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Intervention for Children Exposed to Interparental Violence (IPV): Assessment of Needs and Research Priorities

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In this paper we review the development of interventions for children who have been exposed to interparental violence (IPV), assess current needs in the evaluation of interventions, and provide suggestions for research priorities in this area. Interventions for negative outcomes associated with exposure to IPV only recently have been carefully designed and evaluated, thus knowledge regarding program effectiveness is minimal. Three of the most comprehensive interventions that have been evaluated are presented. Each has demonstrated effectiveness, and focuses on children with different levels of symptoms and distress. However, many questions remain regarding which interventions are beneficial for diverse children with different kinds and intensities of problems. A number of research priorities and suggestions for further improvements in the evaluation of effectiveness of interventions are identified.

KEY WORDS: interparental violence; children; assessment.

Several national agencies have identified best practices for studying the effectiveness of prevention and intervention services. The National Research Council, Institute of Medicine (1998), the National Institute of Mental Health (1993), and the Institute of Medicine (1994), as well as a number of individual researchers, have recommended standards for evaluating services and programs, such as those provided for children exposed to interparental violence (IPV; Graham-Bermann, 2001a; Sullivan & Allen, 2001; Wolfe & Jaffe, 2001). Although there are many programs that have been offered to help children in the aftermath (or in the midst) of exposure to IPV, very few have been systematically evaluated. Furthermore, our understanding of the needs of these children and, hence, the design of intervention programs to help them, has changed over the years. As the following brief history reveals, our knowledge of the myriad of ways in which IPV affects children has grown and continues to develop. This increased understanding has had important implications for designing more beneficial interventions as well as more methodologically sound investigations for these children.

BRIEF HISTORY AND OVERVIEW

To provide historical context, we briefly review some of the first interventions for children of battered women and then focus on more current developments, in terms of understanding both children's intervention needs and treatment evaluation research. The literature regarding children's adjustment in the face of IPV and that related to the evaluation of interventions has evolved over the past 25–30 years.

Context

During the late 1960s and 1970s, violence against women began to receive more attention, largely as a result of the women's movement (Pleck, 1987). The first shelter for battered women opened in California in 1964, and women's organizations such

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as the National Coalition Against Domestic Violence (NCADV) were increasingly active in the United States during the 1970s (Barnett, Miller-Perrin, & Perrin, 1997). In addition, more shelters were opened across the United States, and community programs for battered women were developed (Pagelow, 1984).

Domestic violence was widely identified in the 1980s as a serious problem in American families following publication of the findings of Straus, Gelles, and Steinmetz' epidemiological survey carried out in 1975 (Straus, Gelles, & Steinmetz, 1980). This survey was replicated several times and revealed that older children witnessed assaults between parents and were victims of assaults by other family members in disturbingly high numbers (Straus, 1990). However, shelters for battered women that were first created in the mid-1970s had few structured programs of any kind for children. Most intervention efforts focused their attention on the women and on the men who abused them. Women's services were primarily directed at physical health and safety, as well as assistance in finding housing and work.

The public's awareness of IPV, and of children's exposure and reactions to it, changed considerably during the 1990s, in part because of the strength of the women's movement, research evidence, and high-profile cases, such as the murder of Nicole Brown in California (Schechter & Edleson, 1995). As evidence from additional research studies continued to mount, it became clear that there were consistent negative consequences for most children exposed to IPV (Hughes & Graham-Bermann, 1998; Jaffe, Wolfe, & Wilson, 1990; Jouriles et al., 1998), and that long-term psychological costs were evident (for a review, see Rossman, 2001). Concomitantly, shelters that were developed and built in the 1980s began to expand their services to the children. Many shelters offered programs planned to enhance the children's adjustment (Carlson, 1996; Hughes & Marshall, 1995), and this was the primary setting in which many interventions for children were developed. Most of these programs were designed to provide general support to all children in a shelter or community site, and to alleviate their distress.

Early Intervention Studies (1980s)

In this decade, the development of interventions for children of battered women evolved over time along two tracks: (a) initially, the focus was on understanding the current state of children's treatment needs, to design beneficial interventions, and (b) later, researchers concentrated on evaluating the interventions themselves, in an effort to provide evidence of program success. At that point in time, interventions and evaluations were rather unsophisticated, as might be expected.

Identifying Children's Needs for Intervention

The state of the research in the 1980s focused mostly on the "first track." That is, research was undertaken to describe the reactions of children, who were considered to be the "silent witnesses" and "hidden victims" of domestic violence. Many of these investigations relied upon children of batterers living in shelters and were designed to identify the types and the magnitude of problems, with a focus on adjustment and psychopathology (Hughes, 1988; Hughes, Parkinson, & Vargo, 1989; Wolfe, Zak, Wilson, & Jaffe, 1986). Researchers consistently found that children raised in homes with adult domestic violence were at risk for problematic development, and some investigators who used comparison groups noted that children exposed to interparental violence had higher rates (approximately 50%) of both internalizing and externalizing behavior problems, lower self-esteem, and more difficulties in school relative to children raised in nonviolent families (for reviews, see Graham-Bermann, 1998; Margolin, 1998; Rossman, Hughes, & Rosenberg, 2000). Overall, the primary focus of early studies was the identification and description of negative outcomes for the individual child.

Intervention Evaluations

The first programs were designed in the 1980s to provide support, to reduce problem behaviors, and to enhance coping for children exposed to IPV, and took the form of group interventions. For example, Hughes (1982) developed treatment groups for young children (ages 3.5–11 years) who were in a shelter for more than 10 days. Using pre- and postintervention evaluation this program was judged to be effective in reducing children's anxiety (Hughes & Barad, 1983). Similarly, Jaffe and colleagues developed a program for children aged 5–15 exposed to IPV who lived either in shelters or in the community but who were not in crisis (Wilson, Cameron, Jaffe, & Wolfe, 1989). Again, comparing pre- to postintervention functioning, they demonstrated that children showed fewer

behavioral problems and enhanced their knowledge and coping by the end of the program (Marshall, Miller, Miller-Hewitt, Suderman, & Wilson, 1995). However, all of these evaluations relied on small samples of children. With few exceptions (those noted earlier), the programs for children that existed were informal, were not standardized or manualized, and were not evaluated other than informally. Because these early programs were clinically focused, children of all ages, with all types of problems were included.

RECENT INTERVENTION STUDIES (1990s)

The descriptive focus broadened during the 1990s to include examination of possible mediators and moderators of the children's distress, such as variations in experiences of the mother, of the child, and in the violence exposure itself. Several researchers also began systematic evaluations of the effectiveness of their interventions. These two "tracks" of research focus (i.e., identifying problems and developing and testing methodologically sound interventions) began to merge during this decade. In addition, there was more written about theory as well as methodology. That is, researchers began to concentrate more on elucidating mechanisms by which the impact of exposure to IPV takes place, and identifying moderators of impact, as well as connections among variables that would have important implications for treatment. The main treatment modality continued to be the small group. About this time treatment for children began to expand beyond shelters, although the interventions were still primarily symptom-focused. Only toward the mid- to the later part of the decade was intervention research planned on the basis of theory and hypothesized mechanisms of change.

Focus on Children's Needs for Intervention

Theorized Mechanisms of Impact, Risk, and Protective Factors

Some researchers and clinicians suggested explanatory theories that could account for the impact of IPV on the child (e.g., Graham-Bermann & Hughes, 1998; Hughes & Graham-Bermann, 1998; Rossman et al., 2000). For example, direct mechanisms were thought to operate by having an impact on the child in a straightforward manner, without influencing another factor first. In this instance, direct mechanisms included both the modeling of aggressive behavior and stress in the family (Rossman et al., 2000). The modeling of aggressiveness was thought to heavily influence externalizing type problems (e.g., disobedience, aggressiveness) and the impact of stress was assumed to be reflected in internalizing type problems (e.g., anxiety, depression, trauma symptoms). However, indirect mechanisms were thought to exert their impact by affecting another factor first, then influencing the child's adjustment. Indirect mechanisms studied to date included characteristics of the parent–child relationship, parenting stress, and disciplinary practices (Holden, Stein, Ritchie, Harris, & Jouriles, 1998; Hughes & Etzel, 2001; Jaffe, Poisson, & Cunningham, 2001; Levendosky & Graham-Bermann, 2001). Another construction involved a combination of psychoanalytic theory and trauma theory focused on the parent–infant dyad (Van Horn, Johnson, & Lieberman, 1998). Here abused and traumatized mothers' parenting was considered to be influenced by internalized images, such that mothers projected their hostile feelings about the abuser onto their child and interpreted their child's normal assertiveness as aggression (Lieberman & Van Horn, 1998).

In terms of impact, research focused on both direct and indirect mechanisms, with evidence found for the operation of both types of mechanisms. For example, McCloskey, Figuerado, and Koss (1995) found a direct impact of family violence on child adjustment, and that mothers' mental health did not mediate that adjustment. Sullivan and colleagues found that although family violence had a direct impact on the children's adjustment, it also had an indirect impact on parenting (Sullivan, Nguyen, Allen, Bybee, & Juran, 2000). Related to indirect mechanisms, researchers hypothesized that children become concerned about emotional security as a result of witnessing interparental conflict (Cummings & Davies, 1994). Parenting practices also were posited to mediate children's adjustment. For example, child behavior problems were found to be significantly related to the abuser's irritability (Holden & Ritchie, 1991), as well as mediated through the mother's mental health (Hanson & Hughes, 1998). Women in shelters also were reported as lax and inconsistent in parenting and feeling stressed (Holden et al., 1998). Therefore, evidence was accumulating for the operation of both direct and indirect mechanisms of effect but the longitudinal view was just beginning to be appreciated.

Potential Moderators and Risk Factors

Researchers had been urged to identify and then target probable risk factors that function to sustain the problem or to interfere with adaptation and adjustment. Conversely, program evaluators were advised to assess protective factors, or those elements that serve to amplify success or to help to ameliorate problems (Graham-Bermann, 2001a). These potential risk and protective factors have been investigated as moderating factors in the 1990s, and have included such variables as children's experiences with different types of violence, different patterns of violence the children were exposed to, age, gender, and other associated stresses.

Different Types of Violence Experience and Exposure. Within a group of children exposed to IPV, there are marked differences in what the children may witness and experience (Carlson, 2000). IPV can vary from intensive verbal abuse, to mild violence, to sexual assault, and/or to severe physical violence that includes using or threatening to use weapons. Clearly, the expression of violence is not the same for all batterers. A number of studies have documented variations in IPV (Graham-Bermann, 2001b) and have identified subtypes or profiles of abusers (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000). The most severe violence perpetrators have long histories of violence and are violent across settings, whereas a second group of perpetrators are only violent at home. A third group of perpetrators is moderately violent and has patterns of increased dependency, insecure attachment, and jealousy (Dutton, Saunders, Starzomski, & Bartholomew, 1994). Therefore, even within a group of children exposed to interparental violence, the intensity, severity, and frequency of IPV may vary greatly, thus having an impact on the family climate.

Children also vary in terms of their direct experiences with violence. In the 1990s it was estimated that child physical abuse and IPV co-occur in about half of the families known to experience either type of family violence. For example, an overlap with child abuse of between 40 and 75% was cited when there was also physical violence to the mother in the family (Emery & Laumann-Billings, 1998). Appel and Holden (1998) reviewed studies and estimated the figure to be at least 40%. When Richters and Martinez (1993) assessed the violence exposure of school-age children in Washington, DC, they found that many had been exposed to violence in the community as well as in the home. Several studies documented that exposure to IPV had a greater impact on children's mental health than did exposure to community violence (DuRant, Getts, Dadenhead, Emans, & Woods, 1995; Osofsky, Wewers, Hann, & Fick, 1993). Still, the overlapping incidence of child neglect, sibling violence, and sexual abuse for children exposed to IPV remained unexplored.

Rutter (1990) demonstrated that children with a single risk factor were no more likely to exhibit adjustment problems than were those with no risk factors. However, the addition of a second risk factor predicted a fourfold increase in the likelihood of negative outcomes for the child. For example, Graham-Bermann and Levendosky (1998a) evaluated preschool-aged children exposed to IVP and Wekerle and Wolfe (in press) studied attachment in adolescents exposed to IPV. Both groups of researchers found that children's adjustment was related to their prior abuse and exposure to IPV in the home. Thus, children exposed to multiple forms of violence were identified as high in risk for negative outcomes and frequently those most in need of intervention services (Hughes et al., 1989; Rossman & Rosenberg, 1998).

Age and Gender. During this decade researchers also expanded their understanding of potential moderators by investigating gender, as well as children in younger and older age groups. A differential impact by gender was found in several studies, with boys more likely to exhibit externalizing symptoms and girls more likely to react with internalizing symptoms (Kerig, 1998). Jouriles and Norwood (1995) noted that boys were more at risk for physical child abuse than were girls in families with domestic violence. Graham-Bermann and Brescoll (2000) studied the ways in which IPV affected children's stereotypes of gender, power, and violence, and found that boys and younger children held more stereotyped beliefs about the family and the acceptability of violence than did girls or older children. One study of the prevalence of children's exposure to IPV in five cities revealed that children, particularly young children (ages 0–5 years), were more likely to be present in households with domestic violence, and thus at greater risk of being affected by violence (Fantuzzo, Boruch, Beriana, Atkins, & Marcus, 1997). Given the finding that IPV occurs more often and more intensely early in couples' relationships, very young children are clearly at risk for IPV exposure (O'Leary et al., 1989).

Additional Stressors. A number of studies have shown that family stress and poverty are added risk factors for children exposed to IPV. In these studies, socioeconomic status and associated family stress

were factors considered to increase the risk of the occurrence of physical abuse and domestic violence exposure for the child (Herrenkohl, Herrenkohl, Rupert, Egolf, & Lutz, 1995; Sedlak, 1991) and to reduce the effect of intervention programs designed to reduce children's aggression (Eron et al., 2003). Substance abuse, community violence, and family stress associated with poverty have been identified as added risks in studies of children with behavior problems, as well as children living in families with IPV (Fantuzzo et al., 1997; Pynoos, Steinberg, & Wraith, 1995; Zucker, Fitzgerald, & Moses, 1995).

Potential Mediators

Regarding indirect mechanisms, parent factors (such as mothers' mental health and parenting practices) likely function as potential mediators; thus, many researchers have focused on these characteristics.

Parent Characteristics. Parenting practices and mother's mental health have been identified as potential contributors to risk for children exposed to family violence (Levendosky & Graham-Bermann, 2001, in press). Parenting stress and the presence of multiple forms of violence have been associated with more negative outcomes for children exposed to the abuse of their mothers (Hughes & Etzel, 2001; Levendosky & Graham-Bermann, 1998). Many of these were cross-sectional studies. However, in Sullivan's longitudinal study of abused women, children's behavior problems were found to exacerbate parenting difficulties, not the other way around (Sullivan et al., 2000; Sullivan, Bybee, & Allen, 2002). It is clear that researchers are just beginning to address these and other salient issues that have important implications for interventions with abused women and their children.

Attention to Methodological Improvements

Informal Evaluation of Interventions

The first program evaluations that were described in the research literature early in the 1990s were based on clinically oriented services delivery, and were limited by small samples, design problems, and weak evaluation procedures. For example, a number of the early program assessments relied primarily on the self-report of mothers and the service providers themselves for evidence of a program's success (for reviews, see Graham-Bermann, 2000, 2001a). Other researchers did not use standard or structured manuals and/or created the program content differently for each group of children. Many early studies of children's interventions were designed without appropriate comparison groups and without follow-up, although this changed around mid-decade (Cox, 1995; Ragg, Sultana, & Miller, 1998; Tutty & Wagar, 1994). Thus, it was difficult to determine whether the children would have naturally recovered their functioning over time without any intervention or whether the programs themselves were effective.

New Evaluation Focus

Toward the middle to end of the 1990s, there was a new focus on the empirical evaluation of interventions. At that point we began to see programs that were systematically and rigorously evaluated for effectiveness; these were funded by government grants to academics (e.g., programs developed by Sullivan, Jouriles, and colleagues, and Graham-Bermann, reviewed below). These studies relied primarily on standardized assessments of children's behavioral adjustment, anxiety, and self-regard. Other areas of expansion during this decade included the development of new measures and the identification of additional outcomes that suggested further intervention needs. Research evidence now included the presence of trauma symptoms, PTSD, and cognitive distortions (Graham-Bermann & Levendosky, 1998b; Lehmann, 1997; Rossman, Bingham, & Emde, 1997). Here we learned that approximately 13–60% of children exposed to family violence could be diagnosed with PTSD although the sample groups used in these studies varied widely from families in shelters to community groups and from large to very small samples. The interpersonal schemas of children exposed to IPV were the focus of several studies, including family fears and worries and children's perceptions of parental conflict (Graham-Bermann, 1996; Grych, Seid, & Fincham, 1992). However, in the current decade, researchers are working to improve methodology, to follow children over time, and to build explanatory models rather than to identify individual outcomes that further describe the impact of IPV on children (Levendosky & Graham-Bermann, 2001, in press: Litrownik, Newton, Hunter, English, & Everson, 2003; Ware et al., 2001).

From Treatment Needs to Evaluation (2000)

Since 2000 there has been a greater emphasis on planning intervention studies with the major purpose being the evaluation of a broad range of outcomes, rather than emphasizing individual symptom reduction. Clearly this focus reflects researchers' appreciation of the combinations of factors that affect individual functioning in children exposed to IPV. Another impetus for this change was a series of studies demonstrating variety in children's needs for intervention. For example, researchers demonstrated that children react differentially to repeated violence exposure, with responses ranging from those who evidence major psychological disorders to some who appear resilient and relatively unaffected by these events (Grych, Jouriles, McDonald, Norwood, & Swank, 2000; Hughes, Graham-Bermann, & Gruber, 2001; Hughes & Luke, 1998). Further, the outcome clusters identified in these studies showed that many children have low, medium, or high rates of dysfunction that include both internalizing and externalizing behavior problems, rather than experiencing only one form of dysfunction, for example, aggression problems. Questions for designing effective interventions now include whether it is appropriate to do triage for those with the highest levels of dysfunction, to create treatments with a specific theory of change to address particular types of dysfunction (e.g., aggression, trauma), and whether one size can still fit all.

The availability of resources that describe interventions and their evaluations has also expanded with the Internet (see Table I). A number of websites have been created to share information about the impact of domestic violence, how children are affected, and what programs and resources are available to counter it. Some sites provide access to measures for evaluating aspects of programs. Other websites describe programs for specific populations, such as African American families, and children of different ages. Within this decade (2000s), another central issue for interventions has emerged: the consideration and inclusion of cultural variables.

Table I. Web sites That Describe Intervention Programs and Evaluations of Programs for Women and Children Exposed to IPV

http://www.abanet.org/domviol/home.html Homepage for the American Bar Association's Commission on Domestic Violence
http://www.abanet.org/domviol/stats.html Statistics on prevalence, race, age, gender, same-sex battering, immigrant women, children, dating violence, self-defense, health consequences, law enforcement, PPOs, stalking
http://www.actabuse.com Treatment resource page with sections focusing on domestic violence and rape
http://www.actabuse.com/dvindex.html Includes article on barriers to living without violence for women of color
http://www.aifs.org.au/nch/issues2.html Domestic violence as a form of child abuse: Identification and prevention
http://www.calib.com/nccanch/pubs/otherpubs/harmsway.cfm In Harm's Way: Domestic violence and child maltreatment
http://www.dvinstitute.org Describes the activities and programs available from the Institute on Domestic Violence in the African American Community, University of Minnesota
http://feminist.com/vday/html/resource/nationalorg.htm Informational page with links to other websites
http://www.futureofchildren.org/pubs-info2825/pubs-info.htm?doc_id=70473 Domestic violence and children
http://www.Sandragb.com Describes the Kids Club and parenting groups programs and evaluation measures for children exposed to IPV
http://www.thegreenbook.info/ The Greenbook Initiative
http://www.mincava.umn.edu/hart/risks&r.htm. Children of domestic violence: Risks and remedies
http://www.vaw.umn.edu/library/ccp/ Domestic violence and child maltreatment resources

Cultural Variables

The needs of women and children from diverse cultural groups have long been understood in shelter and community settings, but have only recently been the focus of research studies on children exposed to IPV (Graham-Bermann & Halabu, in press; Zane, Hall, Sue, Young, & Nunez, 2002). A few early studies reported that African American children showed fewer externalizing behavior problems following exposure to IPV than did Caucasian children (O'Keefe, 1994; Stagg, Wills, & Howell, 1989; Westra & Martin, 1981). Other researchers have explored the need for proposing culturally competent solutions to the problems of abusive families with children of color (Bell & Mattis, 2000; Williams, Bogess, & Carter, 2001). Yet another issue that has been identified is that poor children and children in minority families are more likely to be exposed to violence both in the community and at home than Caucasian children and those living in wealthier environments (Root, 1996; Sampson, 1993).

Still, only a few intervention programs take cultural variation into account (Rossman et al., 2000). Take the example of Hokoda and colleagues, who designed a program that focuses on empowering Latina mothers who are Spanish-speaking to help their children in the aftermath of IPV (Hokoda, Edleson, Tate, Carter, & Guerrero, 1998). In other settings, existing programs are being adapted for use with new populations. Yet most program training manuals still do not elucidate the needs of children in diverse ethnic groups. To date, research that tests for the effects of cultural variation on intervention outcomes has not been reported. We could learn from these kinds of studies that take either a comparative approach or a within-groups approach to exploring the salient issues concerning the child, the family, and the cultural context that influence intervention success.

Summary

Our appreciation of the range of and complexity of children's experiences with IPV has grown considerably. Concomitantly, we have come a long way in identifying the needs of children who are exposed to IPV, looking beyond individual psychopathological outcomes to a more nuanced understanding of children's problems that include a host of ecological risk and protective elements in the child's life. Still, the need for well-demonstrated, systematically evaluated, and effective programs looms large. While a number of programs have been tested and published, few researchers and clinicians have been able to design and execute intervention studies that are carefully planned, implemented, and evaluated. However, there are several examples of such work. They each have focused on children with different levels of distress and different needs for intervention. These are presented in some detail in the next section.

Exemplary Studies

Although some intervention evaluations have included comparison groups, very few to date have reported follow-up assessments. Those that have are worth inspecting in detail. The following intervention studies are considered exemplary because they have been designed on the basis of theory and practice, have random assignment of children to different treatment conditions, use appropriate comparison groups, contain pre- and posttreatment assessments, and have a reasonably long follow-up period. They utilize adequate samples and address the needs of children in different cultural groups. Most have relied upon standardized measures with which to assess change. These intervention program evaluations were extensive and supported with government grants. The children's outcomes that have been addressed include externalizing and internalizing behavior problems and emotional distress as well as self-esteem, focusing on the direct mechanisms of modeling and stress. In addition, all three groups of investigators included potential mediators, by including a focus on mothers' mental health and parenting practices in their interventions and evaluations.

Advocacy and The Learning Club

This 16-week intervention for abused women and their children was developed to provide advocacy services to mothers, a 16-week mentoring experience by an undergraduate student for the children, and an educational program (10 weeks of The Learning Club) for the children as well (Sullivan et al., 2002; Sullivan & Davidson, 1998). Mothers receive advocacy in obtaining help with difficult issues regarding their children, obtaining goods and services, legal issues, employment, education, social support, child care, housing, and transportation (Sullivan & Bybee, 1999). Advocacy is initiated as families leave a shelter. This program relies on community psychology

and feminist theory in its assumptions that women are disempowered by their experiences with IPV, are separated from natural supports and resources in their communities, and need instrumental help in the form of a personal advocate who can work with each mother to assess and address her needs. By extension, children (ages 7–11) are thought to be helped when their mothers receive more support and when the children learn new information from a mentor and an educational program. Contact with the family is intense: the trained students work with each family for an average of 9 hr per week. There was remarkably little attrition over the course of the evaluation study (<5%) and compliance and attendance at the psychoeducational/support group were high, as the mentor also provided transportation for children to attend each session of The Learning Club (Sullivan, Campbell, Angelique, Eby, & Davidson, 1994).

Results for the children indicated significant differences in a number of areas between the program and the comparison groups across three time points. Children improved their feelings of self-competence relative to those without the intervention. Mothers maintained an increase in social support and satisfaction with the program. In addition, fewer children who received the intervention were abused by a parent. These changes were maintained at 8-month follow-up (Sullivan et al., 2002; Sullivan & Davidson, 1998). Thus, the advocacy for the women and children, plus the children's group education program, is successful in significantly reducing violence and in changing children's perceptions of themselves.

Project SUPPORT

A targeted, intensive intervention was designed by Jouriles and colleagues for young children exposed to IPV who have high levels of diagnosed aggressive behavior problems (Jouriles et al., 1998, 2001). Only those children diagnosed with conduct disorder and oppositional defiant disorder are included. The program is based on social learning theory with the major premise being that parents need to provide different models and responses so that their children can learn different behaviors following violence exposure.

Similar to the Sullivan program, mothers and children who participate in the program are those just leaving shelters for battered women. The goal of the intervention is to reduce diagnosed conduct and aggression problems in children aged 4–9 years that were exposed to IPV. The program begins with a thorough screening and assessment of the child's behavior problems with goals identified for both the child and the parent. Thirty-six families participated in the evaluation study with half receiving the intervention and half receiving existing services. The goals were accomplished in a number of ways, including weekly sessions with the children and their mothers in the home. On average, the intensive intervention lasted for 8 months with a mean number of 23 home visit sessions per family. The primary focus was on the mothers: each mother met with a therapist weekly for 60–90 min to receive parenting coaching with the goal of building on existing parenting skills. Trained paraprofessionals also provided advocacy for the mothers and served as role models. In addition, children also had a supportive mentor. Weekly supervision sessions were included.

While children in both the comparison and treatment groups improved in their externalizing behavior problems over time, the program proved successful in reducing the conduct and aggression problems at a faster rate. Similarly, mothers' child management skills were enhanced as a result of participation in the program. The program was not successful in producing greater change in internalizing problems than the natural change that occurred over time for children in the comparison group. Still, this program enhanced the parenting capabilities of these Anglo, African American, and Latina mothers. Further, analyses of trajectories of change showed that improvements in the children's externalizing behavior problems were found to remain at 16 months postshelter stay (Jouriles et al., 2001).

The Kids Club

This intervention was designed to foster resilience and to enhance children's recovery from the potentially traumatic effects of exposure to interparental violence (Graham-Bermann, 1992, 2001a). This program takes place over 10 weeks and provides support for children aged 5–13 years old and their mothers. Program goals stem from the belief that children may be traumatized by violence and may develop inappropriate beliefs about gender and the acceptability of IPV in the family. Intervention is needed to help children identify feelings and fears associated with violence exposure, to help change social cognitions (including gender attitudes), and to develop appropriate coping skills and social skills. Thus, sessions are devoted to educating children about family

violence, promoting positive beliefs and attitudes about families and gender, reducing fears and worries, and building their social skills in the small group setting. To develop a consistent therapeutic environment, the children's beliefs, feelings, and skills that are addressed in the Kids Club program are reinforced when mothers also receive support for parenting. The program was developed and then adapted for use with children from a range of ethnically diverse groups, including African American, biracial, Hispanic, Native American, Arab American, international and Caucasian families, among others (Graham-Bermann & Halabu, in press). Group leaders follow a training manual and receive additional training in ethical, cultural, and clinical issues during weekly supervision. This program has been offered in both shelter and community settings.

The evaluation sample consisted of 221 families experiencing IPV, living in urban and suburban communities, who were recruited by flyers and advertising. Children were randomly assigned to a child-only intervention condition, child-plus-mother intervention condition, and treatment as usual (no intervention program) group. The rate of attrition was also low, at 5.7% at the 8-month follow-up. Less than 5% of families were in shelters.

In general, although children in all three groups showed improvement in internalizing problems over time, change was greatest for those in the child-plus-mother groups, next greatest in the child intervention program, and the least improvement was found for the comparison group (Graham-Bermann, 2000). Change in externalizing behavior problems was evident for all three groups but greatest for children in the child-plus-mother treatment group. Thus, while the children's intervention program was useful by itself in reducing the child's adjustment problems, it was more effective when empowerment and parenting support were also provided to the mother. Children who received the intervention had lower rates of PTSD diagnosis than did children in the nonintervention group. The program was not successful in reducing children's depression and impulsivity/distractibility.

Summary of Exemplary Studies

The three studies reviewed earlier set the current standard for excellence in research in the evaluation of intervention programs for children exposed to IPV. That is, they used appropriate comparison groups, which included a wait-list comparison and "treatment as usual." They relied upon random assignment of women and children to treatment conditions. Treatment manuals were developed and followed with supervision provided. Assessment of treatment fidelity also was included. Evaluations relied upon the use of multiple data sources, including child, mother, teacher, or shelter worker, as well as archival data and official documentation such as school records, in some cases. Each study relied upon a power analysis to determine adequate sample size to test for evidence of effects. Federal grant support was clearly critical, with the above criteria nearly impossible to fulfill without such support. While encouraging, such studies are rare, and the field of evaluation research on interventions for a child exposed to interparental violence has a long way to go.

The programs reviewed earlier are based on theory and suggest mechanisms that can account for the impact of interparental violence on the child. Researchers concentrating on the direct impact of modeling have created programs designed to intervene with aggressiveness and other externalizing types of symptoms in children (e.g, the Jouriles et al. program). In addition, the direct impact of stress on children's functioning has led to a focus on internalizing-type difficulties and posttraumatic stress symptoms and beliefs for the child (e.g., the Graham-Bermann program). All three studies reported positive effects when services were provided to the mother as well as to the child. These findings echo studies of treatments for child aggression that have found that success is greater when interventions focus on the child's symptoms as well as parenting education and support (Webster-Stratton & Hammond, 2003).

A number of different conceptual approaches have been offered by these researchers to help account for the diversity of children's symptoms. However, to date, there is no evidence of the superiority of any one conceptual framework over the others in accounting for child outcomes, as many children exposed to IPV suffer a variety of difficulties, inclusive of aggression, anxiety, and low self-competence. Although many researchers adopt a multiple pathways explanation when accounting for children's problems, the comparative value of distinct intervention approaches has not been systematically evaluated. Thus, currently it is unclear whether one treatment paradigm is better than another for reducing specific problematic behavioral outcomes in children with particular treatment needs. Finally, the evidence presented here supports the notion that well-planned and appropriately intense interventions, along with

inclusion of parenting support to mothers, can help lead to a reduction in children's and women's distress following exposure to IPV.

IMPLICATIONS FOR FUTURE INTERVENTION STUDIES AND RECOMMENDATIONS

General Recommendations

One suggestion that emerges from this review is to evaluate existing interventions and treatment programs before expanding to new interventions. It makes sense financially and logistically to assess the effectiveness of intervention programs that are currently in operation. There are over 1,200 shelters for battered women in North America, and at least 800 have children's programs, involving some degree of intervention for children and their mothers (Rossman et al., 2000). It would be helpful to evaluate individual components of the myriad of individual services provided to these families (e.g., parenting groups, support groups, children's groups), as well as the "whole experience" of the services received within the shelter. In doing so we could discover which of the programs are the more effective for what types of children, and which presenting problems require particular lengths of intervention.

Other currently operating paradigms of intervention can be found throughout the community. For example, programs are operated through mental health agencies, community service programs, in court settings, and in hospitals (Sullivan & Allen, 2001). The services provided by communities would also benefit from an evaluation of the extent to which children are actually helped. The study of the effectiveness of combinations of services (e.g., community group programs for children, early mental health screenings, and coordinated police and mental health community response teams) also would provide useful information on how communities are helping to protect children exposed to interparental violence. Effective communities could then serve as models for other communities.

Focus on Beneficial Treatments

Take Individual Differences Into Consideration

The goal would be to match family members' needs with appropriate types of interventions. For example, when examining children's adjustment on an individual basis rather than in the aggregate, researchers provided support for the observation that children responded to their exposure in different ways and with various degrees of distress, with approximately 50–55% of shelter children experiencing moderate to more severe problems in externalizing and internalizing areas (Grych et al., 2000; Hughes & Etzel, 2001; Hughes & Luke, 1998). These figures compare with 18% expected for children in the 4- to 18-year age range using national samples (Achenbach, 1991). Implications of these findings are that although all children would likely benefit from supportive contacts and psychoeducational programs, those children who are in the highly distressed clusters clearly need more immediate and more intensive interventions.

However, the finding that children who are high in externalizing problems are also high in internalizing problems raises a number of additional questions with implications for intervention. For example, do the symptom profiles of children not living in shelters mirror those of sheltered children? Should clinicians adapt or focus their interventions to address children's problems in aggression, their problems in trauma/anxiety, or should programs be tailored to address both needs? The results of the Jouriles et al. program evaluation show clear success in reducing aggression but not in reducing internalizing symptoms. Similarly, the Graham-Bermann program was successful in reducing aggression and anxiety but failed to address depression and impulsivity. All three model programs reduced symptoms relative to comparison groups but not all children were successfully treated. These results suggest that many children who complete intervention programs have unmet needs that can be addressed with additional treatment.

Take Moderators and Risk Factors Into Account

To date, the main outcomes studied have focused on children's attitudes, behaviors, and distress levels, as well as mothers' parenting knowledge, and skills. Given the results of recent studies, evaluation researchers would do well to assess the cumulative risk factors with which many children must contend (Kitzmann, Gaylord, Holt, & Kenny, 2003). The success of particular programs could then be compared for children in terms of the variance of multiple risk factors. In this way intensive intervention programs that target children with more severe distress, and likely involve several family members, could

be identified. Yet, to date, few intervention outcome studies point to analyses of risk or protective factors that may serve to moderate the positive effects of the program under evaluation.

Include Age, Gender, and Cultural Diversity

In addition to the recommendations above, and given the number of young children exposed to interparental violence and children from diverse ethnic groups, it would be helpful to test interventions that are designed specifically for children of different ages and those that take cultural considerations into account. Thus, it is important to assess and to treat children according to their developmental capabilities and needs. Younger children exposed to interparental violence may be best served with programs designed specifically with an eye toward their capacity to understand and to process the salient events in their lives. Concomitantly, when assessing children, it is essential to use measures that capture and evaluate relevant qualities that are sometimes defined by the age of the child. Young children may be best served with interventions that are geared toward helping their mothers, whereas older children and teens may do best in groups for children of similar ages and backgrounds. These are testable hypotheses.

In North America, there are large individual differences within a given cultural group among children and families in terms of their acculturation and their worldview (e.g., Allen & Majidi-Ahi, 1989; Dana, 1993; Weisz et al., 1993). These are issues to be addressed as proven programs are adapted to serve the needs of children in diverse communities (Cohler, Stott, & Musick, 1995; Masten, 2001). Another approach to serving the needs of diverse populations of children exposed to interparental violence is to first adapt and then to evaluate effective programs for use with new populations. It seems that some of the interventions reviewed here have been effective with three ethnic groups: Latina, Anglo, and African American families.

Assess Protective Factors

We also know from reviews of studies of child psychopathology in children exposed to domestic violence that approximately 55–60% of school-age children may not be severely affected, at least at the time of evaluation. It remains unclear whether this group of children is coping adequately, or whether they are doing well and can be considered resilient or at least temporarily unaffected by these family events. Few researchers have examined the "successful" children, the ones who seem to be resilient. Protective factors of all types should be investigated. Partly our knowledge is limited in these regards by reports of analyses that rely on single measures of dysfunction rather than on multiple indices of children's adjustment and few if any reports include measures of positive outcomes. By studying resilience, or those children who may adapt or cope well with exposure to extreme violence in their lives, we may learn more about how children manage to adapt and survive (Masten, 2001). We also can learn what it takes to survive adversity from the study of mothers who parent effectively, and those who manage to leave and stay out of abusive relationships. We can discover properties of communities that successfully reduce violence to women and children. It is possible to translate those findings into intervention programs that promote resiliency and enhance coping skills of both the children and their mothers.

Improve Methodology

Strive for Excellence in Evaluating Treatment Outcomes

Standards of excellence in services to children have now been identified in several volumes dedicated to research, intervention, and social policy for children exposed to interparental violence (see Graham-Bermann & Edleson, 2001; Jaffe, Baker, & Cunningham, in press; Trickett & Schellenbach, 1998; Ward & Finkelhor, 2000). Criteria for well-designed intervention studies include those that contain appropriate comparison groups; pre–post assessments, reasonable follow-ups; structured or "manualized" interventions; reports from different sources; comparative treatments, (e.g., group vs. individual, with or without mother included); different intensities of treatment based on different intensities of need; and that are based on theory and practice. Given the history of research in this area and the review of exemplary studies, a number of other suggestions can be made.

Broaden Intervention and Evaluation Settings

It is imperative that we go beyond reliance on populations of women and children living in or

departing from shelters for battered women, and include cultural factors as well. We know from previous studies that only a small percentage of battered women are estimated to seek shelter following abuse, the results of two of the programs described here may or may not extend to other populations of battered women (Graham-Bermann, 1998). Thus, the effectiveness of interventions for the majority of children exposed to interparental violence, those who do not reside in shelters, remains seriously underexplored.

Expand the Range of Outcomes Studied

In terms of outcomes, many investigators use instruments and methodologies that are broad and general in their approach. However, these instruments may not be sensitive enough for the outcomes researchers wish to assess. That is, most evaluation outcome studies rely on standardized measures of child behavior problems, maternal mental health, and parenting and use those measures repeatedly over short spans of time (a few weeks or months). Yet most of these measures were not created to assess short-term changes in symptoms. In addition to these outcomes, the range of variables that have been measured include the child's increased knowledge of the dynamics of battering and of safety planning, traumatic stress responses, whether the mother feels that the child is better, the extent of maternal help-seeking, and healthier mother–child interactions. In most cases, there are few standardized instruments available for evaluating such constructs. Including both developmentally and culturally appropriate instruments and individualized assessments would be further improvements.

If outcomes are expanded to include resiliency and the child's successful adaptation in the face of the adversity of IPV, additional constructs that tap these outcomes could include children's methods for thinking about and coping with violence, success in finding social support, healthy belief systems about gender and families, the extent to which role models are influential, and mothers' ability to parent effectively under stress. Measures of positive adjustment can be created and tested for use with this population.

Match Populations With Interventions

It is apparent that researchers must examine which populations and which programs are best for children with different symptoms, and with different severity levels of distress. Generic interventions may be appropriate for some segment of the exposed child population; however, additional, more specific interventions will likely be necessary. Researchers need to investigate what types of children, with what characteristics, would be appropriate for different intensities of interventions. Some children might do better with early intervention, and some might benefit from waiting until a later point in their life for treatment. In addition, some portion of the children might not be helped, and aspects of those children, their risk factors, and their contributing circumstances need to be ascertained.

Specify and Test Various Levels of Intensity

Related to matching interventions with needs, the intensity and the duration of interventions are both important to take into account. When intensity of the intervention is considered, a number of issues arise. For example, it would make sense to, but it is currently unclear whether it is important to tailor the intensity of treatment to the level of need of the family members. In another example, the preliminary studies reviewed here suggest that benefits are greater when the intervention is given to the mother plus the child. It is not clear whether referrals for additional services or subsequent interventions (e.g., group therapy plus individual therapy) would be additionally helpful and for whom.

Include Duration

Another important but unexplored issue is the duration and "dosage" of the program. Some intervention programs are not individually tailored but have an established number of sessions. Perhaps we could study outcomes in terms of the number of times children go through a group program, and/or how many sessions are enough to resolve the problem and for whom. Research on "booster" sessions that may provide inoculation against future flare-ups of symptoms should be undertaken. Thus, researchers could test and compare children and mothers who receive the original intervention, those who receive additional interventions or more of the original intervention, and those who receive booster doses of the intervention at a later time. Perhaps the need for additional treatment will vary or peak at particular developmental stages in the child's life. With this

information, interventions can be suited or tailored to the long-term needs of the child.

Create Public Policy for Better Funding

At present, few systematic evaluations have been undertaken for the services provided to children exposed to domestic violence and "best practices" are rarely implemented. A number of reasons for this state can be cited, including a lack of knowledge and skills needed to carry out thorough evaluations and follow-up, as well as a lack of funds. Most shelters struggle to meet costs and have few resources available for computers, people to conduct screenings, and especially, the money to follow families once they leave existing helping agencies (e.g., shelters, public health clinics, mental health clinics). Financial support is a major obstacle that limits research and evaluation of programs. Without external funding at the state or federal level, most agencies and shelters are simply unable to afford to carry out program evaluations. Perhaps insurance companies and communities would appreciate the results of outcome studies that provided cost–benefit analyses of money saved by helping children exposed to IPV.

SUMMARY AND CONCLUSIONS

Overall, although the field of intervention study for children exposed to violence has just begun, advances in the range of interventions, in their sophistication, and their effectiveness have been notable and encouraging. At this point it is likely that there will be an accelerating curve of knowledge and discovery of additional information about effectiveness that is relevant for improving the delivery of services to children exposed to interparental violence. With appropriate federal and state support of shelters, community programs, and evaluation efforts, the degree of help that children receive can be enhanced and the suffering and subsequent problems of these children can be reduced or even eliminated.

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