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Research article

Outcomes of psychotherapeutic and psychoeducative group interventions for children exposed to intimate partner violence

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ABSTRACT

Witnessing violence toward a caregiver during childhood is associated with negative impact on children's health and development, and there is a need for effective interventions for children exposed to intimate partner violence in clinical as well as in community settings. The current effectiveness study investigated symptom reduction after participation in two established group interventions (one community-based psychoeducative intervention; one psychotherapeutic treatment intervention) for children exposed to intimate partner violence and for their non-offending parent. The study included 50 children—24 girls and 26 boys—aged 4–13 years and their mothers. Child and maternal mental health problems and trauma symptoms were assessed pre- and post-treatment. The results indicate that although children showed benefits from both interventions, symptom reduction was larger in the psychotherapeutic intervention, and children with initially high levels of trauma symptoms benefited the most. Despite these improvements, a majority of the children's mothers still reported child trauma symptoms at clinical levels post-treatment. Both interventions substantially reduced maternal post-traumatic stress. The results indicate a need for routine follow-up of children's symptoms after interventions.

1. Introduction

Children's exposure to intimate partner violence (IPV) is associated with more emotional, behavioral, social, and cognitive problems and more trauma symptoms than children who grow up in nonviolent homes (Chan & Yeung, 2009; Evans, Davies, & DiLillo, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). The long-term effects of exposure to IPV have also been shown to include risks of behavioral, mental, and physical health problems in adolescence and adulthood (Cater, Miller, Howell, & Graham-Bermann, 2015; Herrera & McCloskey, 2001; Miller-Graff, Cater, Howell, & Graham-Bermann, 2015; Moylan et al., 2010). This accords with results from the broader field of trauma research. Research has repeatedly shown that witnessing interpersonal trauma as a child carries a high risk of negative impacts on children's health and development through the neurobiological, psychological, and relational effects of trauma and chronic stress (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Felitti et al., 1998; Teicher & Samson, 2016). A substantial proportion, 40%–60%, of children who have witnessed violence toward a caregiver have been estimated to need treatment interventions (Grych, Jouriles, Swank, McDonald, & Norwood, 2000). The accumulated body of knowledge on the negative impact of parental IPV on children's health and development has led to an increased demand for effective interventions within society.

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1.1. Effects of interventions for children exposed to IPV

To prevent or limit the adverse consequences of exposure to IPV, there is a need for accessible interventions for children with clinical-level as well as subclinical-level problems (Graham-Bermann, Miller-Graff, Howell, & Grogan-Kaylor, 2015; Weisz, Sandler, Durlak, & Anton, 2005). Children should ideally be referred for treatment within the healthcare sector—for example, in child and adolescent mental health service units—when their symptoms exceed a threshold that indicates a need for clinical treatment. Alternatively, they could be offered an intervention, typically community-based with a psychoeducative approach, motivated by their exposure to parental IPV even if their problems are not in the clinical range. Unfortunately, few of the interventions designed for children exposed to IPV have been studied or evaluated (Rizo, Macy, Ermentrout, & Johns, 2011).

Among treatment interventions for children exposed to IPV with clinical-level problems, Trauma-Focused Cognitive Behavioral Therapy (TFCBT) and Child–Parent Psychotherapy (CPP) have repeatedly been found to be effective in randomized controlled efficacy trials (Cohen, Mannarino, & Iyengar, 2011; Lieberman, Van Horn, & Ippen, 2005; Lieberman, Ghosh Ippen, & Van Horn, 2006). To varying degrees, these interventions show small to medium sized reductions in children’s symptoms of general psychological distress and trauma reactions, and decreases in parental symptoms of depression and traumatic stress.

The Kids Club group program has been found to be an effective intervention targeting at-risk children before their problems reach clinical levels (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann et al., 2015). Community-based interventions, including group interventions for children, combined interventions for children and their parents, individual interventions for children, and psychoeducative interventions for parents do not typically target post-traumatic stress in children and therefore often do not assess children’s symptoms of trauma in their evaluations. However, other outcomes have been assessed, and promising results have been shown in changing attitudes toward violence and reducing symptoms of distress. The level of improvement might be affected by the recruitment process, since intervention programs in community settings often involve children from more heterogeneous populations and draw upon fewer resources than programs carried out in the context of efficacy trials (Marchand, Stice, Rohde, & Becker, 2011).

The objectives of psychoeducative and psychotherapeutic interventions overlap in some ways and differ in others. Preventive psychoeducative interventions aim to strengthen people’s capacity to handle negative experiences and thereby reduce their risk of future negative effects of trauma, while psychotherapeutic interventions aim primarily to reduce current symptoms and suffering. Both kinds of interventions share the goals of decreasing shame, preventing alienation, and strengthening the capacity to understand and express feelings, thoughts, and experiences.

Current empirically supported treatments for trauma-related psychological problems have much in common and are typically focused on (1) psychoeducation on reactions to trauma and strategies for managing distress; (2) emotion regulation and coping skills; (3) imaginal exposure; (4) cognitive processing, restructuring, and/or meaning making; (5) emotions; and (6) memory processes (Schnyder et al., 2015). Including parents in interventions for children exposed to IPV has also been associated with positive outcomes (Graham-Bermann et al., 2007), although external or confounding variables may also influence outcomes of interventions and should not be overlooked.

1.2. Predictive, mediating, and moderating factors in the outcomes of interventions for children exposed to IPV

The impact of predictive, mediating, and moderating factors on the outcomes of treatment for children exposed to IPV is unclear. Only a few studies have reported associations between child outcomes, such as reductions in emotional, behavioral, and trauma symptoms, and possible confounding variables outside treatment. Young age, initial high levels of child symptoms, high maternal trauma symptoms pretreatment, decreased maternal exposure to violence, and high child attendance at sessions have been associated with greater reductions in psychological symptoms in children after treatment (Broberg et al., 2011; Grip, Almqvist, & Broberg, 2012).

The results of studies investigating predictors, mediators, and moderators of treatment outcomes for children exposed to a broad range of traumatic events suggest that the type of trauma, type of treatment, parental involvement in treatment, dosage (number of treatment sessions), and age may be moderating influences on effect sizes (Silverman et al., 2008).

1.3. Aim and research questions

The aim of the present study was to investigate and compare symptom reduction in children exposed to IPV after their participation in a community-based psychoeducative intervention or a psychotherapeutic treatment. We had five main research questions: (1) What are the outcomes of the two interventions in terms of the children’s emotional, behavioral, and trauma symptoms? (2) What are the outcomes in maternal psychological health and trauma symptoms? (3) Are there associations between the age of the child, the frequency of exposure to IPV, exposure to IPV only versus exposure to IPV and additional physical child maltreatment, and the outcomes of interventions? (4) Do current conditions such as the level of child symptoms of post-traumatic stress pre-intervention, ongoing child visitations with the violent parent, and ongoing parental mental health problems influence outcomes? (5) Does the pre-treatment to post-assessment change in child symptomatology differ between the two types of intervention?

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