(2). https://doi.org/10.1037/0893-3200.21.2.176

McDonald, R., Jouriles, E. N., Ramisetty-Mikler, S., Caetano, R., & Green, C. E. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology*, *20*(1). https://doi.org/10.1037/0893-3200.20.1.137

Miles, Huberman, A. M., & Huberman, A. M. (1994). *Qualitative data analysis: an expanded sourcebook (2nd ed.).* Sage Publications.

Mortensen, J. A., & Barnett, M. A. (2015). Teacher–Child Interactions in Infant/Toddler Child Care and Socioemotional Development. *Early Education and Development*, *26*(2), 209–229. https://doi.org/10.1080/10409289.2015.985878

Mortensen, J. A., & Barnett, M. A. (2016). The role of child care in supporting the emotion regulatory needs of maltreated infants and toddlers. *Children and Youth Services Review*, *64*, 73–81. https://doi.org/10.1016/j.childyouth.2016.03.004

National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network (2002). Early child care and children's development prior to school entry: Results from the NICHD study of early child care. American Educational Research Journal, 39(1), 133–164.

Nicholson, J. H., & Ha, Y. (2022). Intimate Partner Violence, Child Care, and Children's Behavioral Outcomes. *Journal of Family Violence*. https://doi.org/10.1007/s10896-022-00464-9

Nixon, K. L., Bonnycastle, C., & Ens, S. (2017). Challenging the Notion of Failure to Protect: Exploring the Protective Strategies of Abused Mothers Living in Urban and Remote Communities and Implications for Practice. *Child Abuse Review*, *26*(1). https://doi.org/10.1002/car.2417

Osofsky, J. D., & Lieberman, A. F. (2011). A call for integrating a mental health perspective into systems of care for abused and neglected infants and young children. *American Psychologist*, *66*(2). https://doi.org/10.1037/a0021630

Patton, M. Q. (2002). *Qualitative evaluation and research methods (2nd ed.).* Sage Publications.

Pears, K. C., Fisher, P. A., Kim, H. K., Bruce, J., Healey, C. V., & Yoerger, K. (2013). Immediate Effects of a School Readiness Intervention for Children in Foster Care. *Early Education and Development*, *24*(6). https://doi.org/10.1080/10409289.2013.736037

Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Culkin, M. L., Howes, C., Kagan, S. L., & Yazejian, N. (2001). The relation of preschool child-care quality to children's cognitive and social developmental trajectories through second grade. *Child Development*, *72*(5). https://doi.org/10.1111/1467-8624.00364

Peled, E., & Gil, I. B. (2011). The mothering perceptions of women abused by their partner. *Violence Against Women*, *17*(4). https://doi.org/10.1177/1077801211404676

Perry, D. F., & Conners-Burrow, N. (2016). Addressing Early Adversity Through Mental Health Consultation in Early Childhood Settings. *Family Relations*, *65*(1). https://doi.org/10.1111/fare.12172

Seidman. (1991). *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences.* Teachers College Press.

Shonkoff, J. P., & Phillips, D. (2000). *From Neurons to Neighborhoods: The Science of Early Child Development.* National Academy Press.

Spearman, K. J., Hoppe, E., & Jagasia, E. (2023). A systematic literature review of protective factors mitigating intimate partner violence exposure on early childhood health outcomes. In *Journal of Advanced Nursing* (Vol. 79, Issue 5). https://doi.org/10.1111/jan.15638

Sternberg, K. J., Baradaran, L. P., Abbott, C. B., Lamb, M. E., & Guterman, E. (2006). Type of violence, age, and gender differences in the effects of family violence on children's behavior problems: A mega-analysis. *Developmental Review*, *26*(1). https://doi.org/10.1016/j.dr.2005.12.001

Tekin, E. (2021). An overview of the child care market in the United States [White paper]. National Bureau of Economic Research. https://www.nber.org/sites/default/files/2021-10/White%20Paper-Tekin-101.06.21_revised.pdf

Vandell, D. L., Belsky, J., Burchinal, M., Steinberg, L., & Vandergrift, N. (2010). Do Effects of early child care extend to age 15 years? Results from the nichd study of early child care and youth development. *Child Development*, *81*(3), 737–756. https://doi.org/10.1111/j.1467-8624.2010.01431.x

Victor, B. G., Henry, C., Gilbert, T. T., Ryan, J. P., & Perron, B. E. (2019). Child Protective Service Referrals Involving Exposure to Domestic Violence: Prevalence,

Associated Maltreatment Types, and Likelihood of Formal Case Openings. *Child Maltreatment*, *24*(3). https://doi.org/10.1177/1077559519843605

Votruba-Drzal, E., Coley, R. L., Maldonado-Carreño, C., Li-Grining, C. P., & Chase-Lansdale, P. L. (2010). Child care and the development of behavior problems among economically disadvantaged children in middle childhood. *Child Development*, *81*(5). https://doi.org/10.1111/j.1467-8624.2010.01485.x

Watamura, S. E., Phillips, D. A., Morrissey, T. W., McCartney, K., & Bub, K. (2011). Double Jeopardy: Poorer Social-Emotional Outcomes for Children in the NICHD SECCYD Experiencing Home and Child-Care Environments That Confer Risk. *Child Development*, *82*(1). https://doi.org/10.1111/j.1467-8624.2010.01540.x

Yates, T. M., Tyrell, F. A., & Masten, A. S. (2015). Resilience Theory and the Practice of Positive Psychology From Individuals to Societies. In *Positive Psychology in Practice: Promoting Human Flourishing in Work, Health, Education, and Everyday Life: Second Edition*. https://doi.org/10.1002/9781118996874.ch44

Table 4.1 Sample Characteristics

	n	%
IPV Survivor Mothers (*n* = 17)		
Age (average)	29.4	
Relationship with IPV perpetrator		
Currently together	1	5.9
Left within past year	7	41.2
Left >1 year ago	7	41.2
Race/ethnicity		
Non-White Hispanic	3	17.6
Black, American Indian and Alaska Native	1	5.9
White	13	76.5
Focal child's age (*n* = 26)		
0–1 years	6	23
2–3 years	10	38.5
4–5 years	10	38.5
Focal child's gender (*n* = 26)		
Boy	12	46.2
Girl	14	53.8
Focal children's formal diagnoses (*n* = 26)		
Speech delay	5	19.2
Attention deficit and hyperactive disorder	3	11.5
ASD	2	7.7
Attachment Disorder	1	3.8
Professional ECE stakeholders (*n* = 6)		
Age (mean, *n* = 4)	45	
Race/ethnicity		
White	4	
Unknown	2	
Professional Role		
ECE provider/teacher	2	33.3
ECE administrator	2	33.3
ECE Consultant	2	33.3
Worked with children exposed to IPV in current role(s)	4	66.7
Worked with children exposed to IPV in past role	2	33.3

Notes. IPV = intimate partner violence; ECE = early care and education.

CHAPTER 5

CONCLUSION

This dissertation first examined the possible influences of informal, formal home-based, and center-based ECE engagement on the behavioral outcomes of young children who had been exposed to IPV. Findings from this first quantitative study indicated that each respective type of non-parental care may buffer the negative effects of IPV on children's internalizing and/or externalizing behavioral problems (IBP, EBP), with center-based care providing the most expansive protective influence. Having established these benefits of ECE, the dissertation next turns to survivor mothers' ECE decision making and the possible influences of IPV on children's care arrangements. Emerging from this second qualitative exploration was a recurrent theme of mothers' steadfast prioritization of children's safety and well-being—whether that entailed using center-based care with on-site therapeutic services, or parental or other informal care to meet children's need for individual nurturance. Mothers overcame considerable challenges: they resisted IPV perpetrators' restraint of and interference in child care and arranged safe care for their children despite structural barriers to affording and accessing it. Finally, the third study focuses on children's experiences within ECE settings: specifically, the mechanisms by which ECE promoted their resilience. It identified protective factors within ECE environments that may reduce young children's exposure to IPV and related risks, mitigate the negative influences of IPV on their well-being, and support their adaptational systems to help them thrive.

Why ECE?

An estimated 15.5 million U.S. children live in families in which IPV occurred in the past year, and nearly 60% of young children in the U.S. receive regular non-parental care, whether provided by informal babysitters, formal home-based caregivers, or center-based teachers (McDonald et al., 2006; Tekin, 2021). The prevalence of IPV exposure among children engaged in non-parental ECE is not firmly established, but it is highly likely that many ECE providers care for children who are experiencing IPV or have previously been exposed to IPV. Within the sample of 3,108 U.S. children examined in Chapter 2 of this dissertation, for example, more than 29% of those regularly receiving non-parental home-based care at age 3 and nearly 32% of those receiving center-based care lived with mothers who had experienced IPV within the past year. Given the likelihood of widespread ECE engagement among U.S. children who are exposed to IPV, it is important to develop a strong understanding of the role ECE plays in their lives, the factors determining their ECE arrangements, and the mechanisms within ECE settings that contribute to their well-being.

Several characteristics of ECE make it particularly promising as a tool for preventing children's IPV exposure and mitigating its negative influences. First, ECE is a well-timed intervention. Young children are at higher risk for IPV exposure, compared with school-age children (DeJonghe et al., 2005; Finkelhor et al., 2015). Additionally, the time frame of ECE aligns with children's earliest periods of development, during which their brains are extremely sensitive to traumatic stress but also highly plastic (Shonkoff & Phillips, 2000). Thus, reducing young children's trauma exposure and promoting their

healthy development may have profound positive, cascading effects. As findings from Chapter 4 confirm, there is high potential for young children's involvement in out-of-home ECE to reduce their exposure to IPV, to their fathers' harsh parenting and maltreatment, and to maternal and household stress resulting from IPV, during this early period of increased risk. Reminiscent of findings from previous qualitative studies with IPV survivor mothers who had protected their children by temporarily removing them from the home environment (Haight et al., 2007; Hardesty et al., 2008; Kelly, 2009; Nixon et al., 2017; Peled & Gil, 2011), mothers interviewed for this dissertation viewed their children's reduced exposure to IPV and associated stressors as a key protective feature of ECE.

Second, as evidenced by Chapter 4 findings, common features of high quality ECE align closely with some of the most important protective factors for children exposed to IPV, indicating the potential for ECE settings to act as "natural systems of care" (Loomis, 2018, 134). Previous researchers have proposed that quality ECE can provide positive environments in which children can develop emotion regulation, learn to express emotions and assert themselves, develop strong relationships with their caregivers, and connect with supportive communities and networks (Sciaraffa et al., 2018). Chapter 4 findings lend support to these ideas, and additionally highlight that for children exposed to IPV, ECE can play important roles in reducing children's risk exposure, supporting their social development, and serving as a non-stigmatizing point of entry for therapeutic services.

Third, ECE underpins survivor mothers' ability to pursue work and education and

thereby achieve self-sufficiency. It is therefore a likely target for IPV perpetrators, who aim to control their partners, undermine their self-sufficiency, and prevent them from leaving the relationship. Chapter 3 reveals that perpetrators' child care related IPV tactics and motivations reflected both economic abuse (e.g., refusing to provide care to prevent survivors from working or attending school) and the use of children (e.g., threatening to take children from ECE settings to provoke mothers' anxiety). While several qualitative studies within the economic abuse literature have identified some similar tactics (Sanders, 2015; Showalter et al., 2022; Voth Schrag & Edmond, 2017), this dissertation offers the first in-depth examination of perpetrators' child care involvement and influences.

Finally, ECE is widely available and utilized by a majority of U.S. families, which makes it a practical and non-stigmatizing mode of support (Lipscomb et al., 2019). This may be particularly relevant to families experiencing IPV. Distrust of formal systems due to stigma, the perceived punitive consequences of disclosing abuse (Liang et al., 2005; Overstreet & Quinn, 2013), and fears about mandatory reporting and child removal (Lippy et al., 2020) have been shown to importantly affect survivor mothers' help-seeking decisions. It is possible that these types of concerns, in conjunction with limited availability and access, would affect mothers' use of some IPV-specific services. However, based on Chapter 3 findings, there was little indication that survivors' concerns relating to stigma or mandatory reporting undermined their children's ECE engagement. In fact, the one mother participant who chose not to disclose IPV to a formal ECE provider due to these concerns (specifically, her ongoing CPS involvement) utilized center-based care and praised its positive influences on her young daughter.

Interpretation of Study Findings

Quantitative and Qualitative Samples

There were significant differences between the quantitative and qualitative samples of survivor mothers, which should inform the interpretation of results. These related to data collection time frame (1998–2006, vs. 2022–2023), region (U.S. vs. New England region), locale (large cities, vs. mix of smaller urban, suburban, and rural communities), participant race (majority black/African American vs. majority white), and participant immigration status (13% non-U.S. born vs. all U.S. born). Mothers' asynchronous contexts and disparate sociocultural backgrounds no doubt affected their perceptions and decisions relating to ECE (Radey & Brewster, 2007). Additionally, the concentration and accessibility of center-based and family child care options likely differed between the two samples, as higher concentrations of formal and subsidized child care options are typically found within large urban centers, compared with more rural regions.

There was also some variation between samples relating to ECE utilization. Among the 17 mothers interviewed for Chapters 3 and 4, eight were primarily caring for their children and nine were primarily using center-based care at the time of interviews. Most of the mothers primarily caring for children had infants or young toddlers, whereas most mothers utilizing center-based care had preschool or pre-K aged children. Nearly all mothers had used informal child care provided by friends or family members during periods throughout their children's early years. Within the FFCWS sample, survivor mothers' child care arrangements at Year 3 varied more widely. Of the 900 mothers who

reported any IPV within the past year at Year 3, 36.8% primarily cared for their children; 31.2% used home-based care; and 32.0% used center-based care. The Chapter 2 study did not examine child care arrangements at each wave, however; it is possible that at Year 1, when their children were infants and young toddlers, a greater proportion of mothers primarily cared for their children.

In other ways, the two samples of mothers and their children may not be exceedingly different. While child care market and subsidy policies may have influenced these groups of women differently, child care options have not changed dramatically since the early 2000s. Research also indicates that characteristics of IPV perpetration, perpetrators, and survivors are very similar across the rural-urban divide (Edwards, 2015).

Protective Influences of ECE

With these considerations in mind, this dissertation elucidated some of the positive influences ECE has on IPV-exposed young children's well-being, as well as some of the possible underlying processes by which it can protect and support them. Chapter 2 offered compelling evidence that ECE, particularly center-based care, can buffer the negative effects of IPV exposure on children's behavioral outcomes. Results showed that for children exposed to frequent IPV, all types of non-parental care significantly buffered the influences of IPV on both IBP and EBP. For children respectively exposed to physical and coercive abuse, ECE buffered the negative influences of IPV on IBP, and center-based care additionally mitigated the effects of physical IPV on children's EBP.

As discussed in Chapter 2, nearly half of mothers experiencing frequent IPV, but only 15% of mothers reporting less frequent IPV, had experienced both coercive and physical IPV. Although the FFCWS dataset did not include a measure of IPV severity, this experience of both physical and coercive IPV may represent a more severe form of abuse. If so, this would suggest that ECE can play an especially protective role for children experiencing more frequent and more severe IPV. Qualitative data from survivor mother interviews generally support these findings but highlight the importance of quality features within care settings—e.g., child: adult ratios that support caregivers' ability to provide nurturance and individual attention—especially for children exhibiting externalizing behavioral problems.

While Chapter 2 findings clearly point to a protective influence of ECE for young children exposed to IPV, it is less clear whether this influence stemmed from reduced exposure to IPV and associated risks (i.e., risk-focused mechanisms) or from features within children's ECE environments that attenuated the negative influences of IPV on their well-being (i.e., resource-focused mechanisms) and/or promoted their adaptational systems (i.e., process-focused mechanisms). Chapter 4 findings, based on the expert perspectives of survivor mothers and ECE professionals, support all three possibilities. This chapter clarified some of the key protective factors within ECE environments that have helped reduce children's exposure to IPV risks and mitigate its harmful influences. Based on the perspectives of mothers and ECE professionals, mechanisms within ECE environments that promoted children's resilience by reducing risk exposure included less time spent in home environments where IPV occurred, reduced exposure to abusive

fathers' harsh parenting and to maternal stress and anxiety caused by IPV, and prevention of abusive fathers' unsafe contact (e.g., by enforcing court-issued protection orders). Resource-focused mechanisms comprised nurturance, enriching activities, stability, consistency, flexibility, and facilitated access to therapeutic services for children who needed them. Finally, process-focused mechanisms to strengthen children's adaptational systems included support of emotion regulation and social development, which previous studies have identified as two integral domains of competence for young children exposed to IPV (Gewirtz & Edleson, 2007; Howell, 2011).

Despite differences between the samples, findings from Chapter 4 may aid the interpretation of findings from Chapter 2. It is possible that ECE had the most expansive benefits for children exposed to frequent (and likely more severe) IPV due to the overlapping influences of these three respective mechanisms. For children whose mothers were frequently abused, out-of-home care may have offered critical risk-focused benefits, in addition to the other resource- and process-focused protective factors found within their ECE environments. Research shows that children's exposure to severe IPV is associated with co-occurring physical maltreatment (Rousson et al., 2023). Thus, children exposed to frequent IPV may also have been more likely to experience dual exposure to IPV and maltreatment, which is associated with more severe symptomology (Hultmann et al., 2022). For these children, risk-focused mechanisms within ECE settings may have offered protection from both forms of trauma in their homes. Alternatively, children who less frequently witnessed IPV may have still benefitted from the resource- and process-focused mechanisms within ECE settings, but their time spent out of the home may not

have offered the same critical protection.

Factors Constraining ECE's Protective Influence

Despite these benefits, findings from this dissertation also reveal some limitations to the protective influences of ECE for children exposed to IPV. Chapter 4 findings indicate that ECE may play a limited protective role and may in fact exacerbate the harms of IPV on children's well-being when it lacks key quality features. Of particular concern to survivor mothers were high child: adult ratios within home-based or center-based settings, as these undermined providers' ability to support children's social and emotional needs. Two preschool-aged boys were regularly sent home from their respective center-based ECE settings based on externalizing behaviors perceived to endanger other children. One, whose father's severe IPV perpetration had resulted in his temporary foster care placement, ultimately experienced formal expulsion from his preschool center. These two children had been formally diagnosed with attention deficit and hyperactive disorder (ADHD), and with ADHD and autism spectrum disorder (ASD), respectively. The latter child eventually thrived in a specialized preschool for children with autism and developmental disabilities. While not representative, these findings lend support to arguments that traditional ECE environments may lack capacity to adequately support the therapeutic needs of some children exposed to early trauma (Bartlett & Smith, 2019; Mortensen & Barnett, 2016).

Further complicating the potential of ECE to support children exposed to IPV are the obstacles to accessing it. As explored in Chapter 3, IPV perpetrators prevented survivor mothers from using child care altogether; limited and controlled who could

provide care; interfered with survivors' child care arrangements, even after relationships ended; directly harassed and intimidated child care providers, including relative caregivers; abdicated responsibility for caring for children themselves; or provided very low quality or even dangerous care, thereby compelling survivors to find alternate arrangements. Compounding these pernicious IPV-related influences were the intractable barriers to affording and obtaining slots with high quality ECE programs for their young children—common challenges facing working families. For these mothers already facing IPV, structural barriers to accessing and affording ECE were at times insurmountable.

Survivor Mothers' ECE Decisions

In the face of these formidable challenges, mothers' careful selection of ECE based on their understanding of children's key needs, detailed in Chapter 3, served as an important protective factor for their children. Due in large part to their concerns for their children's safety and heightened social, emotional, and developmental needs resulting from IPV, survivor mothers were generally unwilling to compromise on ECE quality. As a result, several of them sacrificed higher paying jobs or higher education opportunities to care for their children full-time or balance care and part-time work. Others relied on trusted family, friends, and acquaintances who, despite lack of formal ECE training, were deemed by mothers to be safe and highly nurturing.

Implications

Findings from this dissertation have important implications for child care subsidy policy, ECE providers, and social workers, advocates, and other professionals working to support families experiencing IPV. These implications are discussed below.

ECE Providers

Current findings highlight the importance of widely adopting a trauma-informed care (TIC) lens into formal ECE training and education, institutional culture, and administration, which should include reflective supervision and other supports for teachers and home-based caregivers. ECE professionals' trauma-informed engagement with all children can ensure that many children exposed to IPV receive the nurturance, stability, consistency, developmental support, and resources needed to thrive. This implication is particularly important given the high prevalence of IPV exposure among young children, and even higher prevalence of IPV exposure among those experiencing socioeconomic disadvantage. TIC within ECE may also reduce the use of exclusionary practices with children exposed to trauma. Early experiences with suspension and expulsion can retraumatize children, undermine child-parent relationships, and establish negative templates for future educational experiences. Trauma-informed ECE systems will also likely benefit ECE teachers and the workforce more broadly. Studies have found that children's behavioral problems, often resulting from early trauma, increase ECE teachers' stress and emotional exhaustion, and lower their capacity to effectively work with the children in their care (Friedman-Krauss et al., 2014; Jeon et al., 2018; Whitaker et al., 2015). Conceptually, when caregivers feel well supported, turnover decreases, which improves children's stability of care. This increased stability can promote children's resilience and thereby enhance ECE environments overall.

In addition to a broader movement towards trauma-informed practices, this study's findings, particularly those of Chapters 3 and 4, also point to a number of ECE

practices that may specifically support IPV survivor mothers and their young children. Several mothers in this sample expressed appreciation for formal ECE procedures, e.g., family questionnaires, to inquire about children's IPV and other trauma exposure. (Importantly, however, ECE provider efforts to facilitate IPV disclosure is not recommended in states that consider children's exposure to IPV to comprise child abuse and neglect.) In addition, ECE providers' non-judgmental and sensitive responses to mothers' disclosure of their children's IPV exposure were viewed by mothers as critical. Based on participants' experiences and trauma-informed best practices, ECE providers should use a safety-oriented approach to mandated reporting of suspected child abuse when the non-abusive parent is an IPV survivor. This may involve informing the survivor parent in advance, offering to make the report together, and helping to connect the survivor parent with safety planning resources.

This dissertation also highlights the critical role informal caregivers, particularly grandmothers, can play in promoting young children's resilience amidst IPV—despite significant caregiving challenges and safety risks. Chapter 2 indicates that informal care by friends or family significantly buffered the effects of frequent and physical IPV on children's internalizing behaviors, as well as the effects of frequent IPV on children's externalizing behaviors. Relative care was not only described by mothers in Chapters 3 and 4 as affordable and convenient, but also as providing long-term support for children. This dissertation provides evidence that in some cases, informal care can be an ideal arrangement for children exposed to IPV, particularly when their needs for one-on-one nurturing care and long-term supportive relationships with safe adults supersede other

needs. Yet, informal care is typically conceptualized as the lowest quality care arrangement, and very few formal supports exist to support informal caregivers of young children (Ha et al., 2012; Lin & Wiley, 2017).

Child Care Subsidy Policy

This study can also help inform state-level efforts to more effectively reach and serve IPV survivor mothers and their young children through child care subsidy programs. It will be important for policymakers to consider the ways to expand access to ECE for this highly vulnerable population. Providing child care to parents who are trying to achieve economic self-sufficiency is a stated core goal of CCDF. For mothers experiencing or fleeing IPV, achieving economic self-sufficiency is of utmost importance to their own and their children's safety and well-being. Chapters 2 and 4 indicate that young children's access to quality ECE can keep them safe and mitigate the negative effects of their IPV exposure. However, when survivor mothers and their children do not qualify for child care subsidies, or are unable to find or afford subsidized ECE, the collective effects of IPV—including perpetrators' interference and restraint, economic disadvantage, compromised mental and physical health, isolation, and emergent needs—may prevent mothers from using ECE despite needing it, and despite its potential benefits for their children. Chapter 3 reveals a number of specific challenges mothers faced in accessing and utilizing subsidies. Reflecting previous research with lower income families, some mothers made "just enough" not to qualify for subsidies, despite not being able to afford non-subsidized care. Others qualified for subsidies but could not afford to pay the gap between what the subsidy covered and what providers charged. Particularly

for mothers living in rural areas, finding local, subsidized ECE with available slots was exceedingly difficult. Much research has examined these types of structural barriers to accessing and using subsidies; continued efforts to understand and address these issues are needed.

In addition, one mother interviewed for this dissertation raised an important safety concern with implications for child care subsidy system processes. While in the process of applying for child care subsidy reauthorization, she was informed that she needed to prove that her child's father and dangerous ex-partner no longer lived with her. Feeling compelled to reach out to him for proof of his new residence, she did so, unsuccessfully. Unbeknownst to this participant, the child care subsidy system within the state where this mother resided had recently introduced a "third party verification form" that allows a landlord, social worker, domestic violence advocate, or other approved third party to verify who resides in the applicant's household. It was unclear whether this mother's experience occurred prior to the adoption of this form, or if there had been a lag or inconsistencies in its implementation. States might consider this and other approaches to ensure survivor mothers do not face pressure to contact abusive ex-partners for documentation. This mother's experience also underscores the importance of training all subsidy system administrators on using safety-focused processes, such as third-party verification and address confidentiality, for IPV survivor parents.

As discussed in Chapter 3, while federal policies have sought to improve child care subsidy access and utilization among some highly vulnerable populations, including children with special needs, and those experiencing homelessness and very low family

income, only California, Georgia, New York, Pennsylvania, and Rhode Island currently offer priority status and other benefits (e.g., waived co-payments and waivers for child support enforcement cooperation) to families experiencing IPV. Maryland also recently adopted a presumptive eligibility period and removed child support enforcement as a condition of families' eligibility for child care subsidies—measures that a subsequent study by the Maryland State Department of Education (MSDE) and Center for Law and Social Policy (CLASP) found were especially beneficial for survivors of IPV. Given the exceptional challenges facing IPV survivor mothers as they seek child care and child care subsidies, detailed in Chapter 3, other states should consider similar policies to support families experiencing IPV.

Service Providers

Last, findings may have implications for building more coordinated systems of care by encouraging collaboration among state-level early childhood systems and community-based advocates, social workers, and other service providers serving IPV survivors and their children. These strategic partnerships may improve survivors' ability to identify and utilize ECE, increase their subsidy utilization, and enhance ECE services to children affected by IPV. Coordination across systems can facilitate more immediate dissemination of knowledge about changes to policies or protocols (e.g., third party verification) that may affect survivors' and their children's safety and access to ECE and subsidies. In Chapter 3, survivors discussed their partners' manipulation of their child care perceptions and choices. Thus, knowledge sharing about child care related IPV tactics within domestic violence resource centers and therapeutic settings may help to

empower survivor mothers contending with similar behaviors, decrease their feelings of isolation, and support their child care decision making and safety planning efforts.

Directions for Future Research

The findings from this dissertation demonstrate that ECE is a critical environment for children exposed to IPV and is deserving of in-depth research. In helping develop a knowledge base about the role of ECE for families experiencing IPV, this dissertation lays groundwork for further study. First, while extensive research has examined the social, emotional, and behavioral outcomes of children exposed to IPV within their home and school environments, very little is known about their functioning within ECE settings. While not the focus of this dissertation, Chapter 4 offers glimpses into IPV-exposed children's adjustment in various ECE contexts. Moving forward, it will be important to examine the extent to which ECE quality features, including the protective mechanisms explored within Chapter 4, influence their health and well-being. A more nuanced understanding of these mechanisms' effects can help to inform ECE best practices and approaches to support children exposed to IPV. Investigating longer-term outcomes of ECE for this population will also be valuable. Preschool programs have been conceptualized by the Centers for Disease Control (CDC) as potentially interrupting the developmental pathways to intergenerational IPV transmission and other harmful outcomes (Niolon et al., 2007). Building on findings from Chapter 2, studies should investigate additional influences of ECE involvement for children exposed to IPV, including social well-being, academic performance, and later risk for adolescent IPV perpetration and victimization.

Further research is also needed to investigate and support trauma-informed ECE approaches. Very few studies have examined trauma-informed approaches within ECE settings, despite indications that children's early trauma exposure has pervasive negative influences on their suspension and expulsion rates, on ECE providers' psychological well-being and on the care they provide, and on ECE workplace stress and turnover rates (Bartlett & Smith, 2019; Friedman-Krauss et al., 2014; Zeng et al., 2019). Additionally, further research is needed to understand the role that informal caregivers play in the lives of children experiencing IPV and other early childhood trauma, and best practices to support them. Mirroring the dearth of formal supports for informal caregivers of young children, there is a notable lack of research on informal caregivers (Lin & Wiley, 2017). Given the important role they play for young children exposed to IPV, as evidenced by Chapter 4 findings, it is crucial to better understand their needs and identify the best means to support them.

Last, this dissertation highlights the need for research examining the impacts of ECE and child care subsidies for IPV survivor mothers. Chapter 3 reveals the integral connections between child care and survivors' self-sufficiency, as well as survivors' prioritization of their children's care. The care of children was a central concern for all mother participants, including those utilizing parental care, non-parental care, and both. Therefore, whenever relevant, research with survivor mothers of young children should address the domain of child care. An important next step will be to develop an understanding of how the child care related IPV tactics revealed in Chapter 3 influence mothers' and children's well-being and longer-term outcomes. Additionally, to inform

efforts to support survivor mothers of young children, additional research is needed to understand the influences of child care and child care subsidies on their employment, school, and other domains of well-being. There is some evidence indicating that child care and child care subsidies are important resources for IPV survivor mothers, but only one study has examined their outcomes. Showalter and colleagues showed that for IPV survivor mothers, receipt of child care subsidies buffered the negative influences of physical IPV on mothers' employment status and number of hours worked (2019). Finally, there is a need to investigate how child care subsidy policies, including recent efforts to prioritize IPV survivors and their children in California, Georgia, New York, Pennsylvania, and Rhode Island, influence survivors' use of child care subsidies and affect their families' safety and well-being.

Conclusion

This dissertation develops a foundational understanding of the influences of ECE on young children exposed to IPV and survivor mothers' ECE decisions. Its three studies contribute to the respective bodies of literature on ECE's influences on young children experiencing trauma, economic abuse, the use of children by IPV perpetrators, and ECE as a resilience-promoting context. Findings show that (a) non-parental child care, particularly center-based care, may attenuate the negative influences of some forms of IPV exposure on young children's behavioral outcomes; (b) survivor mothers arrange their children's care based on safety, trust, and children's needs, despite the profound negative influences of IPV, isolation, and structural barriers; and (c) mechanisms within ECE settings such as reduced exposure to abusive fathers, nurturance, stability,

consistency, flexibility, access to therapeutic services, and support with emotion regulation and social skills can help reduce young children's exposure to IPV and promote their resilience.

References

Bartlett, J. D., & Smith, S. (2019). The role of early care and education in addressing early childhood trauma. *American Journal of Community Psychology*, *64*(3–4). https://doi.org/10.1002/ajcp.12380

DeJonghe, E. S., Bogat, G. A., Levendosky, A. A., Von Eye, A., & Davidson, W. S. (2005). Infant exposure to domestic violence predicts heightened sensitivity to adult verbal conflict. *Infant Mental Health Journal*, *26*(3). https://doi.org/10.1002/imhj.20048

Edwards, K. M. (2015). Intimate Partner Violence and the Rural–Urban–Suburban Divide: Myth or Reality? A Critical Review of the Literature. *Trauma, Violence, and Abuse*, *16*(3), 359–373. https://doi.org/10.1177/1524838014557289

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of Childhood Exposure to Violence, Crime, and Abuse. *JAMA Pediatrics*, *169*(8). https://doi.org/10.1001/jamapediatrics.2015.0676

Friedman-Krauss, A. H., Raver, C. C., Morris, P. A., & Jones, S. M. (2014). The Role of Classroom-Level Child Behavior Problems in Predicting Preschool Teacher Stress and Classroom Emotional Climate. *Early Education and Development*, *25*(4). https://doi.org/10.1080/10409289.2013.817030

Gewirtz, A. H., & Edleson, J. L. (2007). Young children's exposure to intimate partner violence: Towards a developmental risk and resilience framework for research and intervention. *Journal of Family Violence*, *22*(3), 151–163. https://doi.org/10.1007/s10896-007-9065-3

Ha, Y., Magnuson, K., & Ybarra, M. (2012). Patterns of child care subsidy receipt and the stability of child care. *Children and Youth Services Review*, *34*(9). https://doi.org/10.1016/j.childyouth.2012.05.016

Haight, W. L., Shim, W. S., Linn, L. M., & Swinford, L. (2007). Mothers' strategies for protecting children from batterers: The perspectives of battered women involved in child protective services. *Child Welfare*, *86*(4).

Hardesty, J. L., Oswald, R. F., Khaw, L., Fonseca, C., & Chung, G. (2008). Lesbian mothering in the context of intimate partner violence. *Journal of Lesbian Studies*, *12*(2–3). https://doi.org/10.1080/10894160802161364

Howell, K. H. (2011). Resilience and psychopathology in children exposed to family violence. *Aggression and Violent Behavior*, *16*(6), 562–569. https://doi.org/10.1016/j.avb.2011.09.001

Hultmann, O., Broberg, A. G., & Axberg, U. (2022). Child Psychiatric Patients Exposed to Intimate Partner Violence and/or Abuse: The Impact of Double Exposure. *Journal of Interpersonal Violence*, *37*(11–12). https://doi.org/10.1177/0886260520978186

Jeon, L., Buettner, C. K., & Grant, A. A. (2018). Early Childhood Teachers' Psychological Well-Being: Exploring Potential Predictors of Depression, Stress, and Emotional Exhaustion. *Early Education and Development*, *29*(1). https://doi.org/10.1080/10409289.2017.1341806

Kelly, U. A. (2009). "I'm a mother first": The influence of mothering in the decision-making processes of battered immigrant Latino women. *Research in Nursing and Health*, *32*(3). https://doi.org/10.1002/nur.20327

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *American Journal of Community Psychology*, *36*(1–2), 71–84. https://doi.org/10.1007/s10464-005-6233-6

Lin, C. H., & Wiley, A. R. (2017). The relationship of relative child care and parenting behaviors in fragile families. *Children and Youth Services Review*, *82*(July), 130–138. https://doi.org/10.1016/j.childyouth.2017.09.022

Lippy, C., Jumarali, S. N., Nnawulezi, N. A., Williams, E. P., & Burk, C. (2020). The Impact of Mandatory Reporting Laws on Survivors of Intimate Partner Violence: Intersectionality, Help-Seeking and the Need for Change. *Journal of Family Violence*, *35*(3), 255–267. https://doi.org/10.1007/s10896-019-00103-w

Lipscomb, S. T., Hatfield, B., Lewis, H., Goka-Dubose, E., & Fisher, P. A. (2019). Strengthening children's roots of resilience: Trauma-responsive early learning. *Children and Youth Services Review*, *107*. https://doi.org/10.1016/j.childyouth.2019.104510

Liu, J. J. W., Reed, M., & Girard, T. A. (2017). Advancing resilience: An integrative, multi-system model of resilience. *Personality and Individual Differences*, *111*. https://doi.org/10.1016/j.paid.2017.02.007

Loomis, A. M. (2018). The Role of Preschool as a Point of Intervention and Prevention for Trauma-Exposed Children: Recommendations for Practice, Policy, and Research. *Topics in Early Childhood Special Education*, *38*(3), 134–145. https://doi.org/10.1177/0271121418789254

McDonald, R., Jouriles, E. N., Ramisetty-Mikler, S., Caetano, R., & Green, C. E. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology*, *20*(1). https://doi.org/10.1037/0893-3200.20.1.137

Mortensen, J. A., & Barnett, M. A. (2016). The role of child care in supporting the emotion regulatory needs of maltreated infants and toddlers. *Children and Youth Services Review*, *64*, 73–81. https://doi.org/10.1016/j.childyouth.2016.03.004

Niolon, M.C. Kearns, J. Dills, K. Rambo, S. Irving, T.L. Armstead, L. G. (2007). *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies and Practices*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Nixon, K. L., Bonnycastle, C., & Ens, S. (2017). Challenging the Notion of Failure to Protect: Exploring the Protective Strategies of Abused Mothers Living in Urban and Remote Communities and Implications for Practice. *Child Abuse Review*, *26*(1). https://doi.org/10.1002/car.2417

Overstreet, N. M., & Quinn, D. M. (2013). The Intimate Partner Violence Stigmatization Model and Barriers to Help Seeking. *Basic and Applied Social Psychology*, *35*(1), 109–122. https://doi.org/10.1080/01973533.2012.746599

Peled, E., & Gil, I. B. (2011). The mothering perceptions of women abused by their partner. *Violence Against Women*, *17*(4). https://doi.org/10.1177/1077801211404676

Radey, M., & Brewster, K. L. (2007). The influence of race/ethnicity on disadvantaged mothers' child care arrangements. *Early Childhood Research Quarterly*, *22*(3), 379–393. https://doi.org/10.1016/j.ecresq.2007.05.004

Rousson, A. N., Tajima, E. A., Herrenkohl, T. I., & Casey, E. A. (2023). Patterns of Intimate Partner Violence and the Harsh Parenting of Children. *Journal of Interpersonal Violence*, *38*(1–2). https://doi.org/10.1177/08862605221087242

Sanders, C. K. (2015). Economic Abuse in the Lives of Women Abused by an Intimate Partner: A Qualitative Study. *Violence Against Women*, *21*(1). https://doi.org/10.1177/1077801214564167

Sciaraffa, M. A., Zeanah, P. D., & Zeanah, C. H. (2018). Understanding and Promoting Resilience in the Context of Adverse Childhood Experiences. *Early Childhood Education Journal*, *46*(3). https://doi.org/10.1007/s10643-017-0869-3

Shonkoff, Phillips, D., Shonkoff, Jack P, & Phillips, Deborah. (2000). *From neurons to neighborhoods: the science of early child development*. National Academy Press.

Showalter, K., Maguire-Jack, K., & McCloskey, R. (2022). Mothers' Resilience: Experiences of Intimate Partner Violence Survivors at Work. *Children*, *9*(3). https://doi.org/10.3390/children9030373

Tekin, E. (2021). An overview of the child care market in the United States [White paper]. National Bureau of Economic Research. https://www.nber.org/sites/default/files/2021-10/White%20Paper-Tekin-101.06.21_revised.pdf

Voth Schrag, R. J., & Edmond, T. (2017). School Sabotage as a Form of Intimate Partner Violence: Provider Perspectives. *Affilia - Journal of Women and Social Work*, *32*(2), 171–187. https://doi.org/10.1177/0886109916689785

Whitaker, R. C., Dearth-Wesley, T., & Gooze, R. A. (2015). Workplace stress and the quality of teacher-children relationships in Head Start. *Early Childhood Research Quarterly*, *30*(PA). https://doi.org/10.1016/j.ecresq.2014.08.008

Zeng, S., Corr, C. P., O'Grady, C., & Guan, Y. (2019). Adverse childhood experiences and preschool suspension expulsion: A population study. *Child Abuse and Neglect*, *97*. https://doi.org/10.1016/j.chiabu.2019.104149

BIBLIOGRAPHY

Achenbach, T. M. (2004). Manual for the child: Behavior checklist and revised child behavior profile. *Encyclopedia of Psychology, Vol. 2.*, *8*.

Adhia, A., Drolette, L. M., vander Stoep, A., Valencia, E. J., & Kernic, M. A. (2019). The impact of exposure to parental intimate partner violence on adolescent precocious transitions to adulthood. *Journal of Adolescence*, *77*. https://doi.org/10.1016/j.adolescence.2019.11.001

Ahnert, L., Pinquart, M., & Lamb, M. E. (2006). Security of children's relationships with nonparental care providers: A meta-analysis. *Child Development*, *77*(3), 664–679. https://doi.org/10.1111/j.1467-8624.2006.00896.x

Alessi, J. J., and Hearn, K. (1984). Group treatment of children in shelters for battered women. In A. R. Roberts (Ed.), *Battered women and their families: Intervention strategies and treatment programs* (pp. 49–62). New York: Springer.

Anderson, K., & van Ee, E. (2018). Mothers and children exposed to intimate partner violence: a review of treatment interventions. *International Journal of Environmental Research and Public Health*, *15*(9). https://doi.org/10.3390/ijerph15091955

Aratani, Y. (2009). *Homeless children and youth: Causes and consequences*. National Center for Children in Poverty. https://www.nccp.org/wp-content/uploads/2020/05/text_888.pdf

Austin, A. E., Shanahan, M. E., Barrios, Y. V., & Macy, R. J. (2019). A Systematic Review of Interventions for Women Parenting in the Context of Intimate Partner Violence. *Trauma, Violence, and Abuse*, *20*(4), 498–519. https://doi.org/10.1177/1524838017719233

Austin, P. C., & Stuart, E. A. (2015). Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. *Statistics in Medicine*, *34*(28), 3661–3679. https://doi.org/10.1002/sim.6607

Bair-Merritt, M. H., Crowne, S. S., Burrell, L., Caldera, D., Cheng, T. L., & Dugqan, A. K. (2008). Impact of intimate partner violence on children's well-child care and medical home. *Pediatrics*, *121*(3). https://doi.org/10.1542/peds.2007-1671

Bair-Merritt, M. H., Johnson, S. B., Okelo, S., & Page, G. (2012). Intimate partner violence exposure, salivary cortisol, and childhood asthma. *Child Abuse and Neglect*, *36*(7–8). https://doi.org/10.1016/j.chiabu.2011.12.002

Baker, L., & Cunningham, A. (2004). *Helping children thrive / supporting woman abuse survivors as mothers: A resource to support parenting*. London, ON: Centre for Children & Families in the Justice System.

Bancroft, L., Silverman, J. G., & Ritchie, D. (2012). *The batterer as parent: Addressing the impact of domestic violence on family dynamics*. 2nd edition. SAGE Publications, Inc. https://doi.org/10.4135/9781452240480

Bartlett, J. D., & Smith, S. (2019). The role of early care and education in addressing early childhood trauma. *American Journal of Community Psychology*, *64*(3–4). https://doi.org/10.1002/ajcp.12380

Bedrick, E., & Daily, S. (2020). *States are using the CARES Act to improve child care access during COVID-19*. Child Trends. https://www.childtrends.org/publications/states-are-using-the-cares-act-to-improve-child-care-access-during-covid-19

Beeble, M. L., Bybee, D., & Sullivan, C. M. (2007). Abusive men's use of children to control their partners and ex-partners. *European Psychologist*, *12*(1). https://doi.org/10.1027/1016-9040.12.1.54

Belsky, J., & Rovine, M. J. (1988). Nonmaternal care in the first year of life and the security of infant-parent attachment. *Child Development*, *59*(1). https://doi.org/10.1111/j.1467-8624.1988.tb03203.x

Berry, D., Blair, C., Willoughby, M., Garrett-Peters, P., Vernon-Feagans, L., Mills-Koonce, W. R., Cox, M., Burchinal, P., Burton, L., Crnic, K., Crouter, A., Greenberg, M., Lanza, S., & Werner, E. (2016). Household chaos and children's cognitive and socio-emotional development in early childhood: Does childcare play a buffering role? *Early Childhood Research Quarterly*, *34*, 115–127. https://doi.org/10.1016/j.ecresq.2015.09.003

Bidarra, Z. S., Lessard, G., & Dumont, A. (2016). Co-occurrence of intimate partner violence and child sexual abuse: Prevalence, risk factors and related issues. *Child Abuse and Neglect*, *55*. https://doi.org/10.1016/j.chiabu.2016.03.007

Boeckel, M. G., Wagner, A., & Grassi-Oliveira, R. (2017). The Effects of Intimate Partner Violence Exposure on the Maternal Bond and PTSD Symptoms of Children. *Journal of Interpersonal Violence*, *32*(7). https://doi.org/10.1177/0886260515587667

Brandon, P. D. (2004). The child care arrangements of preschool-age children in immigrant families in the United States. *International Migration*, *42*(1). https://doi.org/10.1111/j.0020-7985.2004.00274.x

Braun, V., & Clarke, V. (2014). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Breiding, M. J., Chen, J., & Black, M. C. (2014). Intimate Partner Violence in the United States — 2010. *Centers for Disease Control and Prevention*, 1–96. https://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_ipv_report_2013_v17_single_a.pdf

Burchinal, M. R., Cryer, D., Clifford, R. M., & Howes, C. (2002). Caregiver training and classroom quality in child care centers. *Applied Developmental Science*, *6*(1). https://doi.org/10.1207/S1532480XADS0601_01

Burchinal, M., Howes, C., Pianta, R., Bryant, D., Early, D., Clifford, R., & Barbarin, O. (2008). Predicting child outcomes at the end of kindergarten from the quality of pre-kindergarten teacher-child interactions and instruction. *Applied Developmental Science*, *12*(3). https://doi.org/10.1080/10888690802199418

Camacho, K., Ehrensaft, M. K., & Cohen, P. (2012). Exposure to intimate partner violence, peer relations, and risk for internalizing behaviors: A prospective longitudinal study. *Journal of Interpersonal Violence*, *27*(1), 125–141. https://doi.org/10.1177/0886260511416474

Carlin, C., Davis, E. E., Krafft, C., & Tout, K. (2019). Parental preferences and patterns of child care use among low-income families: A Bayesian analysis. *Children and Youth Services Review*, *99*. https://doi.org/10.1016/j.childyouth.2019.02.006

Carpenter, G. L., & Stacks, A. M. (2009). Developmental effects of exposure to Intimate Partner Violence in early childhood: A review of the literature. *Children and Youth Services Review*, *31*(8), 831–839. https://doi.org/10.1016/j.childyouth.2009.03.005

Carr, C. P., Martins, C. M. S., Stingel, A. M., Lemgruber, V. B., & Juruena, M. F. (2013). The role of early life stress in adult psychiatric disorders: A systematic review according to childhood trauma subtypes. *Journal of Nervous and Mental Disease, 201*(12), 1007–1020. https://doi.org/10.1097/NMD.0000000000000049

Cater, Å., & Forssell, A. M. (2014). Descriptions of fathers' care by children exposed to intimate partner violence (IPV) - relative neglect and children's needs. *Child and Family Social Work*, *19*(2). https://doi.org/10.1111/j.1365-2206.2012.00892.x

Chaudry, A. (2006). Putting children first: How low-wage working mothers manage child care. *Contemporary Sociology, 34*(6), 627–628. https://doi.org/10.1177/009430610503400615

Cheng, T. C. (2013). Intimate Partner Violence and Welfare Participation: A Longitudinal Causal Analysis. *Journal of Interpersonal Violence*, *28*(4). https://doi.org/10.1177/0886260512455863

Child and Adolescent Health Measurement Initiative (2021). 2021 National Survey of Children's Health (NSCH) data query. Available from www.childhealthdata.org

Cipriano, E. A., Skowron, E. A., & Gatzke-Kopp, L. M. (2011). Preschool children's cardiac reactivity moderates relations between exposure to family violence and emotional adjustment. *Child Maltreatment*, *16*(3), 205–215. https://doi.org/10.1177/1077559511408887

Clements, K. A. V., Sprecher, M., Modica, S., Terrones, M., Gregory, K., & Sullivan, C. M. (2022). The Use of Children as a Tactic of Intimate Partner Violence and its Relationship to Survivors' Mental Health. *Journal of Family Violence*, *37*(7). https://doi.org/10.1007/s10896-021-00330-0

Coe, J. L., Parade, S. H., Seifer, R., Frank, L., & Tyrka, A. R. (2020). Household Chaos Moderates Indirect Pathways Involving Domestic Violence, Parenting Practices, and Behavior Problems among Preschool Children. *Journal of Family Violence*, *35*(5). https://doi.org/10.1007/s10896-019-00093-9

Cree, R. A., Bitsko, R. H., Robinson, L. R., Holbrook, J. R., Danielson, M. L., Smith, C., Kaminski, J. W., Kenney, M. K., & Peacock, G. (2018). Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders and Poverty Among Children Aged 2–8 Years — United States, 2016. *MMWR. Morbidity and Mortality Weekly Report*, *67*(50). https://doi.org/10.15585/mmwr.mm6750a1

Creswell, J., & Pioano Clark, V. (2007). Introducing a mixed method design. *Designing and Conducting Mixed Methods Research*, 58–89. https://www.sagepub.com/sites/default/files/upm-binaries/10982_Chapter_4.pdf

Crosnoe, R., Prickett, K. C., Smith, C., & Cavanagh, S. (2014). Changes in Young Children's Family Structures and Child Care Arrangements. *Demography*, *51*(2), 459–483. https://doi.org/10.1007/s13524-013-0258-5

Cui, J., & Natzke, L. (2020). Early Childhood Program Participation: 2019. First Look--Summary. NCES 2020-075. *National Center for Education Statistics*. http://files.eric.ed.gov/fulltext/ED607038.pdf

David, K. B., LeBlanc, M. M., & Self-Brown, S. (2015). Violence Exposure in Young Children: Child-Oriented Routines as a Protective Factor for School Readiness. *Journal of Family Violence*, *30*(3), 303–314. https://doi.org/10.1007/s10896-015-9676-z

de Young, A. C., Kenardy, J. A., & Cobham, V. E. (2011). Trauma in Early Childhood: A Neglected Population. *Clinical Child and Family Psychology Review*, *14*(3), 231–250. https://doi.org/10.1007/s10567-011-0094-3

DeJonghe, E. S., Bogat, G. A., Levendosky, A. A., Von Eye, A., & Davidson, W. S. (2005). Infant exposure to domestic violence predicts heightened sensitivity to adult verbal conflict. *Infant Mental Health Journal*, *26*(3). https://doi.org/10.1002/imhj.20048

DeJonghe, E. S., von Eye, A., Bogat, G. A., & Levendosky, A. A. (2011). Does witnessing intimate partner violence contribute to toddlers' internalizing and externalizing behaviors? *Applied Developmental Science*, *15*(3), 129–139. https://doi.org/10.1080/10888691.2011.587713

DeVoe, E. R., & Smith, E. L. (2002). The impact of domestic violence on urban preschool children battered mothers' perspectives. *Journal of Interpersonal Violence*, *17*(10), 1075–1101. https://doi.org/10.1177/088626002236661

Dichter, M. E., & Rhodes, K. V. (2011). Intimate Partner Violence Survivors' Unmet Social Service Needs. *Journal of Social Service Research*, *37*(5), 481–489. https://doi.org/10.1080/01488376.2011.587747

Domitrovich, C. E., Cortes, R. C., & Greenberg, M. T. (2007). Improving young children's social and emotional competence: A randomized trial of the preschool "PATHS" curriculum. *Journal of Primary Prevention*, *28*(2). https://doi.org/10.1007/s10935-007-0081-0

Dubowitz, H., Thompson, R., Proctor, L., Metzger, R., Black, M. M., English, D., Poole, G., & Magder, L. (2016). Adversity, Maltreatment, and Resilience in Young Children. *Academic Pediatrics*, *16*(3). https://doi.org/10.1016/j.acap.2015.12.005

Early, D. M., & Burchinal, M. R. (2001). Early childhood care: Relations with family characteristics and preferred care characteristics. *Early Childhood Research Quarterly*, *16*(4). https://doi.org/10.1016/S0885-2006(01)00120-X

Economic Policy Institute (2019). *The cost of child care in the United States*.

Edwards, K. M. (2015). Intimate Partner Violence and the Rural–Urban–Suburban Divide: Myth or Reality? A Critical Review of the Literature. *Trauma, Violence, and Abuse*, *16*(3), 359–373. https://doi.org/10.1177/1524838014557289

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational transmission of partner violence: A 20-year prospective study. *Journal of Consulting and Clinical Psychology*, *71*(4). https://doi.org/10.1037/0022-006X.71.4.741

Enchautegui, M. E., Johnson, M., & Gelatt, J. (2015). *Who minds the kids when mom works a nonstandard schedule?* Washington, D.C.: Urban Institute. https://www.urban.org/sites/default/files/publication/64696/2000307-Who-Minds-the-Kids-When-Mom-Works-a-Nonstandard-Schedule.pdf

English, D. J., Marshall, D. B., & Stewart, A. J. (2003). Effects of Family Violence on Child Behavior and Health during Early Childhood. *Journal of Family Violence*, *18*(1). https://doi.org/10.1023/A:1021453431252

Fantuzzo, J. W., & Fusco, R. A. (2007). Children's direct exposure to types of domestic violence crime: A population-based investigation. *Journal of Family Violence*, *22*(7), 543–552. https://doi.org/10.1007/s10896-007-9105-z

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of Childhood Exposure to Violence, Crime, and Abuse. *JAMA Pediatrics*, *169*(8). https://doi.org/10.1001/jamapediatrics.2015.0676

Fogarty, A., Giallo, R., Wood, C., Kaufman, J., & Brown, S. (2020). Emotional-behavioral resilience and competence in preschool children exposed and not exposed to intimate partner violence in early life. *International Journal of Behavioral Development*, *44*(2). https://doi.org/10.1177/0165025419830241

Forry, N. D., Simkin, S., Wheeler, E. J., & Bock, A. (2013) 'You know how it makes you feel': Low-income parents' childcare priorities and definitions of ideal high-quality childcare, *Journal of Children and Poverty*, *19*:2, 107-126.

Friedman-Krauss, A. H., Raver, C. C., Morris, P. A., & Jones, S. M. (2014). The Role of Classroom-Level Child Behavior Problems in Predicting Preschool Teacher Stress and Classroom Emotional Climate. *Early Education and Development*, *25*(4). https://doi.org/10.1080/10409289.2013.817030

Garrido, E. F., Culhane, S. E., Petrenko, C. L. M., & Taussig, H. N. (2011). Psychosocial Consequences of Intimate Partner Violence (IPV) Exposure in Maltreated Adolescents: Assessing More than IPV Occurrence. *Journal of Family Violence*, *26*(7). https://doi.org/10.1007/s10896-011-9386-0

Geffner, R. A., Igelman, R. S., & Zellner, J. (eds.) (2014). *The Effects of Intimate Partner Violence on Children*. New York, Routledge. https://doi.org/10.4324/9781315044026

Georgsson, A., Almqvist, K., & Broberg, A. G. (2011). Dissimilarity in vulnerability: Self-reported symptoms among children with experiences of intimate partner violence. *Child Psychiatry and Human Development*, *42*(5). https://doi.org/10.1007/s10578-011-0231-8

Gewirtz, A. H., & Edleson, J. L. (2007). Young children's exposure to intimate partner violence: Towards a developmental risk and resilience framework for research and intervention. *Journal of Family Violence*, *22*(3), 151–163. https://doi.org/10.1007/s10896-007-9065-3

Giles, L. C., Davies, M. J., Whitrow, M. J., Warin, M. J., & Moore, V. (2011). Maternal depressive symptoms and child care during toddlerhood relate to child behavior at age 5 years. *Pediatrics*, *128*(1). https://doi.org/10.1542/peds.2010-3119

Gomez, A. L., Hardy, A., Fortner, A., Schmit, S., & Ferrette, T. (2022). *Early childhood development – Child care scholarship program Study (Ch. 525 HB995/SB920)*. The Center for Law and Social Policy. https://www.clasp.org/wp-content/uploads/2023/08/2022_Early-Childhood-Development-%E2%80%93-Child-Care-Scholarship-Program56.pdf

Gordon, J. A., Herbst, C. M., & Tekin, E. (2021). Who's minding the kids? Experimental evidence on the demand for child care quality. *Economics of Education Review*, *80*. https://doi.org/10.1016/j.econedurev.2020.102076

Graham-Bermann, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence*, *13*(1). https://doi.org/10.1177/088626098013001007

Graham-Bermann, S. A., & Perkins, S. (2010). Effects of early exposure and lifetime exposure to intimate partner violence (IPV) on child adjustment. *Violence and Victims*, *25*(4). https://doi.org/10.1891/0886-6708.25.4.427

Graham-Bermann, S. A., Gruber, G., Howell, K. H., & Girz, L. (2009). Factors discriminating among profiles of resilience and psychopathology in children exposed to intimate partner violence (IPV). *Child Abuse and Neglect*, *33*(9). https://doi.org/10.1016/j.chiabu.2009.01.002

Grasso, D. J., Henry, D., Kestler, J., Nieto, R., Wakschlag, L. S., & Briggs-Gowan, M. J. (2016). Harsh Parenting As a Potential Mediator of the Association Between Intimate Partner Violence and Child Disruptive Behavior in Families With Young Children. *Journal of Interpersonal Violence*, *31*(11). https://doi.org/10.1177/0886260515572472

Green, K. M., & Stuart, E. A. (2015). *Examining Moderation Analyses in Propensity Score Methods: Application to Depression and Substance Use*. *82*(5), 773–783. https://doi.org/10.1037/a0036515.Examining

Greene, C. A., Chan, G., McCarthy, K. J., Wakschlag, L. S., & Briggs-Gowan, M. J. (2018). Psychological and physical intimate partner violence and young children's

mental health: The role of maternal posttraumatic stress symptoms and parenting behaviors. *Child Abuse and Neglect*, *77*. https://doi.org/10.1016/j.chiabu.2018.01.012

Grip, K. K., Almqvist, K., Axberg, U., & Broberg, A. G. (2014). Perceived Quality of Life and Health Complaints in Children Exposed to Intimate Partner Violence. *Journal of Family Violence*, *29*(6). https://doi.org/10.1007/s10896-014-9622-5

Grych, J. H., Jouriles, E. N., Swank, P. R., McDonald, R., & Norwood, W. D. (2000). Patterns of adjustment among children of battered women. *Journal of Consulting and Clinical Psychology*, *68*(1). https://doi.org/10.1037/0022-006X.68.1.84

Guille, L. (2004). Men who batter and their children: An integrated review. *Aggression and Violent Behavior*, *9*(2), 129–163. https://doi.org/10.1016/S1359-1789(02)00119-2

Ha, Y., Magnuson, K., & Ybarra, M. (2012). Patterns of child care subsidy receipt and the stability of child care. *Children and Youth Services Review*, *34*(9). https://doi.org/10.1016/j.childyouth.2012.05.016

Ha, Y., Ybarra, M., & Johnson, A. D. (2017). Variation in early cognitive development by maternal immigrant documentation status. *Early Childhood Research Quarterly*, *41*(August), 184–195. https://doi.org/10.1016/j.ecresq.2017.07.006

Haight, W. L., Shim, W. S., Linn, L. M., & Swinford, L. (2007). Mothers' strategies for protecting children from batterers: The perspectives of battered women involved in child protective services. *Child Welfare*, *86*(4), 41–62.

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse and Neglect*, *34*(10). https://doi.org/10.1016/j.chiabu.2010.03.001

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). Children's exposure to intimate partner violence and other family violence. *Juvenile Justice Bulletin*. https://www.ojp.gov/pdffiles1/ojjdp/232272.pdf

Hardesty, J. L., Oswald, R. F., Khaw, L., Fonseca, C., & Chung, G. (2008). Lesbian mothering in the context of intimate partner violence. *Journal of Lesbian Studies*, *12*(2–3). https://doi.org/10.1080/10894160802161364

Harding, H. G., Morelen, D., Thomassin, K., Bradbury, L., & Shaffer, A. (2013). Exposure to Maternal- and Paternal-Perpetrated Intimate Partner Violence, Emotion Regulation, and Child Outcomes. *Journal of Family Violence*, *28*(1). https://doi.org/10.1007/s10896-012-9487-4

Hendy, H. M., Eggen, D., Gustitus, C., McLeod, K. C., & Ng, P. (2003). Decision to leave scale: Perceived reasons to stay in or leave violent relationships. *Psychology of Women Quarterly*, *27*(2), 162–173. https://doi.org/10.1111/1471-6402.00096

Herba, C. M., Tremblay, R. E., Boivin, M., Liu, X., Mongeau, C., Séguin, J. R., & Coté, S. M. (2013). Maternal depressive symptoms and children's emotional problems can early child care help children of depressed mothers? *JAMA Psychiatry*, *70*(8), 830–838. https://doi.org/10.1001/jamapsychiatry.2013.1361

Herbst, C. M., Desouza, K. C., Al-Ashri, S., Srivatsav Kandala, S., Khullar, M., & Bajaj, V. (2020). What do parents value in a child care provider? Evidence from Yelp consumer reviews. *Early Childhood Research Quarterly*, *51,* 288–306. https://doi.org/10.1016/j.ecresq.2019.12.008

Heru, A. M., Stuart, G. L., Rainey, S., Eyre, J., & Recupero, P. R. (2006). Prevalence and severity of intimate partner violence and associations with family functioning and alcohol abuse in psychiatric inpatients with suicidal intent. *Journal of Clinical Psychiatry*, *67*(1). https://doi.org/10.4088/JCP.v67n0104

Hibel, L. C., Granger, D. A., Blair, C., & Cox, M. J. (2011). Maternal sensitivity buffers the adrenocortical implications of intimate partner violence exposure during early childhood. *Development and Psychopathology*, *23*(2). https://doi.org/10.1017/S0954579411000010

Hofferth, S. L., & Wissoker, D. A. (1992). Price, Quality, and Income in Child Care Choice. *The Journal of Human Resources*, *27*(1). https://doi.org/10.2307/145913

Hofferth, S., Davis-Kean, P. E., Davis, J., & Finkelstein, J. (1997). The Child Development Supplement to the Panel Study of Income Dynamics: 1997 User Guide. *Survey Research Center, Institute for Social Research*.

Howell, K. H. (2011). Resilience and psychopathology in children exposed to family violence. *Aggression and Violent Behavior*, *16*(6), 562–569. https://doi.org/10.1016/j.avb.2011.09.001

Howell, K. H., & Graham-Bermann, S. A. (2011). The multiple impacts of intimate partner violence on preschool children. *How Intimate Partner Violence Affects Children: Developmental Research, Case Studies, and Evidence-Based Intervention.*, 87–107. https://doi.org/10.1037/12322-005

Howell, K. H., Barnes, S. E., Miller, L. E., & Graham-Bermann, S. A. (2014). Developmental variations in the impact of intimate partner violence exposure during childhood. *Journal of Injury and Violence Research*, *8*(1), 43–57. https://doi.org/10.5249/jivr.v8i1.663

Huang, C. C., Chen, Y., & Cheung, S. (2021). Early childhood exposure to intimate partner violence and teen depression symptoms in the U.S. *Health and Social Care in the Community*, *29*(5). https://doi.org/10.1111/hsc.13240

Huang, C. C., Vikse, J. H., Lu, S., & Yi, S. (2015). Children's Exposure to Intimate Partner Violence and Early Delinquency. *Journal of Family Violence*, *30*(8), 953–965. https://doi.org/10.1007/s10896-015-9727-5

Huang, C. C., Wang, L. R., & Warrener, C. (2010). Effects of domestic violence on behavior problems of preschool-aged children: Do maternal mental health and parenting mediate the effects? *Children and Youth Services Review*, *32*(10), 1317–1323. https://doi.org/10.1016/j.childyouth.2010.04.024

Hughes, H. M., Graham-Bermann, S. A., & Gruber, G. (2004). Resilience in children exposed to domestic violence. *Domestic Violence in the Lives of Children: The Future of Research, Intervention, and Social Policy*, 67–90. https://doi.org/10.1037/10408-004

Hultmann, O., Broberg, A. G., & Axberg, U. (2022). Child Psychiatric Patients Exposed to Intimate Partner Violence and/or Abuse: The Impact of Double Exposure. *Journal of Interpersonal Violence*, *37*(11–12). https://doi.org/10.1177/0886260520978186

Hunter, E. C., & Graham-Bermann, S. A. (2013). Intimate Partner Violence and Child Adjustment: Moderation by Father Contact? *Journal of Family Violence*, *28*(5). https://doi.org/10.1007/s10896-013-9517-x

Huth-Bocks, A. C., & Hughes, H. M. (2008). Parenting stress, parenting behavior, and children's adjustment in families experiencing intimate partner violence. *Journal of Family Violence*, *23*(4). https://doi.org/10.1007/s10896-007-9148-1

Jeon, L., Buettner, C. K., & Grant, A. A. (2018). Early Childhood Teachers' Psychological Well-Being: Exploring Potential Predictors of Depression, Stress, and Emotional Exhaustion. *Early Education and Development*, *29*(1). https://doi.org/10.1080/10409289.2017.1341806

Johnson, A. D., Martin, A., & Brooks-Gunn, J. (2011). Who uses child care subsidies? Comparing recipients to eligible non-recipients on family background characteristics and child care preferences. *Children and Youth Services Review*, *33*(7), 1072–1083. https://doi.org/10.1016/j.childyouth.2011.01.014

Johnson, V. K., & Lieberman, A. F. (2007). Variations in behavior problems of preschoolers exposed to domestic violence: The role of mothers' attunement to children's emotional experiences. *Journal of Family Violence*, *22*(5). https://doi.org/10.1007/s10896-007-9083-1

Katerndahl, D. A., Burge, S. K., Ferrer, R. L., Becho, J., & Wood, R. C. (2012). Understanding intimate partner violence dynamics using mixed methods. *Families, Systems and Health*, *30*(2). https://doi.org/10.1037/a0028603

Katz, E. (2022). *Coercive Control in Children's and Mothers' Lives*. Oxford University Press. https://doi.org/10.1093/oso/9780190922214.001.0001

Kelly, U. A. (2009). "I'm a mother first": The influence of mothering in the decision-making processes of battered immigrant Latino women. *Research in Nursing and Health*, *32*(3). https://doi.org/10.1002/nur.20327

Kendall-Tackett, K. A. (2007). Violence against women and the perinatal period: The impact of lifetime violence and abuse on pregnancy, postpartum, and breastfeeding. *Trauma, Violence, and Abuse*, *8*(3). https://doi.org/10.1177/1524838007304406

Kessler, R. C., Andrews, G., Mroczek, D., Ustun, B., & Wittchen, H.-U. (1998). The World Health Organization Composite International Diagnostic Interview short-form (CIDI-SF). *International Journal of Methods in Psychiatric Research*, *7*(4). https://doi.org/10.1002/mpr.47

Kita, S., Sato, I., Sakka, M., Soejima, T., & Kamibeppu, K. (2021). Does the Use of Childcare Services Reduce the Impact of Intimate Partner Violence on the Quality of Life of Children?: Multiple-Group Structural Equation Modeling. *Applied Research in Quality of Life*, *16*(5). https://doi.org/10.1007/s11482-020-09847-w

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*(2). https://doi.org/10.1037/0022-006X.71.2.339

Klebanov, P. K., & Brooks-Gunn, J. (2008). Differential exposure to early childhood education services and mother-toddler interaction. *Early Childhood Research Quarterly*, *23*(2). https://doi.org/10.1016/j.ecresq.2007.12.001

Klein, S., Mihalec-Adkins, B., Benson, S., & Lee, S. Y. (2018). The benefits of early care and education for child welfare-involved children: Perspectives from the field. *Child Abuse and Neglect*, *79*. https://doi.org/10.1016/j.chiabu.2018.02.015

Kuhlthau, K., & Mason, K. O. (1996). Market child care versus care by relatives: Choices made by employed and nonemployed mothers. *Journal of Family Issues*, *17*(4). https://doi.org/10.1177/019251396017004007

Lee, K., & Ludington, B. (2016). Head Start's Impact on Socio-Emotional Outcomes for Children Who Have Experienced Violence or Neighborhood Crime. *Journal of Family Violence*, *31*(4). https://doi.org/10.1007/s10896-015-9790-y

Levendosky, A. A., Bogat, G. A., & Martinez-Torteya, C. (2013). PTSD Symptoms in Young Children Exposed to Intimate Partner Violence. *Violence Against Women*, *19*(2), 187–201. https://doi.org/10.1177/1077801213476458

Levendosky, A. A., Huth-Bocks, A. C., Semel, M. A., & Shapiro, D. L. (2002). Trauma Symptoms in Preschool-Age Children. *Children*, *17*(2), 150–164.

Levendosky, A. A., Huth-Bocks, A. C., Shapiro, D. L., & Semel, M. A. (2003). The Impact of Domestic Violence on the Maternal - Child Relationship and Preschool-Age Children's Functioning. *Journal of Family Psychology*, *17*(3). https://doi.org/10.1037/0893-3200.17.3.275

Levendosky, A. A., Lannert, B., & Yalch, M. (2012). The effects of intimate partner violence on women and child survivors: An attachment perspective. *Psychodynamic Psychiatry*, *40*(3), 397–434. https://doi.org/10.1521/pdps.2012.40.3.397

Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davidson, W. S., & Von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology*, *20*(4). https://doi.org/10.1037/0893-3200.20.4.544

Levendosky, A. A., Lynch, S. M., & Graham-Bermann, S. A. (2000). Mothers' perceptions of the impact of woman abuse on their parenting. *Violence Against Woman*, *6*(3). https://doi.org/10.1177/10778010022181831

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *American Journal of Community Psychology*, *36*(1–2), 71–84. https://doi.org/10.1007/s10464-005-6233-6

Lieberman, A. F. (2007). Ghosts and angels: Intergenerational patterns in the transmission and treatment of the traumatic sequelae of domestic violence. *Infant Mental Health Journal*, *28*(4), 422–439. https://doi.org/10.1002/imhj.20145

Lin, C. H., & Wiley, A. R. (2017). The relationship of relative child care and parenting behaviors in fragile families. *Children and Youth Services Review*, *82*(July), 130–138. https://doi.org/10.1016/j.childyouth.2017.09.022

Lippy, C., Jumarali, S. N., Nnawulezi, N. A., Williams, E. P., & Burk, C. (2020). The Impact of Mandatory Reporting Laws on Survivors of Intimate Partner Violence: Intersectionality, Help-Seeking and the Need for Change. *Journal of Family Violence*, *35*(3), 255–267. https://doi.org/10.1007/s10896-019-00103-w

Lipscomb, S. T., Hatfield, B., Lewis, H., Goka-Dubose, E., & Fisher, P. A. (2019). Strengthening children's roots of resilience: Trauma-responsive early learning.

Children and Youth Services Review, *107*. https://doi.org/10.1016/j.childyouth.2019.104510

Lipscomb, S. T., Pratt, M. E., Schmitt, S. A., Pears, K. C., & Kim, H. K. (2013). School readiness in children living in non-parental care: Impacts of Head Start. *Journal of Applied Developmental Psychology*, *34*(1). https://doi.org/10.1016/j.appdev.2012.09.001

Liu, J. J. W., Reed, M., & Girard, T. A. (2017). Advancing resilience: An integrative, multi-system model of resilience. *Personality and Individual Differences*, *111*. https://doi.org/10.1016/j.paid.2017.02.007

Liu, M., & Anderson, S. G. (2012). Neighborhood effects on working mothers' child care arrangements. *Children and Youth Services Review*, *34*(4), 740–747. https://doi.org/10.1016/j.childyouth.2011.12.021

Lloyd, S. (2014). Physical Aggression, Distress, and Everyday Marital Interaction. In *Family Violence from a Communication Perspective*. https://doi.org/10.4135/9781483327556.n9

Loeb, S., Bridges, M., Bassok, D., Fuller, B., & Rumberger, R. W. (2007). How much is too much? The influence of preschool centers on children's social and cognitive development. *Economics of Education Review*, *26*(1), 52–66. https://doi.org/10.1016/j.econedurev.2005.11.005

Loomis, A. M. (2018). The Role of Preschool as a Point of Intervention and Prevention for Trauma-Exposed Children: Recommendations for Practice, Policy, and Research. *Topics in Early Childhood Special Education*, *38*(3), 134–145. https://doi.org/10.1177/0271121418789254

Lopez-Duran, N. L., Olson, S. L., Hajal, N. J., Felt, B. T., & Vazquez, D. M. (2009). Hypothalamic pituitary adrenal axis functioning in reactive and proactive aggression in children. *Journal of Abnormal Child Psychology*, *37*(2). https://doi.org/10.1007/s10802-008-9263-3

Love, J. M., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., Brooks-Gunn, J., Chazan-Cohen, R., Tarullo, L. B., Brady-Smith, C., Fuligni, A. S., Schochet, P. Z., Paulsell, D., & Vogel, C. (2005). The Effectiveness of Early Head Start for 3-Year-Old Children and Their Parents: Lessons for Policy and Programs. *Developmental Psychology*, *41*(6). https://doi.org/10.1037/0012-1649.41.6.88

Lundy, M., & Grossman, S. R. (2005). The mental health and service needs of young children exposed to domestic violence: Supportive data. *Families in Society*, *86*(1). https://doi.org/10.1606/1044-3894.1873

Maguire-Jack, K., Hardi, F., Stormer, B., Lee, J. Y., Feely, M., Rostad, W., Ford, D. C., Merrick, M. T., Murphy, C. A., & Bart. Klika, J. (2022). Early childhood education and care policies in the U.S. And their impact on family violence. *Children and Youth Services Review*, *142*. https://doi.org/10.1016/j.childyouth.2022.106653

Manning, L. G., Davies, P. T., & Cicchetti, D. (2014). Interparental Violence and Childhood Adjustment: How and Why Maternal Sensitivity Is a Protective Factor. *Child Development*, *85*(6). https://doi.org/10.1111/cdev.12279

Margolin, G., Gordis, E. B., Medina, A. M., & Oliver, P. H. (2003). The co-occurrence of husband-to-wife aggression, family-of-origin aggression, and child abuse potential in a community sample: Implications for parenting. *Journal of Interpersonal Violence*, *18*(4). https://doi.org/10.1177/0886260502250835

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3). https://doi.org/10.1037/0003-066X.56.3.227

Masten, A. S., & Cicchetti, D. (2010). Developmental cascades. *Development and Psychopathology, 22*(3), 491–495. https://doi.org/10.1017/S0954579410000222

Masten, A. S., & Coatsworth, J. D. (1998). The Development of Competence in Favorable and Unfavorable Environments: Lessons from Research on Successful Children. *American Psychologist*, *53*(2). https://doi.org/10.1037/0003-066X.53.2.205

McCartney, K., Dearing, E., Taylor, B. A., & Bub, K. L. (2007). Quality child care supports the achievement of low-income children: Direct and indirect pathways through caregiving and the home environment. *Journal of Applied Developmental Psychology*, *28*(5–6), 411–426. https://doi.org/10.1016/j.appdev.2007.06.010

McDonald, R., Jouriles, E. N., & Minze, L. C. (2011). Interventions for young children exposed to intimate partner violence. *How Intimate Partner Violence Affects Children: Developmental Research, Case Studies, and Evidence-Based Intervention.*, 109–131. https://doi.org/10.1037/12322-006

McDonald, R., Jouriles, E. N., Briggs-Gowan, M. J., Rosenfield, D., & Carter, A. S. (2007). Violence Toward a Family Member, Angry Adult Conflict, and Child Adjustment Difficulties: Relations in Families With 1- to 3-Year-Old Children. *Journal of Family Psychology*, *21*(2). https://doi.org/10.1037/0893-3200.21.2.176

McDonald, R., Jouriles, E. N., Ramisetty-Mikler, S., Caetano, R., & Green, C. E. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology*, *20*(1). https://doi.org/10.1037/0893-3200.20.1.137

Miles, Huberman, A. M., & Huberman, A. M. (1994). *Qualitative data analysis: an expanded sourcebook (2nd ed.).* Sage Publications.

Mortensen, J. A., & Barnett, M. A. (2015). Teacher–Child Interactions in Infant/Toddler Child Care and Socioemotional Development. *Early Education and Development*, *26*(2), 209–229. https://doi.org/10.1080/10409289.2015.985878

Mortensen, J. A., & Barnett, M. A. (2016). The role of child care in supporting the emotion regulatory needs of maltreated infants and toddlers. *Children and Youth Services Review*, *64*, 73–81. https://doi.org/10.1016/j.childyouth.2016.03.004

National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network (2002). Early child care and children's development prior to school entry: Results from the NICHD study of early child care. *American Educational Research Journal, 39*(1), 133–164.

National Institute of Child Health and Human Development [NICHD] Early Child Care Research, & Duncan, G. (2003). Modeling the Impacts of Child Care Quality on Children's Preschool Cognitive Development. *Child Development*, *74*(5), 1454–1475. https://doi.org/10.1111/1467-8624.00617

National Institute of Child Health and Human Development [NICHD] Early Child Care Research. (1998). Early Child Care and Self-Control, Compliance, and Problem Behavior at Twenty-Four and Thirty-Six Months: The NICHD Early Child Care Research Network. *Child Development*, *69*(4), 1145–1170. https://doi.org/10.1111/j.1467-8624.1998.tb06165.x

National Network to End Domestic Violence (NNEDV) (2020). Domestic violence counts report: National executive summary. Retrieved at: https://nnedv.org/wp-content/uploads/2020/03/Library_Census_2019_national_summary.pdf

Nicholson, J. H., & Ha, Y. (2022). Intimate Partner Violence, Child Care, and Children's Behavioral Outcomes. *Journal of Family Violence*. https://doi.org/10.1007/s10896-022-00464-9

Niolon, M.C. Kearns, J. Dills, K. Rambo, S. Irving, T.L. Armstead, L. G. (2007). *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies and Practices*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

Nixon, K. L., Bonnycastle, C., & Ens, S. (2017). Challenging the Notion of Failure to Protect: Exploring the Protective Strategies of Abused Mothers Living in Urban and Remote Communities and Implications for Practice. *Child Abuse Review*, *26*(1). https://doi.org/10.1002/car.2417

Osofsky, J. D., & Lieberman, A. F. (2011). A call for integrating a mental health perspective into systems of care for abused and neglected infants and young children. *American Psychologist*, *66*(2). https://doi.org/10.1037/a0021630

Overstreet, N. M., & Quinn, D. M. (2013). The Intimate Partner Violence Stigmatization Model and Barriers to Help Seeking. *Basic and Applied Social Psychology*, *35*(1), 109–122. https://doi.org/10.1080/01973533.2012.746599

Owen, A. E., Thompson, M. P., Shaffer, A., Jackson, E. B., & Kaslow, N. J. (2009). Family variables that mediate the relation between intimate partner violence (IPV) and child adjustment. *Journal of Family Violence*, *24*(7). https://doi.org/10.1007/s10896-009-9239-2

Patton, M. Q. (2002). *Qualitative evaluation and research methods (2nd ed.).* Sage Publications.

Pears, K. C., Fisher, P. A., Kim, H. K., Bruce, J., Healey, C. V., & Yoerger, K. (2013). Immediate Effects of a School Readiness Intervention for Children in Foster Care. *Early Education and Development*, *24*(6). https://doi.org/10.1080/10409289.2013.736037

Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Culkin, M. L., Howes, C., Kagan, S. L., & Yazejian, N. (2001). The relation of preschool child-care quality to children's cognitive and social developmental trajectories through second grade. *Child Development*, *72*(5). https://doi.org/10.1111/1467-8624.00364

Peled, E., & Gil, I. B. (2011). The mothering perceptions of women abused by their partner. *Violence Against Women*, *17*(4). https://doi.org/10.1177/1077801211404676

Perizzolo Pointet, V. C., Moser, D. A., Suardi, F., Rothenberg, M., Serpa, S. R., & Schechter, D. S. (2018). *Maternal Trauma and Related Psychopathology: Consequences to Parental Brain Functioning Associated with Caregiving*. https://doi.org/10.1007/978-3-319-65724-0_7

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits." *Infant Mental Health Journal*, *16*(4). https://doi.org/10.1002/1097-0355(199524)16:4<271::AID-IMHJ2280160404>3.0.CO;2-B

Perry, D. F., & Conners-Burrow, N. (2016). Addressing Early Adversity Through Mental Health Consultation in Early Childhood Settings. *Family Relations*, *65*(1). https://doi.org/10.1111/fare.12172

Phillips, D., McCartney, K., & Scarr, S. (1987). Child-Care Quality and Children's Social Development. *Developmental Psychology*, *23*(4). https://doi.org/10.1037/0012-1649.23.4.537

Pico-Alfonso, Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúúa, E., & Martinez, M. (2006). The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide. *Journal of Women's Health*, *15*(5), 599–611. https://doi.org/10.1089/jwh.2006.15.599

Pilarz, A. R., & Hill, H. D. (2017). Child-Care Instability and Behavior Problems: Does Parenting Stress Mediate the Relationship? *Journal of Marriage and Family*, *79*(5), 1353–1368. https://doi.org/10.1111/jomf.12420

Postmus, J. L., Huang, C. C., & Mathisen-Stylianou, A. (2012). The impact of physical and economic abuse on maternal mental health and parenting. *Children and Youth Services Review*, *34*(9). https://doi.org/10.1016/j.childyouth.2012.06.005

Postmus, J. L., Plummer, S. B., McMahon, S., Murshid, N. S., & Kim, M. S. (2012). Understanding Economic Abuse in the Lives of Survivors. *Journal of Interpersonal Violence*, *27*(3), 411–430. https://doi.org/10.1177/0886260511421669

Postmus, J. L., Severson, M., Berry, M., & Yoo, J. A. (2009). Women's experiences of violence and seeking help. *Violence Against Women*, *15*(7), 852–868. https://doi.org/10.1177/1077801209334445

Rachidi, A. (2016). Child care assistance and nonstandard work schedules. *Children and Youth Services Review*, *65*. https://doi.org/10.1016/j.childyouth.2016.03.023

Radey, M., & Brewster, K. L. (2007). The influence of race/ethnicity on disadvantaged mothers' child care arrangements. *Early Childhood Research Quarterly*, *22*(3), 379–393. https://doi.org/10.1016/j.ecresq.2007.05.004

Rajah, V., & Osborn, M. (2022). Understanding Women's Resistance to Intimate Partner Violence: A Scoping Review. *Trauma, Violence, and Abuse*, *23*(5). https://doi.org/10.1177/1524838019897345

Raver, C. C., Blair, C., Garrett-Peters, P., Vernon-Feagans, L., Greenberg, M., Cox, M., Burchinal, P., Willoughby, M., Mills-Koonce, R., & Ittig, M. (2015). Poverty, household chaos, and interparental aggression predict children's ability to recognize and modulate negative emotions. *Development and Psychopathology*, *27*(3). https://doi.org/10.1017/S0954579414000935

Reichman, N. E., Teitler, J. O., Garfinkel, I., & McLanahan, S. S. (2001). Fragile Families: Sample and Design. *Children and Youth Services Review*, *23*(4–5). https://doi.org/10.1016/S0190-7409(01)00141-4

Renner, L. M., & Boel-Studt, S. (2017). Physical family violence and externalizing and internalizing behaviors among children and adolescents. *American Journal of Orthopsychiatry*, *87*(4). https://doi.org/10.1037/ort0000260

Rizo, C. F., Macy, R. J., Ermentrout, D. M., & Johns, N. B. (2011). A review of family interventions for intimate partner violence with a child focus or child component. *Aggression and Violent Behavior*, *16*(2), 144–166. https://doi.org/10.1016/j.avb.2011.02.004

Romano, E., Weegar, K., Gallitto, E., Zak, S., & Saini, M. (2021). Meta-analysis on interventions for children exposed to intimate partner violence. *Trauma, Violence, and Abuse, 22*(4). https://doi.org/10.1177/1524838019881737

Rose, K. K., & Elicker, J. (2008). Parental decision making about child care. *Journal of Family Issues*, *29*(9). https://doi.org/10.1177/0192513X07312103

Rose, K. K., & Elicker, J. (2010). Maternal child care preferences for infants, toddlers, and preschoolers: The disconnect between policy and preference in the USA. *Community, Work and Family*, *13*(2). https://doi.org/10.1080/13668800903314366

Rousson, A. N., Tajima, E. A., Herrenkohl, T. I., & Casey, E. A. (2023). Patterns of Intimate Partner Violence and the Harsh Parenting of Children. *Journal of Interpersonal Violence*, *38*(1–2). https://doi.org/10.1177/08862605221087242

Sanders, C. K. (2015). Economic Abuse in the Lives of Women Abused by an Intimate Partner: A Qualitative Study. *Violence Against Women*, *21*(1). https://doi.org/10.1177/1077801214564167

Sandstrom, H., & Chaudry, A. (2012). "You have to choose your childcare to fit your work": Childcare decision-making among low-income working families. *Journal of Children and Poverty*, *18*(2). https://doi.org/10.1080/10796126.2012.710480

Sciaraffa, M. A., Zeanah, P. D., & Zeanah, C. H. (2018). Understanding and Promoting Resilience in the Context of Adverse Childhood Experiences. *Early Childhood Education Journal*, *46*(3). https://doi.org/10.1007/s10643-017-0869-3

Seidman. (1991). *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences.* Teachers College Press.

Shonkoff, Phillips, D., Shonkoff, Jack P, & Phillips, Deborah. (2000). *From neurons to neighborhoods: the science of early child development*. National Academy Press.

Showalter, K., Maguire-Jack, K., & McCloskey, R. (2022). Mothers' Resilience: Experiences of Intimate Partner Violence Survivors at Work. *Children*, *9*(3). https://doi.org/10.3390/children9030373

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2015). *National Intimate Partner and Sexual Violence Survey: 2015 Data Brief-Update Release*. Atlanta, GA: National Center for Injury Prevention. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

Spearman, K. J., Hoppe, E., & Jagasia, E. (2023). A systematic literature review of protective factors mitigating intimate partner violence exposure on early childhood health outcomes. *Journal of Advanced Nursing*, *79*(5), 1664–1677. https://doi.org/10.1111/jan.15638

Spilsbury, J. C., Kahana, S., Drotar, D., Creeden, R., Flannery, D. J., & Friedman, S. (2008). Profiles of behavioral problems in children who witness domestic violence. *Violence and Victims*, *23*(1). https://doi.org/10.1891/0886-6708.23.1.3

Stark, E., & Hester, M. (2019). Coercive Control: Update and Review. *Violence Against Women*, *25*(1). https://doi.org/10.1177/1077801218816191

Sternberg, K. J., Baradaran, L. P., Abbott, C. B., Lamb, M. E., & Guterman, E. (2006). Type of violence, age, and gender differences in the effects of family violence on children's behavior problems: A mega-analysis. *Developmental Review*, *26*(1). https://doi.org/10.1016/j.dr.2005.12.001

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised conflict tactics scales (CTS2) development and preliminary psychometric data. *Journal of Family Issues*, *17*(3). https://doi.org/10.1177/019251396017003001

Sturge-Apple, M. L., Davies, P. T., Cicchetti, D., & Manning, L. G. (2010). Mothers' parenting practices as explanatory mechanisms in associations between interparental violence and child adjustment. *Partner Abuse*, *1*(1). https://doi.org/10.1891/1946-6560.1.1.45

Swanberg, J. E., & Logan, T. K. (2005). Domestic violence and employment: A qualitative study. *Journal of Occupational Health Psychology*, *10*(1). https://doi.org/10.1037/1076-8998.10.1.3

Tabb, K. M., Huang, H., Valdovinos, M., Toor, R., Ostler, T., Vanderwater, E., Wang, Y., Menezes, P. R., & Faisal-Cury, A. (2018). Intimate Partner Violence Is Associated with Suicidality among Low-Income Postpartum Women. *Journal of Women's Health*, *27*(2). https://doi.org/10.1089/jwh.2016.6077

Tajima, E. A., Herrenkohl, T. I., Moylan, C. A., & Derr, A. S. (2011). Moderating the effects of childhood exposure to intimate partner violence: The roles of parenting characteristics and adolescent peer support. *Journal of Research on Adolescence*, *21*(2). https://doi.org/10.1111/j.1532-7795.2010.00676.x

Tekin, E. (2021). An overview of the child care market in the United States [White paper]. National Bureau of Economic Research. https://www.nber.org/sites/default/files/2021-10/White%20Paper-Tekin-101.06.21_revised.pdf

U.S. Census Bureau. (2013). *Who's Minding the Kids? Child Care Arrangements: Spring 2011* (P70-135). Retrieved from https://www.census.gov/library/publications/2013/demo/p70-135.html

Vandell, D. L., Belsky, J., Burchinal, M., Steinberg, L., & Vandergrift, N. (2010). Do Effects of early child care extend to age 15 years? Results from the NICHD study of early child care and youth development. *Child Development*, *81*(3), 737–756. https://doi.org/10.1111/j.1467-8624.2010.01431.x

Victor, B. G., Henry, C., Gilbert, T. T., Ryan, J. P., & Perron, B. E. (2019). Child Protective Service Referrals Involving Exposure to Domestic Violence: Prevalence, Associated Maltreatment Types, and Likelihood of Formal Case Openings. *Child Maltreatment*, *24*(3). https://doi.org/10.1177/1077559519843605

Voth Schrag, R. J., & Edmond, T. (2017). School Sabotage as a Form of Intimate Partner Violence: Provider Perspectives. *Affilia - Journal of Women and Social Work*, *32*(2), 171–187. https://doi.org/10.1177/0886109916689785

Votruba-Drzal, Coley, R. L., & Chase-Lansdale, P. L. (2004). Child care and low-income childrens development: Direct and moderated effects. *Child Development*, *75*(1), 296–312. https://doi.org/10.1111/j.1467-8624.2004.00670.x

Votruba-Drzal, E., Coley, R. L., Maldonado-Carreño, C., Li-Grining, C. P., & Chase-Lansdale, P. L. (2010). Child care and the development of behavior problems among economically disadvantaged children in middle childhood. *Child Development*, *81*(5). https://doi.org/10.1111/j.1467-8624.2010.01485.x

Watamura, S. E., Phillips, D. A., Morrissey, T. W., McCartney, K., & Bub, K. (2011). Double Jeopardy: Poorer Social-Emotional Outcomes for Children in the NICHD SECCYD Experiencing Home and Child-Care Environments That Confer Risk. *Child Development*, *82*(1). https://doi.org/10.1111/j.1467-8624.2010.01540.x

Webster-Stratton, C., Jamila Reid, M., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years Teacher and Child Training Programs in high-risk schools. *Journal of Child Psychology and*

Psychiatry and Allied Disciplines, *49*(5). https://doi.org/10.1111/j.1469-7610.2007.01861.x

Whitaker, R. C., Dearth-Wesley, T., & Gooze, R. A. (2015). Workplace stress and the quality of teacher-children relationships in Head Start. *Early Childhood Research Quarterly*, *30*(Pt. A), 57–69. https://doi.org/10.1016/j.ecresq.2014.08.008

Yamauchi, C., & Leigh, A. (2011). Which children benefit from non-parental care? *Economics of Education Review*, *30*(6), 1468–1490. https://doi.org/10.1016/j.econedurev.2011.07.012

Yates, T. M., Tyrell, F. A., & Masten, A. S. (2015). Resilience Theory and the Practice of Positive Psychology From Individuals to Societies. In *Positive Psychology in Practice: Promoting Human Flourishing in Work, Health, Education, and Everyday Life: Second Edition*. https://doi.org/10.1002/9781118996874.ch44

Ybarra, G. J., Wilkens, S. L., & Lieberman, A. F. (2007). The influence of domestic violence on preschooler behavior and functioning. *Journal of Family Violence*, *22*(1). https://doi.org/10.1007/s10896-006-9054-y

Zeng, S., Corr, C. P., O'Grady, C., & Guan, Y. (2019). Adverse childhood experiences and preschool suspension expulsion: A population study. *Child Abuse and Neglect*, *97*. https://doi.org/10.1016/j.chiabu.2019.104149

Zippay, A., & Rangarajan, A. (2007). Child care "packaging" among TANF recipients: Implications for social work. *Child and Adolescent Social Work Journal*, *24*(2), 153–172. https://doi.org/10.1007/s10560-006-0073-6

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