



Comprehensive Review of Interventions for Children Exposed to Domestic Violence



Written by:

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For Futures Without Violence

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Executive Summary

Exposure to domestic violence, which can lead to significant health and developmental problems, is a common occurrence for many children. There is an ongoing need to develop and evaluate effective interventions for children exposed to domestic violence (CEDV) and disseminate information about best practices to domestic violence advocacy programs and other service providers. Futures Without Violence received funding from the Department of Health and Human Services, Administration on Children, Youth and Families, Expanding Services to Children and Youth Program to conduct a national scan of interventions for CEDV and create a web-based repository of information about interventions and related resources. A three-prong approach that combined literature reviews, searches of registries and publications on evidence-based practices, and direct inquiry with key informants was employed to identify interventions that span across the continuum of empirical, experiential and contextual evidence.

A total of 23 interventions that serve children and families exposed to domestic violence met inclusion criteria. Four interventions, developed or modified specifically for CEDV, have been evaluated in randomized controlled trials with ethnically diverse study populations. Several other rigorously evaluated interventions for children and adolescents experiencing trauma including CEDV met inclusion criteria. A wide array of innovative and emerging interventions that can be offered in a variety of community-based settings by different types of service providers, including domestic violence advocates, was also identified. Nearly all of the interventions have conducted some type of evaluation ranging from randomized controlled trials to pre- and post-test comparison studies. A key characteristic of interventions developed or modified for CEDV is that they work concurrently with non-battering parents and their children. Many interventions use multi-modal treatment approaches that combine psycho-education and socio-emotional skills with other forms of therapy. Information about this broad array of interventions, which is supported by different types and levels of evidence, can help domestic violence advocates and other service providers to make evidence-informed decisions about program development for CEDV.

Introduction

Childhood exposure to domestic violence (CEDV) is all too common. Estimates calculated from a multistage sample design of the 48 contiguous states suggest that 15.5 million American children live in dual-parent households in which physical domestic violence has occurred in the past year and seven million are living in homes with ongoing severe physical domestic violence.¹ Data from a national survey of caregivers indicated that nearly 5% of infants (less than 12 months old) have witnessed inter-parental physical or sexual assault.² Estimates would be much higher if other forms of domestic violence such as emotional abuse and sexual coercion were included. According to the National Survey of Children's Exposure to Violence, rates for witnessing the assault of a family member, which includes assault of a brother or a sister by a parent, are fairly constant throughout childhood, with all age groups falling within the range of 6% to 11%.³

The physical, mental, neuro-developmental, and behavioral effects of childhood exposure to domestic violence are well documented.^{4,5,6,7,8,9} Not all children exposed to violence will develop trauma or trauma symptoms however their experiences matter.¹⁰ As noted by the National Child Traumatic Stress Network in their resource on domestic violence and children, many children are resilient if given the proper help following traumatic events.¹¹ The support of family and community are essential to strengthening children's capacity for resilience and their ability to recover and thrive.¹² There is an ongoing need to identify effective programming to serve and support children and families living with domestic violence and to secure more funding to evaluate existing and emerging practices that have not yet been rigorously evaluated.

Futures Without Violence received funding for a technical assistance and resource development project to address CEDV from the Department of Health and Human Services, Administration on Children, Youth and Families, Expanding Services to Children and Youth Program. One of the goals of the project was to help domestic violence programs and allied organizations serving children and youth access information on the best practices for CEDV and facilitate their capacity to translate this evidence on effective interventions into service delivery. To achieve this goal, a two-step process was employed. The first step was to conduct a national scan of interventions for CEDV. The second step was to organize the findings into a web-based, user-friendly format that would be accessible to domestic violence advocates and other service providers working with children and families exposed to domestic violence. The purpose of this paper is to describe the methods used to conduct the national scan of interventions for CEDV and to provide an overview of its findings.

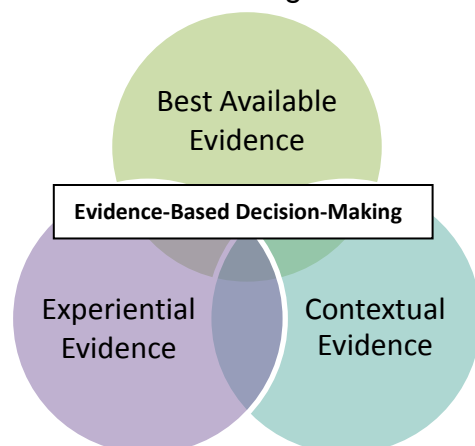
The methodology described below reflects our intention to identify a wide range of services across multiple systems that serve children and families affected by domestic violence. There is an increasing emphasis from Federal agencies and other funders to use evidence-based strategies, but at the same time, there remains the need to ensure that evidence-based models are flexible enough to accommodate the needs of different cultures, ethnicities, and communities. Our approach was informed by the

understanding that most services for CEDV have existed for only a few decades and therefore these services are supported by varying types and levels of evidence. Many of the earliest programs serving CEDV grew out of grass-roots efforts and community-based responses. Some of these programs have been operating for more than 20 years but may have had limited opportunities for evaluation. Funding to evaluate the effectiveness of interventions for CEDV has been limited and there have been significant barriers to using true experimental designs such as randomized controlled trials with community-based services. These barriers include concerns about safety, cost, ethical considerations when working with domestic violence, and the diverse needs of different cultures and communities. Another key consideration is that decades of field experience have informed some of the best practices for working with CEDV. With all of this in mind, the best evidence of an intervention's efficacy may be a combination of research and practice that can be used by advocates and others to influence systems of service delivery.

The national scan was designed to identify interventions across a continuum of evidence ranging from those that are well-supported by empirical evidence, to interventions that are practice-informed but unsupported by evidence, to innovative practices just emerging in the field. The Centers for Disease Control and Prevention (CDC) has published a guide describing how evidence should be considered along a continuum.¹³ While there is no universal agreement about how evidence-based practices and levels of evidence are defined, the CDC guide outlines three facets of evidence that are important and necessary to make evidence-based decisions: the best available research evidence, experiential evidence, and contextual evidence.

The best available research evidence is empirical evidence from evaluative research that measures the impact of an intervention. Experiential evidence is based on professional insight, understanding, and skill, as well as the expertise accumulated through time spent working in the field. Contextual evidence is based on factors that address how useful a strategy is, its feasibility of implementation in a particular setting, and its relevancy and acceptability in a community. These three facets of evidence overlap and each facet provides unique insights into evidence-based decision-making (see Figure 1).

Figure 1. Framework for Thinking About Evidence (CDC, 2011)



Methods

An inclusive approach spanning the continuum of evidence was developed to identify interventions supported by empirical evidence, interventions informed by research, and interventions primarily supported by experiential and/or contextual evidence. Our methodology was influenced by the understanding that there may be only a few interventions for CEDV that had been rigorously evaluated and our emphasis on identifying as wide a range as possible of both well-established and emerging practices.

Three strategies were employed to collect and synthesize information about interventions for CEDV. The first strategy was to conduct literature reviews in several databases for peer-reviewed journals and publications. The second strategy was to review evidence-based registries and publications. The third strategy was direct inquiry with key informants, which included a review of abstracts on promising practices submitted to a national domestic violence and health conference to identify community-based interventions that may not be published or included in evidence-based registries.

Inclusion criteria for all three of the strategies employed to identify interventions for the national scan were:

- 1) The intervention works with children exposed to domestic violence and/or their families to address issues related to CEDV, where serving children exposed to domestic violence was defined as an intervention that was specifically developed for or modified to address CEDV with children and/or family members or an intervention that addresses childhood trauma and identifies CEDV as a primary source of trauma.
- 2) The intervention provides information along the continuum of evidence that is relevant to service delivery for CEDV.

Systematic Literature Review

Focused searches were conducted using PubMed, Academic Search Premier, EBSCO's CINAHL and Psychology and Behavioral Sciences Collection databases, PsycINFO, and PsycBOOKs. Searches used a combination of subject headings and keywords to identify interventions for CEDV. The following search terms were used: 'children' or 'adolescents', 'domestic violence' or 'intimate partner violence', and 'intervention' or 'service' or 'program' or 'treatment'. Searches were limited to studies published in English from 1990 or later. This combination of keywords yielded 3,264 abstracts with considerable redundancies due to the overlap of databases. One-hundred and forty-nine journal articles and 5 book chapters were retrieved for review. Backward searches were conducted through the references of articles. Nineteen journal articles and two book chapters met the inclusion criteria. A total of seven interventions for the national scan were identified through review of the 19 journal articles and two book chapters.

Evidence-Based Practice Registries and Publications

Web-based registries of evidence-based practices and one related publication were reviewed using search functions when available and otherwise were manually browsed. The keywords, 'children' or 'adolescents' and 'domestic violence' or 'intimate partner violence' were used to electronically and manually search for interventions related to CEDV. The following registries and publication were reviewed:

- National Child Traumatic Stress Network Empirically Supportive Treatments and Promising Practices (<http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>)
- National Registry of Evidence-Based Programs and Practices (<http://nrepp.samsha.gov>)
- Office of Juvenile Justice and Delinquency Program Model Program Guide (<http://www.ojjdp.gov/mpg>)
- California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org)
- Promising Practices Network on Children, Families, and Communities (www.promisingpractices.net)
- Center for Children and Families in the Justice System (www.lfcc.on.ca)
- Child Welfare Practice Innovation, Safe Start Center (www.safestartcenter.org/innovation/)
- The Cochrane Library (www.thecochranelibrary.com)
- Blueprints for Violence Prevention (www.colorado.edu/cspv/blueprints/modelprograms.html)
- *Evidence-based & Evidence-informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-based and Evidence-informed Categories*, published by FRIENDS National Resource Center for Community-Based Child Abuse Prevention [CBCAP], 2009. Publication can be downloaded at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf

Six interventions that had not been previously identified through the literature searches met the inclusion criteria. Additional background information was also abstracted and synthesized for the seven interventions that had been previously identified during the literature review.

Direct Inquiry

Additional strategies beyond literature searches and reviewing registries of evidence-based practices were needed to identify community-based interventions that may have not been evaluated, are in the process of being evaluated, have limited evaluation, or have evaluation results that have not been published. These interventions are important sources of experiential and contextual evidence. Direct inquiry was employed to identify interventions for CEDV that were unlikely to be identified through literature reviews and searches of evidence-based practices. Two strategies were employed for direct inquiry. The first strategy was contacting key informants across the United States and Canada to ask for referrals to programs that they knew about. In addition, abstracts on promising practices that were accepted for presentation at a national domestic violence conference were reviewed to identify potential interventions for CEDV and authors of the abstracts were contacted to find out more about the interventions.

A letter explaining the technical assistance project and the purpose of the national scan was sent to 53 key informants via e-mail. The letter asked key informants' help in identifying best and promising practices for CEDV. An outline of the type of information that was needed about interventions was included. Specific language in the letter emphasized our interest in identifying emerging practices and interventions that were "innovative, culturally relevant, and serving diverse and under-served populations." Key informants included professors, researchers and service providers working in the fields of domestic violence, children exposed to violence, child welfare and maternal and child health. Domestic violence organizations including the National Resource Center on Domestic Violence, domestic violence shelters and state coalitions were contacted. A snowball sampling technique was employed whereby key informants were asked to identify other persons that should be contacted. This process yielded an additional 10 key informants. A total of 63 key informants were contacted and 16 interventions that had not been previously identified through the literature review and review of registries/publications for evidence-based practices were identified for consideration in the national scan.

Two of the referrals provided by key informants did not respond to repeated inquiries by e-mail with delivery confirmation. Sufficient information about the interventions could not be found elsewhere to determine if the interventions met inclusion criteria so these two referrals were eliminated from consideration. Four of the referrals did not meet the inclusion criteria of being an intervention for CEDV. Of the four referrals that did not meet the inclusion criteria, two were resources related to CEDV (a series of parent-child education materials that address the effects of domestic violence on children and a domestic violence training program for pediatric providers). Summaries of the two

resources were developed for another section of the website. A total of 10 interventions that met the inclusion criteria were included in the national scan.

Abstracts that were submitted and accepted as innovative/promising practice program reports at the 2009 National Conference on Health and Domestic Violence were also reviewed. Three abstracts were identified as potential interventions for CEDV and follow-up was attempted with the authors of the abstracts. The author of one of the abstracts did not have current contact information and could not be located. Another author did not respond to repeated e-mail inquiries with delivery confirmations to determine if the program met inclusion criteria. One program developer was contacted, information was provided, and it was determined that the intervention did not meet the inclusion criteria.

Intervention Template Development

The next step was to abstract, synthesize, and organize information about each intervention into a user-friendly format for a website where the primary audience would be domestic violence advocates. Several web-based, evidence-based national registries were reviewed to evaluate formats and identify essential fields of information that should be included. A key resource that informed the standardized intervention template for this project was the National Child Traumatic Stress Network (NCTSN) website on empirically supported and promising practices (<http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>) and their publication, *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information*.¹⁴ The NCTSN collaborated with the National Crime Victims Research and Treatment Center at the Medical University of South Carolina to compile a list of empirically supported treatments and promising practices for traumatized children and their families, including interventions being implemented by sites within the NCTSN. The NCTSN developed an intervention template that was then sent to program developers to solicit additional information about their interventions. The intervention templates were reviewed, revised, and then evaluated and categorized by an expert panel. The template used in the NCTSN publication placed special emphasis on including information that would help users to consider the appropriateness of any given intervention for their communities and target populations.

The development of the intervention template for the national scan followed a process similar to the procedure employed by the NCTSN. A prototype of the intervention template was reviewed and refined by Futures Without Violence Children's Program staff. A primary objective for the national scan was to ensure that we included and presented information in a format that would be useful to domestic violence advocates and other community-based service providers. Another key consideration was to organize the information into an appropriate format for a web-based database that could be easily updated. Data fields included whom to contact for more information, a basic description of the intervention which included the program setting, types of service providers used to deliver the intervention, and the length of program. Information in the template on the population served included the ages of children eligible for services,

parent involvement and adaptations for different ethnic/racial and cultural groups. Data fields about evaluation focused on the study design, characteristics of the study population, key findings, and related publications. Information about training, manuals, and other resources were also included in the template and an open field was added to highlight unique and innovative characteristics of the intervention.

Information was abstracted from journal articles, evaluation studies, other publications, websites, e-mails and teleconferences with program developers and researchers. The draft intervention template was e-mailed to program developers to ask for missing and additional information. Once returned, the template was reviewed and edited as needed. The edited template was then e-mailed back to program developers for final review and approval.

Categorizing Interventions and Website Development

As noted in the CDC's publication about understanding and using evidence for decision-making¹³, there is no universal agreement about how to define levels of evidence. While there is general agreement about the gold standard of a rigorous evaluation study needing to use a true experimental design, usually a randomized controlled trial in clinical and health related research, how interventions are classified relative to the level of evidence supporting the intervention has not been standardized. Most systematic evidence reviews involve panels of experts who may use different classifications, requirements, and terminology to categorize interventions. Depending on how and why interventions are selected for review and how the classification system is structured, an intervention may be reviewed and rated in one registry for evidence-based practices but not included in another registry for a variety of reasons.

Due to the inclusive approach of the national scan to identify and include interventions across the continuum of evidence, including practice-informed interventions and emerging practices, it was decided that it was not practical to rate interventions by the level of supporting evidence. It was decided that a more appropriate and efficient strategy was to take advantage of the many existing systematic evidence reviews conducted by panels of experts. We employed the same strategy used in the recent publication by the U.S. Department of Justice (DOJ) and the U.S. Department of Health and Human Services (DHHS) to highlight evidence-based programs for children exposed to violence.^{15*} Registries and two related publications for evidence-based practices were reviewed to abstract information about whether an intervention identified in the national scan had been reviewed and/or rated. This information was added to the intervention template to provide a national snapshot of the status of the intervention based on our findings.

Profiles of the interventions were constructed from the intervention templates for the website (www.promisingfutureswithoutviolence.org) and appear under the heading, *Interventions for Children & Youth* and the sub-heading, *Program Models*. Interventions

* This publication was not included in our review because it was not published until after our searches were completed.

are listed alphabetically and can be located using different search functions which include the following fields: language of population being served, age of child, settings for the intervention, ethnic/racial group served, service provider education level, and replication. An important feature of this website is that it is a dynamic resource that is periodically being updated with new information and interventions. Interventions continue to be identified, reviewed, and considered for inclusion on the website. Recommendations come from domestic violence advocates, domestic violence coalitions, colleagues, and others. The website solicits information about interventions and announcements are made at national domestic violence conferences and other events asking participants to visit the website and contact Futures Without Violence about interventions to be considered for review. Interventions are reviewed by a staff person from the Children's Program at Futures Without Violence and a consultant to determine if the program should be considered for more in-depth review. If it is decided that an intervention should be considered, information is gathered from the published literature, registries/publications for evidence-based practices, and through direct inquiry with program developers to develop an intervention template that is used to create the program profile for the website.

Overview of Interventions

An overview of the 23 interventions that were identified through the national scan is provided below. For the purpose of this paper, the interventions are organized by the method associated with how the intervention was first identified during the national scan. These categories are not mutually exclusive. Interventions identified in the literature review were included in one or more of the registries/publications for evidence-based practices. Most of the interventions identified in the literature review were mentioned during direct inquiry with key informants. One of the interventions identified through direct inquiry was added to an evidence-based registry after we first identified and reviewed the intervention. More detailed information about all of the interventions can be found in their respective program profiles at the www.promisingfutureswithoutviolence.org.

Literature Review

Seven interventions for CEDV were identified in the systematic literature review. Five of these interventions were designed or modified to specifically address CEDV. Four of the CEDV-specific interventions were evaluated with randomized controlled trials and one was evaluated using a pre- and post-intervention design without a control group. Two other interventions, both evaluated in randomized controlled trials, were developed for children exposed to violence but not limited specifically to domestic violence exposure. Brief summaries of the seven interventions identified in the literature review are described below in two sections. The first section describes the five interventions that have been developed or modified specifically for CEDV and evaluated with children exposed to domestic violence. The second section describes two interventions that were designed and evaluated with children exposed to violence but not limited to domestic violence exposure. All seven interventions are summarized in Table 1.

Interventions Developed or Adapted for CEDV

Child-Parent Psychotherapy (CPP) is a therapeutic intervention for CEDV and other trauma. Based at the San Francisco General Hospital in California, CPP is the core intervention used by the Child Witness to Violence Project in Boston, Massachusetts (described later in this paper) and is available worldwide. CPP works with the non-offending parent, usually mothers, and children through five years of age. CPP is delivered in weekly joint child-parent sessions that are guided by child-parent interactions and child's free play. The joint child-parent sessions are designed to change mothers' and children's maladaptive behaviors, support appropriate interactions between the mother and her child, and help to guide the mother and child in understanding and working through the trauma they have experienced. The intervention, delivered by therapists, usually ranges between 12 to 40 sessions. CPP places special emphasis on cultural competence through awareness about different cultural values on parenting, gender and role expectations, spiritual beliefs, and other cultural considerations that affect how families function. The developers have expertise in Spanish and Portuguese and the CPP manual has been translated into Spanish, French, and Italian. Several randomized controlled trials have evaluated CPP with diverse study populations including Latino and African American families.^{16,17,18}

In a randomized controlled trial with children exposed to domestic violence, 75 multiethnic (38.7% mixed ethnicity, 28% Latino, 14.7% African American, 9.3% white, 6.7% Asian) preschool-age children and their mothers were randomized to CPP or case management plus community referral for individual treatment.¹⁹ The children and mothers randomized to CPP attended 60-minute sessions for 50 weeks (mean number of sessions attended was 32.09). At the end of the one-year treatment period, children who received CPP had fewer total behavior problems, decreased traumatic stress symptoms, and were less likely to be diagnosed with traumatic stress symptoms compared to children in the control group. Mothers receiving CPP showed fewer posttraumatic stress avoidance symptoms compared to mothers in the control group. Six-months after the intervention had ended, children who participated in CPP had significantly fewer behavior problems and their mothers had less severe psychiatric symptoms compared to children and mothers who received only case management and community referrals.²⁰

Kids' Club and Moms Empowerment is an intervention for CEDV that is available in numerous locations across the United States as well as other countries. Kids' Club and Moms Empowerment works with mothers and their children, ages 5-13 years old. The program has been implemented with Latino/Hispanic and African American mothers and children. This 10-week intervention, delivered by mental health service providers, uses a combination of parent groups to address parenting skills and children groups for behavior management with an emphasis on social skill development. The parenting program is designed to support and empower mothers to discuss the impact of violence on their children's development, to build parenting competence, to provide a safe place for discussing parenting fears and worries, and to build social connections within a supportive group. The children's group creates a safe and trusting place for children to

learn how to understand and express emotions about their experiences and learn basic social, emotional, and coping skills.

A controlled trial of Kids' Club and Moms Empowerment was conducted with sequential assignment to three conditions: child-only intervention (CO), child-plus-mother intervention (CM), and a wait-list comparison.²¹ Graduate students in clinical psychology and social work were paired with community-based therapists to provide intervention services. The study population consisted of 181 children and their mothers. Slightly more than half (52%) of the children were Caucasian, 34% were African American, 9.5% were biracial, and 4.5% were from other ethnic/racial backgrounds. There were two children's groups determined by age (6-8 years and 9-12 years) and the groups were gender mixed. Seventeen percent of mothers were currently living with their abusive partner and 68% had some contact with their abusive partner but were not living together at the beginning of the study. The women had been in abusive relationships for an average of 10 years.

The CM condition (child-plus-mother) was most effective in reducing the percentage of children in the clinical range from baseline to post-treatment and at 8-month follow-up compared to children in the child-only intervention (CO). Children in the CM condition showed greater levels of improvement in violence-related attitudes and in externalizing behavior problems (e.g. aggression, defiance) from baseline to post-treatment compared to children in the child-only intervention. From baseline to eight months after the intervention ended, children in the CM condition experienced a 77% reduction of internalizing behaviors and a 79% reduction of externalizing behaviors. Children's changes in attitudes about violence were maintained for the CM condition while there was a significant deterioration in attitudes among children in the CO condition eight months after the intervention ended. Reductions in mothers' posttraumatic stress symptoms were associated with reductions in children's internalizing problems.²² Additional analyses indicated that children's disclosures of domestic violence in the group intervention were associated with greater improvement in those children's internalizing behavioral adjustment problems and their attitudes and beliefs about the acceptability of violence.²³

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a therapeutic intervention that focuses on the reduction of posttraumatic stress disorder (PTSD) symptoms through individual therapy sessions with children, ages 3-18 years old, individual sessions with parents, and joint parent-child sessions. TF-CBT has been translated into many languages and adapted for Native American and Alaska Native children. It can be delivered in a variety of settings including the home, schools, and residential care. While the length of this therapist-delivered intervention is usually 12 to 16 sessions, TF-CBT has been modified into a shorter version for mothers and children staying at domestic violence shelters. There have been many randomized controlled trials conducted that demonstrate the effectiveness of TF-CBT in reducing children's symptoms of PTSD.^{24,25,26} Our review focuses on the evaluation of the modified version of TF-CBT for CEDV.

A randomized controlled trial was conducted in a domestic violence shelter for children (45% White, 41% Black, 14% Biracial) with domestic violence exposure-related PTSD symptoms.²⁷ Children and mothers were randomly assigned to receive 8 sessions of TF-CBT or child-centered therapy (usual care) from shelter-based social workers. TF-CBT was shortened to 8 sessions (45-minutes in length) to accommodate the average length of stay at the shelter. Revisions were made to the TF-CBT model to focus on how children could feel safer in the face of ongoing danger. Brief TF-CBT was more effective than child-centered therapy in improving children's DV-related PTSD (driven by greater decreases in hyperarousal and avoidance symptoms) and anxiety.

Project Support is a home visitation program designed to work with mothers and children who have experienced domestic violence. Project Support works with children, ages 4-9 years old, who meet the diagnostic criteria for oppositional defiant disorder or conduct disorder. Weekly home visits are provided by therapists who help mothers with problem solving skills while also teaching them child management and nurturing skills designed to strengthen the mother-child relationship and reduce their children's conduct problems. The intervention is usually six months in duration with an average of 20 home visits.

A randomized controlled trial of Project Support was conducted with 66 mothers departing from domestic violence shelters with at least one child exhibiting clinical levels of conduct problems.²⁸ The mean age of mothers was 29.8 years old and there were 3.5 children in the household on the average. Forty-one percent (41.2%) of the families were Caucasian, 20.6% were Hispanic, and 38.2% were Black, not of Hispanic origin. Home visits began after mothers and their children departed from the shelter. Families in the comparison group were contacted monthly, provided instrumental and emotional support services, and were encouraged to use community services. Families who participated in Project Support as well as families in the comparison group received tangible goods such as household items and referrals for financial assistance. At 20-month follow-up, children whose mothers had participated in Project Support had greater reductions in conduct problems compared to children in the comparison group. Mothers receiving Project Support services displayed greater reductions in inconsistent and harsh parenting and psychiatric symptoms compared to comparison group mothers. Changes in mothers' parenting and traumatic stress symptoms accounted for a sizable proportion of Project Support's effects on children's conduct problems.

A pilot study of a **shelter-based group intervention with mothers and children exposed to domestic violence** was identified in our literature review.²⁹ The parenting group focused on strengthening the parent-child relationship and promoting positive discipline practices. The children's group intervention created a safe environment for children to express their feelings and experiences and promoted skill development on safety planning, problem solving and other social and emotional skills such as relaxation techniques. This community-based intervention was developed through a partnership between the YWCA and a women's shelter in Calgary, Alberta, Canada. The intervention was offered over a 10-week period. A pre- and post-test intervention comparison study was conducted with 47 children, ages 6-12 years old. After the

intervention, children had fewer behavioral problems although there was a discrepancy between parents' ratings of their children's internalizing behaviors and children's self-reported ratings of internalizing behaviors. Children demonstrated increased knowledge of their understanding of abuse and parents' ratings of their own stress levels related to their children were also significantly lower by the end of the intervention.

Interventions for Children Exposed to Violence

Two interventions, identified in the literature review, were developed for and evaluated in randomized controlled trials with children exposed to violence, including, but not limited to, domestic violence. The interventions are briefly described below and included in Table 1.

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) was developed for children who have witnessed violence including domestic violence. This classroom-based intervention is delivered by school-based mental health clinicians. Using a skills-based approach, CBITS helps children to process traumatic memories, express their grief, learn relaxation skills, challenge upsetting thoughts and improve social problem-solving. Drawings are used as a tool to help children express themselves and process what they have learned. CBITS was initially designed for children in 3rd through 8th grades. It has been adapted for high school age students, low-literacy students, students in foster care and students in faith-based settings. The intervention is offered in 10 group sessions plus at least one individual session for each student and up to four group meetings with parents. The CBITS training manual and materials have been translated into Spanish.

A randomized controlled trial of CBITS was conducted with 6th grade students who were randomly assigned to an early intervention group (61 students) or a delayed intervention comparison group that received the intervention three months after the early intervention group (65 students).³⁰ The students were primarily Latino/a and socioeconomically disadvantaged. At three-month follow-up, students in the early intervention group had significantly lower rates of PTSD symptoms compared to students who not yet received CBITS (the delayed intervention group). Approximately two-thirds (67%) of the early intervention group reported less severe symptoms of depression than what would have been expected without the intervention. Youth in the early intervention group also had less psychosocial dysfunction reported by parents. At six-month follow-up, there was no difference in PTSD symptoms, depression, or psychosocial dysfunction between the early intervention and the delayed intervention group (both groups had now received the intervention). This means that the positive effects were maintained in the early intervention group and that the delayed intervention group had achieved positive outcomes similar to the early intervention group. Other studies have evaluated the effectiveness of CBITS with rural American Indian children living on a reservation³¹ and traumatized immigrant children.³²

Parent-Child Interaction Therapy is a behavioral family interaction that utilizes step-by-step, live coached sessions with the parent/caregiver and the child to address

children's behavioral problems and reduce the risk of child maltreatment. The therapist provides coaching from behind a one-way mirror using a transmitter and receiver system. The length of the intervention is 12 to 20 sessions. The emphasis is on improving the quality of parent-child relationships and changing negative parent-child interaction patterns. This therapist-delivered intervention has also been adapted to be delivered by teachers and there is a modified version of PCIT called CARE that has been used extensively in domestic violence shelters. Developed for children, ages 2 -7 years old, PCIT has been adapted for children through 12 years old. PCIT has been evaluated with African American children and adapted for Native American families. It has also been translated into Spanish. A list of evaluation studies, including randomized controlled trials that have demonstrated the effectiveness of PCIT can be downloaded at www.PCIT.org.

In one randomized controlled trial of PCIT, parents were randomly assigned to one of three interventions: 1) PCIT, 2) PCIT plus individualized services, or 3) standard community-based parenting group.³³ Two years after the intervention ended, 19% of parents who received PCIT had re-reports of physical child abuse compared to 49% for parents who received a standard community-parenting group intervention. There was no difference between PCIT and PCIT plus individualized services.

Practitioners of PCIT have described how the intervention can be modified to address the effects of domestic violence on mothers and their children and the impact of victimization on mothers' parenting skills.³⁴ PCIT should not be used for CEDV if the domestic violence is ongoing.

Registries/Publications for Evidence-Based Practices

Six interventions for children experiencing different types of trauma including CEDV were identified through our review of registries for evidence-based practices and a related publication. The Child Witness to Violence Project, a leading authority on CEDV, uses Child-Parent Psychotherapy as its main intervention. Child and Family Traumatic Stress Intervention (CFTSI) has been shown to be effective in a randomized controlled trial with children experiencing trauma including CEDV. Another intervention, Child-Adult Relationship Enhancement (CARE), has been used extensively with domestic violence shelters. Three of the six programs were developed specifically for adolescents: Seeking Safety (SS for Adolescents), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), and Target-A: Trauma Affect Regulation. Descriptions of these interventions are provided below and summarized in Table 1.

The Child Witness to Violence Project at Boston Medical Center, an intervention for CEDV and other childhood trauma, uses Child-Parent Psychotherapy (CPP) as the primary intervention.³⁵ As previously noted, CPP has both child and parent components which include case management, parent guidance and individual therapy. The parent component helps parents to understand how trauma affects children and attachment,

how to handle conflict in the parent-child relationship and addresses the trauma associated with being a victim of domestic violence. The child component addresses symptoms associated with CEDV including aggression, sleep problems, difficult peer relationships and child-parent conflicts. Parents and children up to 8 years of age are seen at this hospital-based program. Mental health clinicians provide the intervention and the length of service is variable depending on the needs of the child and family. The Child Witness to Violence Project serves a diverse population that includes many African American, Latino/a and African families. Their training curriculum, "Shelter from the Storm: Clinical Intervention with Children Exposed to Domestic Violence" has been translated into Spanish.³⁶

The primary intervention used at the Child Witness to Violence Project, CPP, has been extensively evaluated with young children and families and received the highest rating by the National Child Traumatic Stress Network as an evidence-based treatment. The evaluations of CPP were conducted by the developers of the treatment at San Francisco General Hospital. The Child Witness to Violence Project at Boston Medical Center is linked with their program for evaluation and for dissemination of the treatment. Evaluation results from a randomized controlled trial of CPP with children exposed to domestic violence included decrease in trauma-related symptoms of the child, improvements in cognitive/developmental scores and decrease in maternal trauma-related symptoms.¹⁹

Child and Family Traumatic Stress Intervention (CFTSI) provides brief psychoeducation and early intervention to address posttraumatic stress reactions and prevent the onset of posttraumatic stress disorder (PTSD) among children, ages 7-18 years old, who experience trauma including CEDV. CFTSI focuses on improving social or familial support and coping skills by working with caregivers and their children to improve parent-child communication and teaching behavioral skills that help the caregiver and child to cope with trauma symptoms. Mental health clinicians deliver CFTSI in 4-6 sessions in a mental health/clinical setting. The parent handouts are available in Spanish.

A randomized, controlled comparative effectiveness trial of CFTSI was conducted with 106 adult caregivers (90% female) and their children.³⁷ The study population included African American, Hispanic and multiethnic families. Referrals to the voluntary program were made by police, from a forensic sexual abuse program, and a pediatric emergency room. Children had been exposed to a potentially traumatic event in the past 30 days and had reported at least one new symptom on the Posttraumatic Checklist. Witnessing violence was the form of trauma for 19% of the children who participated in the study. Families were randomized to CFTSI or a protocolized psychoeducational and supportive four-session intervention. At three-month follow-up, children who received CFTSI were 65% less likely to meet the criteria for PTSD compared to children who received the other intervention. CFTSI reduced the odds of partial (sub-clinical) and full PTSD by 73%. Children who received CFTSI also had significantly lower severity of PTSD symptoms compared to children who received the other intervention.

Child-Adult Relationship Enhancement (CARE), a modified version of Parent-Child Interaction Therapy (PCIT), was developed to be used by non-clinical service providers working in a wide range of settings including domestic violence shelters and homeless shelters. CARE skills can be taught to domestic violence advocates and other service providers including home visitors, day care workers, foster parents and homeless shelter staff in approximately 3 to 6 hours. CARE uses live coaching with adult caregivers and their children to enhance the adult-child relationship. CARE is seen as an ongoing service to promote skill development versus a treatment with a prescribed number of sessions. It has been translated into Spanish. While there are numerous evaluations of PCIT, there has not been any formal evaluation of CARE.

Seeking Safety (SS for Adolescents) is a present-focused, coping skills therapy for adolescents that targets posttraumatic stress disorder and substance abuse problems. The intervention, which can be adapted for any setting, can be delivered by clinicians, case managers, domestic violence advocates, and other youth-serving professionals. SS for Adolescents addresses 25 different topics including healing from anger, asking for help, and coping with triggers. The service provider can choose which topics are needed, so the length of the intervention varies. SS for Adolescents is available in Spanish, French, German, Dutch, Chinese and Swedish.

SS for Adolescents was evaluated in a randomized controlled trial with 33 outpatient adolescent girls who met DSM-IV criteria for both PTSD and substance use disorder.³⁸ The average age of the girls was 16 years old; 78.8% were Caucasian and 21.2% were of minority descent. Girls who received SS for Adolescents plus treatment-as-usual were compared to girls who received treatment-as-usual alone. The most common trauma history was sexual abuse (87.9%); many had multiple trauma and the average age when the first trauma occurred was 8.75 years old. The average attendance was 11.78 sessions. At the end of the intervention, girls in the intervention group reported lower rates of substance abuse and improved cognitions related to substance abuse and PTSD compared to girls who only received just treatment-as-usual. Girls in the SS for Adolescents intervention group experienced greater reductions in trauma-related symptoms compared to girls in the treatment-as-usual group.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) is group psychotherapy for adolescents, ages 12-21 years old, which is skill-based and present-focused to help teens deal with ongoing, chronic stress such as living in a home with domestic violence. The 16-week intervention is provided by therapists in a wide range of settings, including clinics, schools, group homes, residential treatment facilities, juvenile justice centers, and foster care programs. Core components of SPARCS include promoting skills for mindfulness practice, communication, coping, problem-solving, and understanding trauma and triggers. SPARCS has been used with ethnically diverse groups including African American, Latino, Native American, LGBTQ, and refugee/immigrant youth. SPARCS has also been used with gang members, adolescents in rural settings, traumatized teens who are pregnant or parents of young children, youth in foster care, and runaway/homeless

youth living in shelters. It has been adapted into a six-session version for youth staying at short-term facilities and there are also two peer-led versions.

The National Child Traumatic Safety Network reported some of the preliminary findings from a pilot study of SPARCS.¹⁴ Demographic information about the study population was not provided. Youth who received SPARCS had fewer conduct problems as well as fewer problems with inattention/hyperactivity. There were also significant reductions in PTSD symptoms with improvement in the overall severity of PTSD among adolescents who completed the 16-session treatment. Results from another pilot study, the Evidence-Based Practices Pilot (EBPP) conducted by the Illinois Department of Children and Family Services in conjunction with the Mental Health Services and Policy Program at Northwestern University, indicated that adolescents in foster care who received SPARCS were less likely to run away, less likely to experience placement interruptions, and reported fewer risk behaviors compared to foster care youth in the standard care group.¹⁴

Trauma-Affect Regulation (Target-A): Guidelines for Education and Therapy for Adolescents and Pre-Adolescents focuses on the treatment of PTSD. Target-A uses a strengths-based approach that emphasizes seven skills to help teens learn how to regulate their emotions, manage trauma memories, and become better at taking care of themselves and recovering from trauma. Target-A has been translated into Spanish, Hebrew, Dutch and French. The intervention has been implemented with youth, ages 10-18 years old, from diverse backgrounds including Native American, Canadian Indigenous, African American, African, Southeast Asian and Eastern European immigrant youth. Target-A for adolescents is offered in 10 to 12 individual or group sessions that can include parents and families. The intervention is provided by clinicians, case managers, rehabilitation specialist and teachers in a variety of settings including clinics, residential programs and schools, and also as a case management strategy.

Evaluation studies of Target-A with adolescent study populations are in progress according to the National Child Traumatic Stress Network¹⁴ and the National Registry on Evidence-Based Programs and Practices (<http://nrepp/samsha.gov>). Results from a small pilot trial with 24 predominantly Latino and African American juvenile probation clients, ages 10-18 years old, indicated reductions in PTSD avoidance/numbing symptoms, post-traumatic thoughts, and negative coping. Youth also reported increased hope and self-efficacy skills.

Direct Inquiry

Ten interventions were identified through direct inquiry. While these interventions represent a broad range of services, they naturally grouped into three general categories: research-informed interventions for CEDV and other trauma, practice-informed interventions for children exposed to violence, and innovative and emerging practices with families experiencing domestic violence. In the absence of publications

associated with an intervention, the primary sources of information were conversations and correspondence with program developers.

Research-Informed Interventions for CEDV and other Trauma

Several of the interventions that were identified through direct inquiry employed one or more interventions that have been shown to be effective for CEDV and/or other childhood trauma. This group of interventions is referred to as research-informed because one or more of the services offered are supported by research. Three research-informed interventions are described below and summarized in Table 1.

Children's Domestic Violence Response Team (CDVRT) is a coordinated team response that offers a menu of therapeutic options and case management. Based in Seattle, Washington, CDVRT is a partnership between a mental health agency, a domestic violence victim service agency and the YWCA. Advocates do an initial screening and talk with parents about the program. Wrap-around meetings with the team, consisting of a domestic violence advocate and a mental health clinician, are offered, and when needed, the mental health clinician can do a strengths-based family assessment. The team works with the supportive parent to develop a service plan. Therapeutic options include the following interventions that have been shown to be effective for CEDV and/or other trauma: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT) and Kids' Club and Moms Empowerment. CDVRT is provided in mental health clinics. No length of service is specified as it depends on the service plan and what interventions are selected.

The Family Center at Kennedy Krieger Institute offers several evidence-based interventions for children, ages 0-18 years old, with exposure to violence including domestic violence. Interventions include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), the Chicago Parenting Program and Alternatives for Families: Cognitive Behavioral Therapy. Mental health clinicians can provide these services at the clinic, in the home, or at school. The length of the intervention varies based on which interventions are used and the setting. Services are available in English, Spanish, and Sign Language.

The Vermont Child Trauma Collaborative, a state-wide training and consultation system for trauma-informed care, employs a trauma-informed framework called ARC (Attachment, Self-Regulation & Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth). The Collaborative is part of the State of Vermont's Department of Mental Health. ARC is an adaptable treatment framework to guide service providers who work with children and adolescents who have experienced trauma including exposure to domestic violence. Mental health clinicians integrate ARC with psychoeducation, skills for strengthening relationships and other techniques including relaxation, art therapy, and movement therapy.

Practice-Informed Interventions for Children Exposed to Violence

There were four practice-informed interventions designed to address childhood exposure to violence, including curricula for therapeutic group intervention with parents and children, identified through direct inquiry. The interventions are described below and summarized in Table 1.

The Child Witness Project, in London, Ontario, Canada, is part of the Centre for Children and Families in the Justice System. The purpose of the project is to support and prepare child and teen witnesses and thereby reduce their likelihood of being retraumatized by being a witness, while also enhancing their ability to communicate evidence effectively to the court system. Any child, 4-18 years old (and developmentally delayed young adults), who is a victim/complainant or has witnessed a violent crime and is expected to testify is eligible for services. Services are provided by a mental health clinician, usually at the courthouse. Non-offending parents and other caregivers are involved in the intake assessment and can also receive support and services if expected to testify. The program has worked with First Nations on cultural adaptations for Canadian Indigenous children.

The Child Witness Project is a long-standing intervention that has published reports about their services and lessons learned in the field.³⁹ Project staff solicit feedback from families and court observation studies have been conducted to rate the quality of children's testimony. A comparison of specialized court preparation for children to the status quo court support provided to adult witnesses indicated an increase in children's knowledge of court procedures, reduced levels of children's anxiety, and improved quality of testimony.⁴⁰

PALS-A Peace Learned Solution is a structured, creative arts therapeutic program for CEDV. Based in Willingboro, New Jersey, PALS is a partnership between the New Jersey Division of Youth and Family Services and Providence House Willingboro Division and a domestic violence shelter. PALS services include weekly and individual therapy, case management, and after-school programs and day care activities. Therapists are experienced in providing art and drama therapy. The program, located within a counseling center, is six-months in length and offered to children, 3-12 years old. Non-offending parents are required to participate in an eight-week series of classes to learn about domestic violence before their children can be admitted to the PALS Programs. Participation in PALS is limited to families that are not currently experiencing domestic violence. Some services are provided in Spanish.

An evaluation study of PALS was conducted using a pre- and post-test design with a comparison group (Linda Jeffrey, Rowan University, written communication, January 12, 2011). Children exposed to domestic violence who received six months of intensive treatment, including weekly and individual therapy through PALS, were compared to children who participated in a 10-week psychoeducation group. At the end of the six-month intervention, children in the PALS intervention group demonstrated substantial

improvement in emotional and behavioral functioning compared to children who did not receive the intensive treatment. These findings are pending publication.

Community Group Program for Children and Mothers' Exposed to Woman Abuse is a collaboration between community-based agencies including women's shelters, child protection services, children's mental health centers, preventive services for families, youth detention centers, and second stage housing for women and children who have left domestic violence situations. Located in East London, Ontario, Canada, services are provided in secure settings at participating agencies. Groups for mothers and their children, ages 4-16 years old, run concurrently for 12 weeks. Clients are self-referred. Support groups for adolescents are gender-specific. The intervention is designed to address children's posttraumatic stress disorder and other effects of CEDV. The children's group focuses on improving children's adaptive functioning, reducing socio-behavioral problems associated with CEDV, and teaching children safety skills. The intervention manual has been translated into French.

A pre- and post-test comparison study of the Community Group Program for Children and Mothers' Exposed to Woman Abuse was conducted with 17 mothers and 14 children.⁴¹ Comparison of pre-group and post-group scores indicated statistically significant decreases in children's post-intervention scores for externalizing and internalizing behaviors, decreases in behavioral problems, and decreases in attention problems. The children's group scores were also significantly higher for pro-social behaviors after the intervention. Another pre- and post-group comparison study was conducted with 31 children, ages 7-15 years old, and their mothers.⁴² Prior to the intervention, 59% of children replied that they would try to stop a fight between their parents compared to 10% after the intervention. After the intervention, 84% of children replied false to the statement that "sometimes children are the cause of their parents abusive behavior/fights" compared to 55% before the intervention. Nearly three-quarters (74%) of mothers/caregivers reported positive changes in their child as a result of the intervention. Changes reported by mothers included less violence against siblings, better listening, and the child not being as frustrated. Ninety-two percent of children indicated that they would recommend the group to a friend who had violence problems in his or her family.

Northnode: 12-Week Curricula for Children and Caregivers Affected by Domestic Violence are interactive therapeutic curricula designed for group intervention with children, ages 8-12 years old, and their adult caregivers. Developed by Northnode, a non-profit service organization in Massachusetts that works with children and families experiencing domestic violence, in collaboration with several agencies that provide services to CEDV, the curricula incorporates content from the publication, *Group Treatment for Children Who Witness Woman Abuse, A Manual for Practitioners*.⁴³ The curriculum for the children's group includes content on helping children to identify and express their feelings, promotes pro-social behaviors, and teaches problem solving and safety skills. The adult group curriculum helps caregivers to understand the reasons their children need to be part of the children's group, that victims and their children are not responsible for abusive behaviors, how to recognize abusive behaviors, how abuse

affects adults and children, strategies for supporting their children, problem-solving and safety planning and related issues such as substance abuse and sexual abuse. The curricula are available in Spanish.

A pre- and post-test comparison study of Northnode was conducted with children receiving clinical services from nine different social service agencies who completed the 12-week intervention.⁴⁴ The findings that are qualitatively described in the report include increases in safety planning skills, increases in knowledge about violence, and improved conflict resolution skills after children completed the curriculum. Sixty-four percent of caretakers gave the highest helpfulness rating regarding the group for their child and 83.5% reported that the goals they set for their children were met or exceeded. Fifty-six percent of the caregivers reported they had enough information about the children's group while 43% felt they did not have as much information as they would like.

Innovative and Emerging Practices with Families Experiencing Domestic Violence

The last three interventions described in this paper describe innovative and emerging practices to work with parents on issues related to domestic violence. One intervention works directly with fathers who have exposed their children to domestic violence and other forms of abuse. Another intervention offers separate parenting classes for offending and non-offending parents affected by domestic violence. The last intervention described here integrates intervention for domestic violence, substance abuse, and parenting. The interventions are summarized in Table 1.

Caring Dads: Helping Fathers Value Their Children is a 17-week, manualized group parenting intervention for men who have been identified as or are at high risk for maltreating their children and/or exposing them to domestic violence. Specific goals of the intervention are to engage men in the process of examining how they parent, increase their awareness of child-centered parenting, eliminate their abusive behaviors, promote respectful, non-abusive co-parenting with children's mothers, recognize the impact of their abusive behaviors, and connect them with other service providers to help their children be safe and recover from trauma. To ensure safety and freedom from coercion of domestic violence victims and children, there is systematic outreach to mothers and ongoing, collaborative case management with fathers and service providers working with the men's families. Collaborative case management is combined with motivation-enhancing, psychoeducational, and cognitive-behavioral intervention methods to address core risk mechanisms for fathers' abusive behaviors. Caring Dads, which is based in Toronto, Ontario, Canada, is offered in a variety of settings including batterers' intervention programs (BIP), family service agencies, shelters, child protective service agencies and mental health service agencies for children and families. The intervention can be provided by program staff including social workers, child protection workers, therapists, BIP staff, and probation officers. Caring Dads has been modified for Aboriginal clients and translated into Swedish and German.

Results from a preliminary evaluation of Caring Dads described pre-and post-test scores for 23 fathers.⁴⁵ At the end of the intervention, fathers' levels of hostility, denigration, rejection of their children, and their level of anger arousal to child and family situations had decreased significantly compared to before the intervention. A larger pre- and post-test comparison study was conducted with 98 fathers.⁴⁶ Most of the fathers had been "strongly encouraged" to participate in Caring Dads; 57% were referred by child protection services and 25% were referred by probation. Nearly half (46%) of the men were living with at least one child while the others had regular contact. At the end of the 17-week intervention, the most significant changes were in the areas of parenting and co-parenting. There were statistically significant reductions in group mean scores for fathers' laxness, over-reactivity, and hostility. At the individual level, 43% of men were classified as recovered or improved for reactivity, 25% had recovered or improved with regard to hostile behaviors, and 43.5% were recovered or improved relative to over-reactivity. More than one-third (36%) of the men showed improvement large enough to be clinically significant for co-parenting skills.

Christians as Family Advocates-CAFA Parenting Program provides separate parenting classes for parents who have committed domestic violence and parents who are victims of domestic violence. This program, based in Eugene, Oregon, helps parents to become healing agents in their children's lives by teaching parents positive parenting and empathy skills for their children. The intervention, offered at a domestic violence program/shelter in 15 sessions, integrates elements from Filial Play Therapy. Because many of the clients cannot read, there is an emphasis on experiential learning through role playing, demonstrations, and practicing skills such as empathy. No evaluation studies had been conducted at the time of the national scan. The developers noted that filial play therapy, a core component of CAFA, has been researched with many different populations.

Connections is a domestic violence intervention for substance-involved mothers and their children that is delivered within Mothercraft's Breaking the Cycle (BTC) substance abuse intervention program.⁴⁷ Connections is a manualized group curriculum that addresses the impact of domestic violence on children, parenting, and substance use recovery. Connections and BTC are available at Mothercraft, an organization based in Toronto, Ontario, Canada. The goal of Connections and BTC is early intervention to reduce risk and enhance development of substance-exposed children by addressing maternal substance abuse problems and strengthening the mother-child relationship while recognizing that domestic violence is an issue for many mothers and their children.

Connections is offered in six sessions and is delivered concurrently to mothers with other interventions including substance abuse treatment, mental health counseling, child care, parenting services, domestic violence advocacy, and other services. Goals of the intervention include increasing maternal knowledge about the impact of domestic violence on children, enhancing substance abuse recovery and parenting, early identification and planning for children who are impacted by domestic violence, substance abuse, and parenting problems, and integrating trauma-informed services for

these issues. Connections has been adapted for use with Aboriginal clients and the training manual has been translated into French. Connections was evaluated as part of a larger evaluation of BTC in a longitudinal study over a two-year period. According to the program's director, Margaret Leslie, unpublished results from the study suggested increased ability of mothers to resist substance use relapse, decreased symptoms of depression and anxiety in mothers, mothers had more empathy and appropriate expectations with children, and decreases in mothers' levels of parenting distress (Margaret Leslie, written communication, Nov 6, 2010).

Discussion

Only seven interventions for CEDV were identified in the literature review using search terms that focused on childhood exposure to domestic violence. All but one of the interventions identified in the literature review were evaluated with randomized controlled trials and were featured in two or more registries for evidence-based practices. Five of these interventions were designed or adapted to specifically address CEDV, all of which work concurrently with mothers and their children. Only one intervention worked with children beyond 12 years old or the 8th grade. Improving mothers' parenting skills and children's social and emotional skills were common characteristics of interventions that specifically address CEDV. While the length of the interventions varied from eight sessions to one-year of treatment, it is encouraging that several brief interventions have been shown to be effective for CEDV. These interventions are diverse in their applications ranging from a home visitation program to a brief cognitive behavioral therapy intervention at a domestic violence shelter. However, only one of these interventions can be delivered by non-clinicians.

The review of registries/publications on evidence-based practices identified an additional six interventions, three of which are targeted to traumatized adolescents. The number of registries/publications on evidence-based practices that an intervention was included in ranged from one to three, demonstrating the variability that occurs between registries in evaluating and rating evidence-based practices. The interventions identified through the evidence-based practice registries/publications were more diverse in terms of the types of providers that can provide the intervention and the types of settings where services are offered. Two of the interventions can be provided by domestic violence advocates and four of the interventions could be implemented in community-based, nonclinical settings, including domestic violence shelters, homes, schools and residential treatment facilities.

Direct inquiry with key informants identified an additional 10 interventions for children exposed to violence and their families. Four of these interventions are designed to be delivered by mental health clinicians or therapists, while the others can be delivered by nonclinical service providers or a team approach that combines domestic violence advocates and mental health clinicians. Settings include domestic violence shelters, courts, home, schools, batterers' intervention programs, and a substance abuse program. Two of the interventions offer a menu of proven to be effective treatments while another combines an evidence-based practice with other emerging practices. All

but one of the interventions has done some type of program evaluation, usually a pre- and post-test comparison design with encouraging results. There are two interventions that focus entirely on working with parents; one with fathers who perpetrate violence and the other works separately with parents who perpetrate domestic violence and victimized parents. Another intervention addresses co-occurring domestic violence victimization and substance abuse and how these problems can impact parenting and children. One intervention is included in a registry for evidence-based practices. It was added to the registry after the national scan began.

Several strengths emerged during the national scan. There are interventions for CDEV that have been evaluated with randomized controlled trials using strategies such as usual care or wait-list comparison groups to address concerns regarding the use of control groups that do not receive the intervention. Reviewing the evaluation studies for these interventions may provide insights on ethical considerations and safety concerns for program developers and advocates who are contemplating evaluation designs. Not including the programs that implemented interventions that have already been proved to be effective, there were only two interventions identified during the national scan that did not report some type of evaluation activity. This should encourage advocates and others to consider what initial steps may be feasible to start building an evidence base for the work they are currently doing.

Funding for evaluation, particularly for experimental designs such as randomized controlled trials, which are expensive and time-consuming, should be targeted to existing practices with experiential, contextual, and limited empirical evidence, as well as new and emerging practices. Program developers and advocates may find opportunities through partnering with other community agencies and universities to conduct evaluation of community-based services. While there are several interventions in this review that have been evaluated with one randomized controlled trial and these interventions have been replicated in many other locations, evaluation has not been replicated. More evaluation of these interventions in community-based settings with under-served populations is needed. Because the timeline on responding to funding proposals for evaluation studies is often short, researchers and advocates should be encouraged to build relationships so they can be prepared when funding announcements are released.

A number of the interventions identified through direct inquiry involve interagency collaboration and creative partnerships such as those described in the Community Group Program for Children and Mothers Exposed to Women Abuse, CDVRT, Northnode, and PALS. These interventions may provide additional ideas about innovative partnerships and funding opportunities while involving multiple systems and promoting a trauma-informed, coordinated community response. Advocates may identify entities that have not considered as potential partners in the past even though these entities are working with many of the same families that advocates also serve. By educating other service providers about how domestic violence can affect service delivery, advocates may be able to find common ground to integrate services, ensure that safety considerations are being incorporated into service delivery in other settings,

and identify strategies for cost-sharing. One example of where there may be emerging opportunities for collaboration and coordinating services is federally funded home visitation programs that are required to meet Federal benchmarks for addressing domestic violence with the families they serve.

Many of the interventions are provided by mental health clinicians or therapists. Partnering with mental health and social service agencies to create teams of advocates and therapists can expand both entities' capacity to meet the needs of children and families exposed to domestic violence. In the randomized, controlled trial of Kids' Club and Moms Empowerment, university graduate students partnered with trained therapists to provide services. The CDVRT intervention relies on teams of domestic violence advocates and mental health clinicians who work together to develop a service plan for parents and children.

All of the interventions specifically designed to address CEDV as well as number of the other interventions work concurrently with children and their non-battering parents/caregivers. A guiding principle based on evidence-based practices for CEDV is the importance of the parent-child dual advocacy approach. Simultaneous treatment of mothers and their children appears to be an effective approach to service delivery that would also provide opportunities to coordinate and enhance safety considerations. While several of the interventions acknowledge and address the co-occurring mental health needs of victimized parents, only one program, Connections, addressed mental health and victimization. This is a persistent gap in the field of trauma-informed services for families with mental health issues that are also experiencing domestic violence.

Most of the interventions use multi-modal approaches that combine more than one type of treatment. There is a strong emphasis on social-emotional learning, skill development and relaxation techniques. Interventions are often provided as a combination of individual and group sessions. There are components of psychoeducation and empowerment training integrated with cognitive behavioral therapy. Some programs such as the Kennedy Kreiger Institute and CDVRT offer a menu of treatment options. The Vermont Child Trauma Collaborative combines a trauma-informed therapy framework with relaxation techniques, art therapy and movement therapy. Advocates may identify strategies to integrate and expand the types of services they are currently offering.

There is a trend for emerging practices that focus on parent training and psycho-education about the impact of domestic violence on children. Trauma-informed parenting interventions have been developed for parents who are abusers, parents who are victims of domestic violence and victimized parents with substance abuse problems. Learning more about these programs can help advocates to promote trauma-informed parenting with their clients and enhance existing parenting programs that they may work with or refer families to. Parenting programs may also provide opportunities for collaboration and partnership as advocates consider the needs of their clients and communities.

It is encouraging that interventions specifically developed to address CEDV as well as several other interventions for childhood trauma that are supported by empirical evidence were evaluated with ethnically diverse populations. There is considerable emphasis across interventions in terms of working with families from different cultural backgrounds. Many of the resources associated with the interventions have been translated into more than one language. Advocates who are working with clients who come from different cultural backgrounds or have special needs may consider contacting researchers to find out if they have worked with that particular population or have interest in learning more about how to adapt services. Researchers need to engage in ongoing dialogue with domestic violence advocates to understand more about unmet and emerging needs in rural, underserved and culturally diverse communities.

With increasing emphasis on evidence-based practices, the national scan identified sources of information that will help advocates and other service providers to examine options that may mesh with their objectives and client populations. There is no one-size-fits-all option and evidence-based decision-making about interventions that span the continuum of evidence is an evolving process. Several interventions are manualized so detailed information is available to help advocates make informed decisions in choosing models and adapting existing services.

Conclusion

We know more than ever before about effective strategies to work with children exposed to domestic violence. There is a growing body of empirical, experiential and contextual evidence supporting interventions for CEDV that domestic violence advocates and other service providers can draw from to make evidence-informed decisions about the services they offer. The multi-prong approach used in the national scan was essential to identify interventions across the continuum of evidence for CEDV. A comprehensive search strategy that goes beyond traditional literature reviews can benefit any area of inquiry about best practices. This approach is particularly crucial for emerging topics like CEDV where research only began a few decades ago. Our findings reflect the ingenuity of communities and service providers to address the needs of children and families exposed to domestic violence.

While we intentionally developed an approach that would be more comprehensive and inclusive, a significant limitation to this national scan was that were community-based and emerging practices that were missed. That is why it is imperative that there is ongoing solicitation to nominate interventions for consideration. In addition, there should be periodic literature reviews and reviews of registries and publications on evidence-based practices to update the national scan and the website. Since the national scan was completed, more interventions have met inclusion criteria and have been added to the website while others are currently in the data collection or review phase. New programs that have been added to the website include Camp Hope, Discovery Dating, Parent-Child Trauma Recovery (PCTRP), A Window Between

Worlds, Attachment, Self-Regulation, and Competency: A Comprehensive Framework with Complexly Traumatized Youth (ARC), and Real Life Heroes (RHL).

The national scan provided a foundation of information about interventions for CEDV that has been compiled into a dynamic, on-line resource that will continue to expand as we learn more about existing and emerging practices. With the growing emphasis on trauma-informed interventions, innovations occurring in the field and the recognition that children exposed to domestic violence are often experiencing other adversities, search terms should be expanded to identify interventions that address other forms of childhood trauma. These interventions are likely to be working with children who have been exposed to domestic violence even when it is not identified as the primary source of trauma. Expanding the scope of the searches to include other trauma-informed interventions is likely to provide insights on innovative treatments such as engaging technology for online psycho-education and counseling to reach underserved areas, addressing problems that are highly correlated with CEDV such as substance abuse, bullying, gang involvement and teen pregnancy, and offer more opportunities for collaboration and funding.

VII. Table 1. Characteristics of Interventions for CEDV that Met Inclusion Criteria for National Scan

Intervention	DV-Focus	Focus on Specific Trauma-Symptom	Provider Type	Child's age/grade	Setting	Length	Cultures Served	Evaluation	Findings	Reviewed in EB-Registry/Resource
SOURCE: LITERATURE REVIEW										
Child-Parent Psychotherapy (CPP)	Yes	No	Therapist	0-5 yrs old	Hospital/clinic	12-40 sessions	Spanish, Portuguese, African American	RCT	↓ children's behavior problems and traumatic stress symptoms ↓ mother's posttraumatic stress avoidance symptoms	NREPP CA EB Clearinghouse EB-Practices NCTSN
Kids' Club and Moms Empowerment	Yes	No	Therapist	5-13 yrs old	Mental health agencies, supportive housing, shelters	10 weeks	African American; Latino/a and Hispanic	RCT	↓ internalizing and externalizing behaviors improvements in violence-related attitudes	CA EB EB-Practices
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Yes	PTSD	Therapist	3-18 yrs old	DV shelters, trauma clinics, health settings, residential foster care, homes	12-16 weeks; 8 weeks for DV shelters	African American; American Indian and Alaska Native; Latino/a	RCT	↓ children's DV-related PTSD symptoms and anxiety	NREPP PP Network CA EB Clearinghouse OJJDP Model Program NCTSN
Project Support	Yes	ODD; Conduct Disorder	Therapist	4-9 yrs old	Home visits	6 months, average 20 sessions	African American; Latino/a	RCT	↓ children's conduct problems ↓ mothers' inconsistent and harsh parenting and traumatic stress symptoms	CA EB Clearinghouse EB-Practices
Shelter-Based Group Intervention with CEDV	Yes	No	Group facilitators	6-12 yrs	DV shelter	10 weeks		Pre- and post-test design	↓ children's behavioral problems ↑ children's understanding of abuse ↓ parents' level of stress	
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)	No	No	School-based mental health clinician	3 rd -8 th grades	Schools	10 sessions	African American; Latino/a; Native American children living on reservations	RCT	↓ children's PTSD symptoms ↓ children's symptoms of depression ↓ children's psychosocial dysfunction	NREPP PP Network EB CA Clearinghouse NCTSN
Parent-Child Interaction Therapy (PCIT)	No	No	Therapists	2-12 yrs old	Clinical and residential settings; Head Start	12-20 sessions	Native American; Asian	RCT	↓ re-report of physical maltreatment ↓ negative parent-child interactions ↓ ODD behaviors	NREPP CA EB Clearinghouse EB-Practices NCTSN



Table 1. (Continued) Characteristics of Interventions for CEDV that Met Inclusion Criteria for National Scan

Intervention	DV-Focus	Focus on Specific Trauma-Symptom	Provider Type	Child's age/grade	Setting	Length	Cultures Served	Evaluation	Findings	Reviewed in EB-Registry/Resource
SOURCE: REGISTRIES AND PUBLICATIONS OF EVIDENCE-BASED PRACTICES										
Child Witness To Violence Project	No	No	Mental health clinician	0-8 yrs	Hospital-based	Variable	African American; Latino/a; African	Refer to findings for CPP		CA EB
Child and Family Traumatic Stress Intervention (CFTSI)	No	PTSD	Mental health clinician	7-18 yrs	Mental health/clinical setting	4-6 sessions	African American, Hispanic, multiethnic	RCT	Children less likely to meet criteria for PTSD and children with PTSD had lower severity scores	EB Practices NCTSN
Child-Adult Relationship Enhancement (CARE)	No	No	Non-clinical service provider, DV advocate	No age range	DV shelters; homeless shelters; day care; and other	Ongoing part of services	Translated into Spanish	No findings reported	Adapted version of PCIT; no formal evaluation of CARE	NCTSN
Seeking Safety (SS; Adolescents)	No	No	Therapist, DV advocate, case manager, other service providers	Adolescent	Any setting including mental health, home-based care, prisons, residential services	Flexible; 25 topic modules	Translated into Spanish, French, German, Dutch, Chinese, Swedish	RCT	↓ self-reported substance abuse ↓ PTSD/trauma-related symptoms ↓ other psychopathology	NREPP CA EB EB Practices
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	No	No	Mental health clinician; two peer-led versions	12-21 yrs	Clinics, schools, group homes, residential treatment facilities, juvenile justice centers, foster care programs	16 sessions; 6-week session for short-term facilities	African American, Latino/a; Native American, LBGTO, refugee/immigrant Some handouts translated into Spanish	Pilot Studies	↓ Conduct problems, inattention and hyperactivity ↓ PTSD symptoms Less likely to run away Less likely to experience placement interruptions ↓ risk behaviors	CA EB EB Practices NCTSN
Trauma Affect Regulation: TARGET-A	No	PTSD	Clinician, case manager, rehabilitation specialist, teacher	10-18yrs	Clinics, residential settings, schools	10-12	African American; Latino/a; Native American; Canadian Indigenous; African, Southeast Asian and Eastern European immigrants	Pilot trial Larger studies in progress	↓ youth's PTSD avoidance/numbing ↓ youth's post-traumatic thoughts ↓ youth's negative coping ↑ youth's hope & self-efficacy	CA EB NCTSN



Table 1. (Continued) Characteristics of Interventions for CEDV that Met Inclusion Criteria for National Scan

Intervention	DV-Focus	Focus on Specific Trauma-Symptom	Provider Type	Child's Age	Setting	Length	Cultures Served/Languages	Evaluation	Findings	Reviewed in EB-Registry/Resource
SOURCE: DIRECT INQUIRY (continued)										
Children's Domestic Violence Response Team (CDVRT)	Yes	No	Teams of advocates and mental health clinicians	Not specified	Community-based agencies	Depends on service plan			Refer to findings for TF-CBT, PCIT and Kids' Club and Moms Empowerment	
Kennedy Krieger Institute	No	No	Mental health clinician	0-18 yrs	Clinic, home, School-based	Variable	Spanish; Sign Language		Refer to findings for TF-CBT, PCIT, SPARCS	
Vermont Child Trauma Collaborative	No	No	Mental health clinician	Children/adolescents	Mental health centers	Variable			Uses ARC Framework	
Child Witness Project	No	No	Mental health clinician	4-18 yrs; Developmentally delayed young adults	Courts	Variable	First Nations	Unpublished results from comparison of services	<ul style="list-style-type: none"> ↑children's knowledge of court procedures ↓children's levels of anxiety ↑improved quality of testimony 	
PALS: Peace-A Learned Solution	Yes	No	Therapist	3-12 yrs	Counseling center	6 months	Some services available in Spanish	Pre- and Post-test design; in press	<ul style="list-style-type: none"> ↑improvement in emotional and behavioral functioning 	
Community Group Program for Children and Women Exposed to Woman Abuse	Yes	No	Variety of service providers	4-16yrs	Secure community settings	12 weeks	Manual translated into French	Two pre- and Post-test designs	<ul style="list-style-type: none"> ↓children's internalizing and externalizing behaviors, behavioral and attention problems ↓percentage of children blaming themselves for violence ↓percentage of children saying they would try to stop fight ↓violence against siblings, improved listening, less frustration 	



Table 1. (Continued) Characteristics of Interventions for CEDV that Met Inclusion Criteria for National Scan

Intervention	DV-Focus	Focus on Specific Trauma-Symptom	Provider Type	Child's Age	Setting	Length	Cultures Served/Languages	Evaluation	Findings	Reviewed in EB-Registry/Resource
SOURCE: DIRECT INQUIRY (continued)										
Northnode: 12-Week Curricula for Children and Caregivers Affected by DV	Yes	No	Variety of service providers	8-12 yrs	Not specified	12 weeks	Manual translated into Spanish	Pre- and post-test	↑ children's safety planning and conflict resolution skills ↑ children's knowledge about violence Nearly two-thirds of parents gave the highest rating re: group being helpful for their children	
Caring Dads: Helping Fathers Value Their Children	No	No	Social worker, therapist, program staff	For fathers	BIP programs, shelters, CPS, Mental health, family service agencies	17 weeks	Being modified for Aboriginal clients; Training manual translated into Swedish and German	Pre- and post-test	↓ fathers' levels of hostility, denigration and rejection of children ↓ fathers' levels of angry arousal to child and family situations	CA EB
Christians as Family Advocates	Yes	No	DV advocate	For parents	DV shelters/programs	15 sessions		None indicated		
Connections and Breaking the Cycle	Use	No	Agency staff	For mothers with substance abuse issues	Designed to be delivered concurrently with other services including substance abuse treatment, mental health counseling, parenting services, advocacy, and early intervention	6 sessions	Adapted for Aboriginal clients; training manual translated into French	Unpublished results from longitudinal study	↑ mother's ability to resist substance use relapse ↓ mothers' symptoms of depression and anxiety ↑ maternal relationship capacity and comfort with closeness/intimacy ↑ empathy skills and appropriate expectations in parenting role ↓ parenting stress over time	

CA EB=California Evidence-Based Clearinghouse (www.cebc4cw.org)

DV=domestic violence

DV Focus=intervention designed specifically to address CEDV

EB Practices=Practices for CEV=Evidence-Based Practices for Children Exposed to Violence, A Selection of Federal Databases, published in 2011

NCTSN=National Child Traumatic Stress Network Empirically Supportive Treatments and Promising Practices (www.nctsn.org)

NREPP=National Registry of Evidence-Based Programs and Practices ([http://nrepp/samhsa.gov](http://nrepp.samhsa.gov))

ODD=Oppositional Defiant Disorder

OJJDP=Office of Juvenile Justice and Delinquency Prevention Model Programs Guide (www.ojjdp.gov/mpg)

PP Network=Promising Practices Network (www.promisingpractices.net)

PTSD=Posttraumatic Stress Disorder

RCT=Randomized Controlled Trial



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Futures Without Violence works to prevent violence within the home, and in the community, to help those whose lives are devastated by violence because everyone has the right to live free of violence.

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