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Gary M. Burlingame

Rachel A. Arnold

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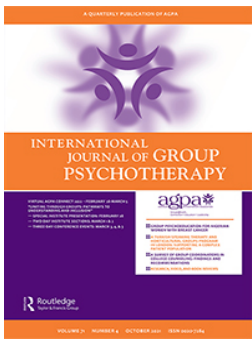
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Rachel A. Arnold & Gary M. Burlingame

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RESEARCH REVIEW

Treating Children Exposed to Domestic Violence: Group-Based Intervention

RACHEL A. ARNOLD, M.S.

GARY M. BURLINGAME, PH.D., CGP, DFAGPA 

Domestic violence is a serious societal problem that sadly threatens many children. Results from the National Survey of Children's Exposure to Violence (NatSCEV) demonstrate that nearly 26% of children are exposed to family violence during their lifetime, including psychological/emotional intimate partner violence, physical intimate partner violence, parental assault of a sibling, and/or other family violence (Hamby et al., 2011). The consequences can be significant. For instance, childhood exposure to intimate partner violence is associated with mental health issues, such as posttraumatic stress and anxiety symptoms (Hamby et al., 2011). While rates of domestic violence have been declining in the past few decades (Truman & Morgan, 2014), an increase in rates may be occurring from COVID-19. More specifically, Bradbury-Jones and Isham (2020) gave the following bleak warning regarding COVID-19: "Domestic violence rates are rising, and they are rising fast" (p. 2047). As Bradbury-Jones and Isham (2020) explain, one reason for this rise could be because "home is often the space where physical, psychological, and sexual abuse occurs" (p. 2047), making increased time at home during the pandemic problematic for sufferers of domestic violence. In all, it is clear that childhood exposure to domestic

violence is serious and consequential, as well as a timely issue to consider given the COVID-19 pandemic. Fortunately, results for interventions discussed in the following two articles by Overbeek et al. (2017) and Pernebo et al. (2019) give hope that the consequences of childhood exposure to domestic violence can be mitigated through proper intervention.

REVIEW OF STUDY 1

Overbeek, M. M., De Schipper, J. C., Willemsen, A.M., Lamers-Winkelmann, F., & Schuengel, C. (2017). Mediators and treatment factors in intervention for children exposed to interparental violence. *Journal of Clinical Child & Adolescent Psychology*, 46(3), 411–427. doi:10.1080/15374416.2015.1012720

Overbeek et al. (2017) studied the outcomes of 134 children in the Netherlands who were randomized to one of two community-based preventative group interventions. One intervention had a focus on interparental violence (IPV) and included treatment goals related to trauma, emotions, coping, and parenting. The other intervention was a supportive intervention and included common factors related to positive attention, having a structured environment, sharing experiences, distraction, social support, and group interaction. After randomization, 88 children were included in the IPV intervention, and the remaining 46 children in the sample were randomized to the common factors intervention. A larger sample size was allocated to the IPV intervention to increase statistical power in the analyses run by the authors. Both interventions included nine 90-minute sessions with concurrent caretaking parent sessions and child sessions. Thirty-six groups in total were included, of which 26 were IPV-focused and 10 were common factors. Children were aged 6 to 12 years old and had experienced prior exposure to IPV but were excluded if the violence was ongoing.

The primary outcome was the 10-item Posttraumatic Stress subscale of the self-report Trauma Symptom Checklist for Children (TSCC) and the 27-item Posttraumatic Stress subscale of the parent-report Trauma Symptom Checklist for Young Children (TSCYC).

The study also measured variables that might be related to the intervention's success in reducing posttraumatic stress. These variables included children's emotion differentiation and coping skills as well as parenting stress and psychopathology and the quality of parent-child interactions; all were analyzed as potential mediator variables. One measure was the Differentiating Emotions subscale of the Emotion Awareness Questionnaire. Another was the Positive Cognitive Restructuring, Distraction, and Seeking Support subscales of the How I Coped Under Pressure Scale, assessing the child's coping skills. Parenting stress was measured with the Parenting Stress Index. Parental psychopathology was assessed by a summative score comprised of posttraumatic stress (Impact of Events Scales—Revised [IES-R]) and depression and anxiety (Hospital Anxiety and Depression Scale). Parent-child interactions were analyzed using the Family Interaction Task at posttest. Additionally, qualitative analysis of videotaped sessions explored whether exposure to trauma-specific and nonspecific treatment factors was more present in either condition, as well as whether exposure to factors was associated with improvement.

Both interventions produced statistically significant improvement on posttraumatic stress symptoms (TSCC/TSCYC), with a smaller percentage of children in the IPV condition endorsing posttraumatic stress symptoms in the clinical range at both baseline (i.e., 25% vs. 50%) and follow-up (i.e., 15% vs. 21%) compared to the common factors intervention. Baseline differences in posttraumatic stress were not recognized as a limitation, and it is unclear if these were addressed by the analysis. The two interventions were also differentiated according to the exposure to treatment factors. In contrast to the common factor intervention, the IPV intervention showed a statistically significant advantage on emotion-focused strategies, coping skills, and sharing experiences (both related and unrelated to IPV) in child sessions. Results suggested that children exposed to trauma-specific treatment factors had significantly increased coping skills and decreased levels of posttraumatic stress symptoms. On the other hand, exposure to nonspecific factors was related to significant improvement in levels of parental psychopathology and positive parent-child interactions. Improvement in children's posttraumatic stress was linked to better emotion differentiation, parental stress, and

parental psychopathology for both interventions. Parental psychopathology emerged as a mediator of outcome; specifically, the authors found that “improvements in parental psychopathology mediated the association between greater exposure to nonspecific factors in parent sessions and decreases in children’s clinical levels of [posttraumatic stress] symptoms” (p. 422). This may indicate that parental mental health and children’s mental health are interconnected, which is an idea that previous research has also supported (e.g., Packard, 2010; Smith, 2004; Vostanis et al., 2006).

These results suggest that both common factor and IPV interventions produce improvement in posttraumatic stress. Improvement is associated with changes in a number of other variables, including increases in emotion differentiation and decreases in parental stress and parental psychopathology. Both nonspecific and trauma-specific factors further contribute to change in these variables.

The study had a few notable limitations. For instance, there was no nontreatment control groups included, making it difficult to know if change would have occurred without any intervention. However, the authors note that the amount of time since the violence stopped was not predictive of baseline levels of posttraumatic stress, nor did it moderate decreases in problems; thus, “the passing time alone did not reduce the problems of children exposed to IPV” (p. 424). Another limitation was that a greater percentage of children in the common factors condition (i.e., 50%) scored in the clinical range for posttraumatic stress symptoms at baseline than children in the IPV intervention (i.e., 25%), raising questions about the comparability of the condition samples. As the authors note, only posttest observations of parent-child interactions were included. If pretest observations were included and changes over time in interactions were observed, this change “may have been a better predictor for changes” (p. 424) over time in posttraumatic stress symptoms. Further, without pretest observations of parent-child interactions, it is unclear whether the condition samples differed at baseline. Finally, the authors did not test for group effects. Thus, the effects of intragroup dependency on statistical significance are unknown.

REVIEW OF STUDY 2

Pernebo, K., Fridell, M., & Almqvist, K. (2019). Reduced psychiatric symptoms at 6 and 12 months' follow-up of psychotherapeutic and psychoeducative group interventions for children exposed to intimate partner violence. *Child Abuse & Neglect, 93*, 228–238. <https://doi.org/10.1016/j.chiabu.2019.05.002>

Pernebo et al. (2019) studied the long-term outcomes of 50 children in Sweden who had received treatment in one of two group interventions with their nonoffending parent. Nineteen children and their mothers received a formal psychotherapy group that was contrasted with a community-based psychoeducation group composed of 31 children and their mothers. An earlier study (Pernebo et al., 2018) described the psychotherapy group as “trauma-focused time-limited psychotherapy . . . based on trauma theory, attachment theory and psychodynamic theory” (p. 217), and identified treatment goals related to symptom reduction, addressing alienation and shame, and expressing and understanding feelings, thoughts, and experiences. The psychoeducative intervention (also described by Pernebo et al., 2018) included the goal of improving coping skills, but like the other condition also addressed alienation and shame and the expression and understanding of feelings, thoughts, and experiences. In the current study, the children were not randomized; rather, the study “had a naturalistic design” that studied the interventions “in their natural settings” (p. 230). Children included in the study were aged 4 to 13 years old and had experienced prior exposure to domestic abuse. All children in the sample had been exposed to intimate partner violence toward a caretaker. The majority (62%) of the children had exposure to child physical abuse, with one experiencing ongoing physical abuse and eight experiencing ongoing verbal abuse at the start of treatment. The interventions were 12 to 15 sessions, lasting 90 minutes with concurrent parent sessions and child sessions. (It is unclear why there was a range in number of sessions.) Eleven groups were included, of which five were psychotherapeutic groups and six were psychoeducational groups.

The authors assessed continuing levels of exposure to violence, child mental health, children’s posttraumatic stress symptoms, child emotionality and emotional regulation, maternal mental health, and mothers’

posttraumatic stress symptoms using multiple time points: baseline, post-treatment, a 6-month follow-up, and a 12-month follow-up. These variables were measured using the revised Conflict Tactics Scales (CTS2), the Strengths and Difficulties Questionnaire (SDQ-P), the Trauma Symptom Checklist for Young Children (TSCYC), the Emotion Questionnaire for Parents (EQ-P), the Brief Symptom Inventory (BSI), and the Impact of Event Scale—Revised (IES-R) respectively.

Both interventions produced positive outcomes, with the authors reporting “sustained, continuing, and additional significant improvements in children’s symptoms of general psychological health and trauma symptoms” (p. 233). For example, from pretreatment to the 6-month follow-up, children in both interventions showed improvements in mental health (e.g., total difficulties; emotional symptoms) and trauma symptoms (e.g., depression; anger). These improvements were mostly sustained at the 12-month follow-up. Of note, baseline differences in trauma symptoms were controlled for in the multiple regression. Specific results varied according to the intervention and the analyses, but improvement appeared to be stable at follow-up. When comparing the amount of change achieved by the two interventions, the study authors reported greater improvements in avoidance behavior for participants in the psychotherapy groups from posttreatment to the 6-month follow-up. Otherwise, there were no other significant differences between the two interventions at the follow-up period.

This study had a few limitations to note. Like Overbeek et al. (2017), this study did not include a nontreatment control group (nor did it include any other sort of control group). Further, children were not randomized into conditions. Sample sizes were small and also differed between the psychoeducative group (i.e., 31 children) and the psychotherapeutic groups (i.e., 19 children). Finally, like Overbeek et al. (2017), the authors did not test for group effects. Thus, the effects of intragroup dependency on statistical significance are unknown.

CLINICAL IMPLICATIONS

The Pernebo et al. (2019) findings provide evidence that children exposed to intimate partner violence can be successfully treated with traditional group therapy and psycho-educational group interventions,

with improvement found on general mental health, posttraumatic stress symptoms, and emotional regulation outcomes. When these findings are combined with Overbeek et al. (2017), there is evidence that differing treatment modalities are effective. Notably, both studies reported on interventions that involved the children and their nonoffending/care-taking parent. Therefore, clinicians may want to consider including parents in the treatment of domestic violence. Further, clinicians should consider the use of group treatment modalities, with both studies giving evidence for the effectiveness of group programs. Evidence for the effectiveness of psychological interventions in treating children exposed to domestic violence provides a beacon of hope: Through proper treatment, children can be protected from the devastating effects on mental health that are associated with domestic violence. Especially given the increasing rates of domestic violence during COVID-19 in which families are less able to access traditional group therapy (with many group programs being “reduced in size, cancelled, or moved online” [Moreno et al., 2020, p. 815] in response to the pandemic), the availability of such interventions is clearly a timely and important issue to consider. To get help for domestic violence and learn about local resources, the National Domestic Violence Hotline can be accessed at any time over the phone at 1-800-799-SAFE (7233) or over chat (<https://www.thehotline.org/>).

ORCID

Gary M. Burlingame  <http://orcid.org/0000-0002-1280-6904>

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Rachel A. Arnold, M.S.
E-mail: rahundgr@byu.edu