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The effectiveness of intervention for adolescents exposed to domestic violence

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ABSTRACT

The purpose of this study is to evaluate the effectiveness of a 10-week group intervention for adolescents who were exposed to domestic violence in their home, and compare behavioral and emotional symptoms between adolescents with direct or indirect exposure to domestic violence. Participants of the group intervention (N = 32) reported an increase in knowledge of domestic violence based on quiz scores of pre- and post-tests. Compared to those without direct exposure to domestic violence, the participants that were directly exposed to domestic violence presented greater symptoms in the subscales of the Child Behavioral Checklist and the Revised Children's Anxiety and Depression Scale. Such findings are discussed along with previous literature. The study also discusses limitations related to internal and external validity threats and suggestions for future replication of the group intervention toward adolescents who were exposed to domestic violence and the related program evaluation.

1. Introduction

Among most social work professionals and researchers in other related fields, domestic violence is considered to be a serious threat to the health and well-being of families and children, including adolescents. Millions of American children and adolescents are witnesses to parental violence each year, with some researchers reporting annual numbers as high as 25 million (Chanmugam, 2011; Lee, Kolomer, & Thomsen, 2012; Szndrowski, 1999). The occurrence rates cited in such reports vary from study to study according to each author's conceptualization of the term domestic violence, as the term is defined differently among researchers. The range of elements that characterize domestic violence definitions within literature include physical, sexual, and emotional abuse (Calvete & Orue, 2013), psychological abuse (Jouriles, McDonald, Mueller, & Grych, 2012), and also verbal aggression (Smith & Moore, 2013). Any type of such elements can be considered violent due to the negative effects on children who experience it (Jouriles et al., 2012).

The negative effects of domestic violence exposure on children are often severe and can be life-long (Zinzow et al., 2009). As of 2010, over 100 studies had documented these effects (Willis et al., 2010). Children and adolescents who are exposed to domestic violence, especially interparental violence, report significant detriments in their mental health conditions, such as depression, anxiety, anger, and elevated internalizing and externalizing behavioral problems, including increased aggression, as well as dating violence perpetration in their later life (Calvete & Orue, 2013; Jouriles et al., 2012).

Children and adolescents may experience domestic violence exposure in one of two ways—*indirectly* as a witness, and/or *directly* as a victim of abuse (Calvete & Orue, 2011; Wolf & Foshee, 2003). Exposure to domestic violence is a "stressful and traumatizing experience for children whether they are merely witnesses or victims" (Smith & Moore, 2013, p. 750). To clarify, direct experience of abuse may be regarded as child maltreatment rather than domestic violence (Merrick & Latzman, 2014). However, domestic violence includes any type of violence within family members, including child abuse. Specific negative effects of domestic violence exposure have been found to vary depending on what type of exposure the child or adolescent has been subjected to.

A child or adolescent who has experienced direct victimization of abuse, is more likely to exhibit internalized symptoms (Calvete & Orue, 2013). Such symptoms that are common to child victims of violence and well documented within the literature include anxiety and depression (Bourassa, 2007; Lee et al., 2012; Peltonen, Ellonen, Larsen, & Helweg-Larsen, 2010; Smith & Moore, 2013), emotional

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dysregulation (Jouriles et al., 2012), as well as post-traumatic stress disorder (PTSD) (Calvete & Orue, 2013; Chanmugam, 2011; Spilsbury et al., 2008).

Research has found that children and adolescents who are direct targets of domestic violence are more likely to display the negative effects in an external manner. Aggression is the most frequently documented external problem associated with domestic violence exposure in childhood and adolescence (Bourassa, 2007; Calvete & Orue, 2011, 2013; Jouriles et al., 2012; Lee et al., 2012; Parker, Stewart, & Gantt, 2006; Spilsbury et al., 2008; Szndrowski, 1999; Wolf & Foshee, 2003). Other external effects common to child witnesses of domestic violence include delinquency, substance abuse, behavioral problems, and dating violence perpetration (Szndrowski, 1999, Zinzow et al., 2009). Some researchers suggest that outward aggression is more common in children and adolescents who witness violence within their homes, because they are more likely to develop the view that violence is "an integral part of loving and [thereby] reflect this perception in their behavior toward others" (Willis et al., 2010, p. 553).

While multifaceted service needs for this population are prominent, outcomes of group-based support interventions for adolescents are far less reported than the outcomes of children in literature. Meanwhile, the most widely recommended intervention strategy for children and adolescents is to alleviate the participants' emotional and behavioral problems (Lee et al., 2012; Parker et al., 2006; Vickerman & Margolin, 2007). Parker et al. (2006) studied the effectiveness of expressive writing for 15 female adolescents between the ages of 12 and 17 who had been exposed to domestic violence. The findings showed that a 6-month expressive writing program, along with psychoeducational activities regarding self-esteem and relationship skill-building, helped alleviate dysphoric mood, negative affect and self-evaluation, somatic complaints, and depression. Expressing their emotions and personal experience in relation to domestic violence, and incorporating positive words from a list of personal strengths into their narratives, was a helpful method to develop coping skills for female adolescents who were exposed to domestic violence (Parker et al., 2006). Another group-based intervention for children ages 6–11 attempted to improve the negative emotional and behavioral effects that result from exposure to domestic violence (Lee et al., 2012). The program has a psychoeducational focus and addresses topics such as identifying and understanding feelings, defining abuse, safety planning, and solving conflicts without violence with respective session goals and objectives. After completion of the 10-week program, 27 participants showed improvement in their depressive symptoms, psychosocial impairments, and problematic behaviors such as fears, phobias, anger, aggression, sleeping problems, interaction with siblings, mood, and hitting (Lee et al., 2012).

Research evidence has found adolescence to be a particularly vulnerable period to experience violence within the home (Peltonen et al., 2010). However, relatively little focus has been put on the developmental impact that domestic violence has on an adolescent. Studies that differentiate adolescents from younger children are less common, and particularly, the age range of 15–19 is "neglected in most studies on exposure to interparental violence" (Bourassa, 2007, p. 692). The research evaluating intervention strategies specifically for adolescent victims and witnesses of domestic violence is still in a nascent state (Chanmugam, 2011). Consequently, "The American Psychological Association Commission on Violence and Youth recommends expanding data collection on domestic violence and providing interventions for young witnesses" (Parker et al., 2006, p. 46). In consideration to the gap in research that exists because of the limited number of evaluation studies targeting adolescents compared to children, the purpose of this study is to investigate the effectiveness of the Mantra intervention for adolescents exposed to domestic violence. Specifically, research questions include: after the completion of Mantra, 1) are there differences in adolescents' knowledge on domestic violence?; 2) is the intervention for adolescents exposed to domestic violence effective in the way of alleviating the participants' behavioral and emotional difficulties?; and 3) are there differences in behavioral and emotional difficulties between adolescents who have witnessed and experienced domestic violence?

1.1. The Mantra program

Mantra is a 10-week support group program for adolescents ages 11–19 exposed to domestic violence. The curriculum was developed and implemented by two practitioners with master's degrees in social work and counseling (Bedell & Thomsen, 2008) in a victim support agency in the Southeast. The intended functions of the curriculum were to increase the participants' awareness and knowledge of domestic violence and the effect of domestic violence on their emotions and behaviors, and to help develop safe and healthy responses to domestic violence and its influence. Mantra was created using the format from Heroes Great and Small, a group for child sexual abuse survivors founded in 1990 by staff of Harbor House Child Advocacy Center in Rome, GA (The Heroes Team, n.d.). Between 1999 and 2001, staff of the Heroes team trained practitioners in the organization that facilitated Mantra on how to present the curriculum and how to recreate the program. The curriculum was later revised by another community-based agency to fit children who had witnessed or experienced domestic violence, especially children ages 6–11 (Lee et al., 2012; Thomsen & Wilson, 2008). The curriculum then underwent another revision to produce a program adapted to fit adolescents, which is Mantra. The Mantra curriculum is based on literature regarding domestic violence prevention and early intervention programs toward children and adolescents exposed to domestic violence. Measures of intended outcomes of Mantra were also chosen based on literature and an expert's recommendation. Table 1 presents goals and target outcomes of Mantra curriculum.

The first two cohorts of Mantra were facilitated by its creators and then other providers in the same organization coming into leadership positions with Mantra. In general, one practitioner, generally assisted by a master's level intern, led the 90-minute program each week with trained volunteers who were individual mentors of participants. The mentors served as a support system to the participant throughout the program. Participation was voluntary and inclusion criteria included adolescents between the ages of 11–19, who witnessed, or were direct victims of domestic violence; and who had a parent or guardian's permission and support to engage in the group. A yes/no question regarding each type of emotional, physical, coercive control, and sexual abuse was asked during the written pre-group assessment. If a potential participant answered 'yes', s/he was asked to provide the frequency (1–5 Likert scale) of that particular witnessed and/or experienced abuse. Potential adolescent Mantra participants were excluded if they/their (1) still lived with the identified alleged perpetrator in the family home; (2) had more pressing mental health needs such as suicidal ideation or active substance abuse; (3) confidentiality could not be assured due to a currently filed, open contested divorce case with the alleged perpetrator as one of the biological parents; (4) could not be present at Mantra on a consistent basis; (5) was on either end of the Mantra age spectrum or had previously been diagnosed with a developmental delay or assessed to be developmentally inappropriate for the current Mantra cohort; (6) behaviors during the pre-group assessment were out of control and not appropriate for the group setting. Those who did not meet the criterion of (5) were also considered for the Superheroes program whose target age was children or for adult support groups and/or individual counseling. The exclusion criteria attempted to ensure the participants' relevance to the Mantra program and their safety in the group. Ongoing basis review of the participants' safety was another priority of the Mantra administers. Multi-layered decision-making groups and safety net existed including a Mantra facilitator-led team and collaboration between the Mantra facilitator and in-agency advocate for the same client. Clinical supervision at the level of the Mantra administers and the implementing agency regarding the participants' safety was available.