

Updated Comprehensive Review of Interventions for Children Exposed to Domestic Violence



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For Futures Without Violence

UPDATED COMPREHENSIVE REVIEW OF INTERVENTIONS FOR CHILDREN EXPOSED TO DOMESTIC VIOLENCE

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I. EXECUTIVE SUMMARY

Many children and youth experience domestic violence, which can lead to significant physical, mental, behavioral, cognitive, and developmental problems. There is an ongoing need to develop and evaluate effective interventions for children exposed to domestic violence (CEDV), as well as to disseminate information about best practices to domestic violence advocacy programs, community partners, and other service providers. Futures Without Violence (FUTURES) received funding in 2010 from the Department of Health and Human Services (DHHS) and the Administration on Children, Youth and Families, through the Expanding Services to Children and Youth Program, to conduct a baseline national scan of interventions for CEDV and create a web-based repository of interventions and related resources. A three-pronged approach, which combined literature reviews, searches of evidence-based practice registries, and direct inquiry with key informants, was employed to identify interventions that spanned the continuum of empirical, experiential, and contextual evidence. Following completion of the baseline scan in 2012, the web-based resource, www.promisingfutureswithoutviolence.org became available online. FUTURES received additional funding from DHHS to update the national scan in 2017. Findings from the updated national scan have been added to this publication.

A total of 23 interventions that serve children and families exposed to domestic violence met inclusion criteria in the baseline scan conducted in 2012. Four interventions, developed or modified specifically for CEDV, had 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 community-based settings were identified. While most interventions are delivered by mental health providers, in a few cases a team approach and a nonclinical model can be implemented by domestic violence advocates instead. Nearly all of the interventions have conducted some type of evaluation ranging from randomized controlled trials to pretest/posttest studies. A key characteristic of interventions developed or modified for CEDV was that they work concurrently with the parent survivor and their children. Many of the interventions identified only work with mothers who are survivors at this time. Many of these interventions used multi-modal treatment approaches that combine psycho-education and socio-emotional skills with other forms of therapy.

The update of the national scan, conducted in 2017, nearly doubled the number of interventions that met inclusion criteria for CEDV. A total of 22 interventions for children and families exposed to domestic violence that had not been previously identified during the baseline national scan

were added to both this report and the web-based resource. Two of these interventions were developed specifically for CEDV; the remainder address a broad range of types of trauma including CEDV. The number of interventions identified reflects not only the proliferation of different programs and services for traumatized children but also an increased awareness of exposure to domestic violence as a significant source of trauma for children. As we learn more about the co-occurrence of exposure to domestic violence and other childhood adversities, interventions that address a broad range of types of trauma will continue to help meet the needs of CEDV. Several interventions were designed to address multiple traumas, complex trauma, and chronic exposure to trauma.

The majority of interventions in the update national scan were identified in the review of evidence-based practice registries. Most of the interventions are supported by some level of empirical data; many have been evaluated in at least one randomized trial. As was found in the baseline national scan, most of the interventions are delivered by mental health professionals. There are two nonclinical interventions: one uses paraprofessional parent coaches, while the other is a school based intervention that can be delivered by school staff. All but a few of the interventions involve caregivers in order to promote trauma-informed parenting skills and strengthen the parent-child relationship. There appears to be increasing awareness of opportunities to provide services in the school setting for children who have experienced trauma: eight of the newly identified interventions were developed for or included schools as a site for implementation. There is also a trend to serve families in their natural environment: more than half of the interventions can be implemented in clients' homes.

While most of the interventions use multi-modal treatment approaches, as was found with the interventions identified by the baseline national scan, there are some new focuses and strategies based on the findings from the update scan. A number of interventions include mind-body strategies to promote relaxation, coping skills, and self-regulation. Two play-based mental health interventions have been added. There are also two interventions that focus on family reunification, a particularly complex reality when working with families experiencing domestic violence. Among the newly added interventions working with adolescents, one addresses the intersection between trauma and grief. Another was developed to reach homeless, street-involved youth who have experienced trauma, including CEDV. One of the interventions translated into a language other than English is an adaptation of an evidence-based parenting intervention for Native American and Alaska Native children. Another family-based intervention has been modified for Spanish-speaking-only families.

Information about this broad array of interventions, supported by different types and levels of evidence, can help domestic violence advocates and other service providers make

evidence-informed decisions about program development for CEDV and other adversities. More information about the interventions described in this report can be found online at www.promisingfutureswithoutviolence.org. Given the number of new interventions identified during the update scan, particularly interventions that have been reviewed in evidence-based practice registries, periodic updates of the national scan are recommended. There should be ongoing discussion between CEDV experts and community partners to generate strategies to identify community-based and emerging practices in future updates of the national scan.



II. INTRODUCTION

Childhood exposure to domestic violence (CEDV) is all too common. Data from a national survey of caregivers indicated that nearly 5% of infants (fewer than 12 months old) have witnessed inter-parental physical or sexual assault.¹ 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, while seven million American children live in homes with ongoing severe physical domestic violence.² Estimates would be much higher if other forms of domestic violence such as emotional abuse and sexual coercion were included. According to the most recent National Survey of Children's Exposure to Violence, 5.8% of minors have witnessed a parent assault another parent or parental partner in the past year. One out of four (25.0%) 14- to 17-year-olds have witnessed a parent assault another parent or partner in their lifetime.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 still matter.¹⁰ As noted by the National Child Traumatic Stress Network in their resource on domestic violence and children, most children are resilient if given the proper help following traumatic events.¹¹ The support of family and community is 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.

In 2010, Futures Without Violence received funding for a technical assistance and resource development project to address CEDV from the Department of Health and Human Services and the Administration on Children, Youth and Families, through the 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 www.promisingfutureswithoutviolence.org, 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. An update of the baseline national scan was conducted in 2017, and the website was updated in 2018. The purpose of this paper is to describe the methods used to conduct the baseline and update national scans of interventions for CEDV and to provide an overview of the 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, highlighted section with this text: However, many evidence based models fall short in reflecting the complex realities of diverse communities. In order for evidence based strategies to be culturally relevant and helpful to diverse communities, they need to be flexible and culturally adaptable. 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. While some of these programs have been operating for more than 20 years, there may have been limited opportunities for evaluation at that time. Obtaining funding to evaluate the effectiveness of interventions for CEDV remains challenging and there are persistent concerns regarding safety and ethical considerations with regard to using true experimental designs such as randomized controlled trials. Another key consideration is that decades of field experience have informed many best practices for working with CEDV.

The baseline and update national scans were 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 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). The best evidence of an intervention's efficacy for CEDV is likely to be a combination of research and practice takes the three facets of evidence into consideration and can be used by advocates and others to influence systems of service delivery.

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



III. 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 specifically designed to address CEDV that have 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 for the baseline and the update of the national scan. The first strategy was to conduct literature reviews in several databases for peer reviewed journals and publications. The second strategy was to review registries of evidence-based practices. The third strategy was direct inquiry with key informants. A review of abstracts on promising practices submitted to a national domestic violence and health conference was also included as part of direct inquiry for the baseline scan in order 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 as 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.

i. Systematic Literature Review

Focused searches were conducted using PubMed, Academic Search Premier, EBSCO's CINAHL and Psychology and Behavioral Sciences Collection databases. 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'.

Baseline Scan: Systematic Literature Review

For the baseline national scan conducted in 2011-2012, searches were limited to studies published in English from 1990 onward. This, along with the previously mentioned combination of keywords, yielded 3,264 abstracts with considerable redundancies due to overlap between the databases. One-hundred and forty-nine journal articles were retrieved for review after eliminating these redundancies. Backward searches were then conducted through these articles' references, which resulted in nineteen journal articles and two book chapters that met the inclusion criteria. A total of seven interventions for the national scan were identified through review of these nineteen journal articles and two book chapters.

Update of Scan: Systematic Literature Review

Searches for the update of the national scan were limited to studies published in English from 2012 through April, 2017. Using the same databases and combination of keywords used in the baseline scan, 1037 abstracts were identified for review, with considerable redundancies between the databases. Forty-eight journal articles were retrieved for review after eliminating these redundancies. Backward searches were then conducted through these articles' references. Of the 48 journal articles retrieved, six described interventions for CEDV in non-English speaking countries and were excluded from consideration. Two of the publications were reviews of domestic violence interventions for children and families. Seven articles were identified that met the inclusion criteria. These yielded four previously unidentified interventions for CEDV for the update of the literature review.

ii. Evidence-Based Practice Registries and Publications

Web-based registries of evidence-based practices and one related publication were reviewed for the baseline scan. Search functions were used when available and when not available, the resource was 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 publications were reviewed:

1. National Child Traumatic Stress Network Empirically Supportive Treatments and Promising Practices (<http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>)
2. National Registry of Evidence-Based Programs and Practices (<https://nrepp.samhsa.gov/landing.aspx>)
3. Office of Juvenile Justice and Delinquency Program Model Program Guide (<http://www.ojjdp.gov/mpg>)

4. California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org)
5. Promising Practices Network on Children, Families, and Communities (www.promisingpractices.net)
6. Center for Children and Families in the Justice System (www.lfcc.on.ca)
7. Child Welfare Practice Innovation, Safe Start Center (At the time of the update, this resource could not be located online)
8. The Cochrane Library (www.thecochranelibrary.com)
9. Blueprints for Violence Prevention (www.colorado.edu/cspv/blueprints/modelprograms.html)
10. *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. (At the time of the update, this article could not be located online).

Six interventions for CEDV that had not been previously identified through the literature searches met the inclusion criteria during the baseline scan.

For the update of the national scan, the online evidence-based practice registries (1-9) were reviewed for interventions that had not previously been identified by the baseline scan. Seventeen interventions for CEDV met inclusion criteria and have been added to this publication and the online resource (www.promisingfutureswithoutviolence.org).

iii. 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 accepted for presentation at a national domestic violence conference were

reviewed for the baseline scan in 2012 to identify potential interventions for CEDV, and the authors of the abstracts were contacted to find out more about the interventions.

Baseline Scan (2012): Direct Inquiry

A letter explaining the technical assistance project and the purpose of the national scan was sent to 53 key informants via e-mail for the baseline scan. 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 marginalized 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.

In addition, 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.

Update Scan: Direct Inquiry

A modified methodology for direct inquiry was used for the update of the national scan in 2017. Futures Without Violence worked with a subject matter expert on children exposed to domestic violence to conduct outreach to 29 lead contacts affiliated with interventions/programs that are currently featured on the www.promisingfutureswithoutviolence.org website. Inquiries were done via e-mail using language similar to the letter that was sent to key informants during the baseline scan in 2012. A snowball technique was employed whereby contacts were asked to share any new information about their programs and information about any new or promising practices they were aware of that should be investigated. Direct inquiry yielded four interventions that had not been previously identified through the literature review or the review of registries for evidence-based practices. One of the four interventions met the inclusion criteria for being an intervention for CEDV and was added as part of the update scan.

iv. Website Profile Development

The final step of the baseline national scan 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 the Futures Without Violence Children & Youth 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, as well as a basic description of the intervention which included the program setting, types of service providers used to deliver the intervention, and the length of the 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.

The same template and process of soliciting feedback about interventions from authors and program developers was used in the follow-up scan conducted in 2017.

v. 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 that the gold standard is a rigorous evaluation study that uses a true experimental design—usually a randomized controlled trial in clinical and health related research—how interventions are classified relative to levels of evidence short of this gold standard 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. 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 a 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 gather 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 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 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 and Youth 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.

IV. OVERVIEW OF INTERVENTIONS

An overview of the 23 interventions identified through the baseline national scan and an additional 22 interventions identified in the update of the national scan is provided below. For the purpose of this paper, the interventions are organized by the method through which the intervention was first identified (literature review, evidence-based practice registry or direct inquiry). These categories were not mutually exclusive. In the baseline scan, some interventions identified in the literature review were included in one or more of the online evidence-based practice registries. In the baseline scan, most of the interventions identified in the literature review were also identified during direct inquiry. In the follow-up scan, there was no overlap between interventions identified in the literature review and direct inquiry. As was the case in the baseline scan, a number of interventions identified in an evidence-based practice registry appeared in more than one registry. More detailed information about all of the interventions can be found in their respective profiles at www.promisingfutureswithoutviolence.org.

A summary of the interventions identified by each search method for the baseline and update national scans is found in Table 1. The baseline literature review covered a much longer period of time (from 1990 through 2011) than the literature review for the follow-up scan (2012 through April, 2017). A major contrast between the baseline scan and the follow-up scan is the number of interventions identified through review of evidence-based practice registries: 6 interventions in the baseline scan, versus 17 interventions in the follow-up scan. Conversely, there were 10 interventions identified by direct inquiry during the baseline scan, and only one in the follow-up scan. An asterisk (*) following the name of an intervention indicates that it was identified during the update of the national scan conducted in 2017.

Table 1. Number of Interventions Identified by Search Method

Search Method	Baseline Scan	Follow-up Scan	Total
Literature Review	7	4	11
Evidence-Base Practice Registries	6	17	23
Direct Inquiry	10	1	11

i. Literature Review

Baseline Scan

Seven interventions for CEDV were identified in the systematic literature review in the baseline scan. 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.

Update Scan

Four interventions were identified in the literature review of the follow-up scan. One study, “Community-Based Group Interventions for Women and Children Exposed to Intimate Partner Violence,” compared two group interventions for women and children exposed to domestic violence in a randomized controlled trial. Another intervention, Theraplay, has two qualitative studies evaluating implementation of a modified version of this intervention with caregivers and children exposed to domestic violence.

The other two interventions identified in the literature review of the follow-up scan were developed for children exposed to violence/trauma, including CEDV. Brief summaries of the eleven interventions identified in the baseline and follow-up literature reviews are described below in two sections. The first section describes interventions that have been developed or modified specifically for CEDV. The second section describes interventions that were designed for children exposed to violence but not specifically or limited to CEDV. Interventions identified during the follow-up national scan in 2017 that have been added to the report are marked with an asterisk (*) following the name of the program in order to distinguish between interventions identified in the baseline and follow-up scans.

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 adult survivor, usually mothers, and children up to five years old. CPP is delivered in weekly joint child-parent sessions that are guided by child-parent interactions and child 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 of children exposed to domestic violence, 75 multiethnic 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

Community-Based Group Interventions for Women and Children Exposed to Intimate Partner Violence* are discussed in a journal article describing the evaluation of two group interventions with mothers and children exposed to intimate partner violence (domestic violence): a goal-oriented group intervention and an emotion-focused group intervention.²¹ The effectiveness of the two interventions in reducing family violence and increasing psychosocial well-being of women and children exposed to domestic violence by addressing posttraumatic coping strategies were compared. Both interventions are delivered by master's level therapists or counselors.

The goal-oriented group intervention integrated cognitive behavioral approaches with components utilized in motivational interviewing. Women and children, in their separate groups, chose a goal to work on that related to decreasing nonadaptive coping strategies and/or increasing adaptive strategies. The joint mother-child group sessions followed the session themes of the women-only and children-only groups.

The emotion-focused group intervention employed an integrated cognitive behavioral approach to educate and empower mothers and children regarding relationships, emotions, and coping, and processing this information within the relational context of the groups. A curriculum was developed for the women's group that focused on healthy and unhealthy relationships and the influence of nonadaptive and adaptive strategies. A parallel process was developed for the children's group that helped children identify and express emotions, enhance their understanding of the behaviors of self and others related to wants, needs and feelings, develop coping strategies, understand abuse, and learn strategies for staying safe. The joint mother-child group sessions continued the session theme of the separate groups for women and children.

The two community-based group interventions were compared in a randomized trial. Mothers and children (ages 6 to 12 years old) exposed to domestic violence were recruited from family homeless shelters and randomized to one of the two community-based interventions: the goal-oriented group intervention or the emotion-focused intervention. Both interventions were five weeks in length and met weekly. Each intervention held separate groups for mothers and children that were followed by co-facilitated sessions for women and children together.

Women and children in both interventions reported decreased family conflicts (arguments within the family). Children also reported reductions in peer conflicts and increases in emotional well-being and self-esteem. Greater decreases for family conflict were reported by women in the goal-oriented intervention compared to the emotion-focused intervention. Improved social support was reported by women in both treatment groups with greater improvement in the emotion-focused intervention compared to the goal-oriented intervention.

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.²² 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 year-olds and 9-12 year-olds), and the groups were gender mixed. 17% of mothers were currently living with a partner who uses violence and 68% had some contact with their partner who uses violence 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, as well as at the 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 violent 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.²³ 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, as well as in their attitudes and beliefs about the acceptability of violence.²⁴

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 mothers departing from domestic violence shelters with at least one child exhibiting clinical levels of conduct problems.²⁵ 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 the 20-month follow-up, children whose mothers 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 in psychiatric symptoms compared to comparison group mothers. Changes in mothers' parenting and traumatic stress symptoms accounted for a sizable proportion of Project Support's effect on children's conduct problems.

A shelter-based group intervention with mothers and children exposed to domestic violence, evaluated in a pilot study, was identified in the baseline literature review.²⁶ 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 posttest 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.

Theraplay*, developed to address complex relational trauma, is structured play therapy for children (ages 0-18 years old) and parents that promotes attachment, self-esteem, trust in others and joyful engagement. Theraplay is interactive and relationship-based with an emphasis on strengthening the parent/caregiver-child relationship. The core components of Theraplay focus on:

- structure (key concepts: safety, organization, regulation)
- engagement (key concepts: connection, attunement, expand positive affect)
- nurture (key concepts: regulation, secure base, worthiness)
- challenges (key concepts: competence, confidence, supports exploration)

Theraplay can be delivered with an individual family or with a group. While Theraplay is delivered in 18-25 weekly sessions with four follow-up sessions over the following year, there is a shorter version of Group Theraplay that has been adapted for women and children in domestic violence shelters. Other settings for Theraplay include community agencies, hospitals and clinics, residential care facilities, adoptive homes, and schools. Theraplay resources has been translated into Finnish, German, Japanese, Korean, Spanish, and Swedish.

There are many publications about Theraplay, including two controlled studies^{27,28} of Theraplay conducted in Hong Kong that indicated positive outcomes. One evaluation of Theraplay with children in grades 2-4 demonstrated significant reductions in internalizing behaviors following

8 weeks of Group Theraplay compared to children in the waitlist group.²⁷ In another evaluation of Group Theraplay with children with disabilities, there was significant improvement in social communication among children in a yearlong Group Theraplay program compared to the control group.²⁸

There are two evaluations of Group Theraplay with women and children exposed to domestic violence. Linda Dodd²⁹ conducted a pretest, posttest, and qualitative evaluation of Group Theraplay with a small group of mothers and their pre-school children in a domestic violence shelter in England. The intervention, of unspecified length, was delivered by a multidisciplinary team that included workers from the shelter, a child protection worker, and a psychologist. Compared to pretest scores, post-group scores suggested small reductions on the Parenting Daily Hassles Scale. Mothers' and group leaders' feedback about the intervention were positive. Mothers reported improvements in their children's social skills, behavior, and development (happier, better eating, and more confident), and fewer violent and aggressive behaviors. Group leaders noted that the children were much calmer after the first week.

Bennett and colleagues³⁰ described experiences with Group Theraplay with women and children at a domestic violence shelter. The Theraplay groups were facilitated by faculty from a nursing school and children services staff members at the shelter. The six-week intervention had two weekly sessions; the first weekly session was for children and the second weekly session was for mothers and children. Program content was expanded to address the needs of children exposed to violence. Adaptations included adding content on learning about violence and being able to discuss worries, concerns, and feelings about violence. Key questions addressed as part of the evaluation included concerns related to respect for personal boundaries and mothers' authority, concerns related to structure and competitiveness and concerns related to balancing fun activities with serious discussion. Overall, these concerns did not pose barriers to implementation. With regard to structure, original concerns about changing membership from week to week did not prove to be problematic. Both mothers and children looked forward to the groups and valued this as quality time.

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.^{31,32,33} 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 with domestic violence exposure-related PTSD symptoms.³⁴ 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.

Interventions for Children Exposed to Violence

The literature review of the baseline scan identified two interventions that were designed for children exposed to violence, including, but not limited to, domestic violence: Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) and Parent-Child Interaction Therapy (PCIT). Two more interventions that include domestic violence as a potential source of trauma were identified during the literature review of the follow-up scan. Cue-Centered Treatment (CCT) works with youth experiencing chronic exposure to violence/trauma while Stepped-Care Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) works with young children experiencing posttraumatic stress symptoms. Descriptions of the four interventions addressing childhood exposure to violence are described below. Interventions identified during the follow-up scan are marked with an asterisk (*) following the name of the program to distinguish between interventions identified in the baseline and follow-up scans.

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).³⁵ The students were primarily Latino/a and socioeconomically disadvantaged. At the three-month follow-up, students in the early intervention group had significantly lower rates of PTSD symptoms compared to students who had 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 the six-month follow-up (after both groups had received the intervention), there was no difference in PTSD symptoms, depression, or psychosocial dysfunction between the early intervention, and the delayed intervention groups. This means that the positive effects were maintained in the early intervention group and that the delayed intervention group 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 reservation³⁶ and traumatized immigrant children.³⁷

Cue-Centered Treatment (CCT)* works with youth (ages 8 to 18 years old) who have experienced chronic exposure to violence/trauma, and their caregivers to help them understand how current emotional experiences may be related to trauma and linked to maladaptive behaviors. Symptoms addressed by CCT include posttraumatic stress disorder (PTSD) and emotional/behavioral dysregulation, as well as negative cognitions and self-attributions. CCT combines elements from cognitive, behavioral, psychodynamic, expressive, and family therapies to help youth and caregivers learn about the importance of traumatic stress, how responses that are initially adaptive can become maladaptive, how to manage maladaptive responses to traumatic reminders (cue), how to cope with stress, and express emotions. Settings for CCT, delivered in 15 sessions, include schools, clinics, residential care, and community agencies. A therapist guide for CCT has been published in English.³⁸

CCT has been evaluated in a randomized controlled trial in a school setting.³⁹ Compared to a waitlist group, youth who received CCT had greater reductions in PTSD symptoms, anxiety, and depression. The intervention group also reported greater improvement in youth's overall functioning and reductions in caregivers' levels of anxiety and depression. These gains were maintained at the three month follow-up.

A second randomized controlled trial is currently underway. This study compares the effectiveness of CCT, TF-CBT, and treatment-as-usual with trauma-exposed youth. The aims of the study are to determine which components of treatment are most essential, which treatment is most suitable for which youth, and to identify neuromarkers of treatment outcome.

Parent-Child Interaction Therapy (PCIT) 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 also been adapted for children up to 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, parents were randomly assigned to one of three interventions: 1) PCIT, 2) PCIT plus individualized services, or 3) a standard community-based parenting group.⁴⁰ 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 parent survivor and their children and the impact of victimization on adult survivors' parenting skills.⁴¹ PCIT should not be used for CEDV if the domestic violence is ongoing.

Stepped-Care Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)* is a two-step approach to TF-CBT (see description below) that was developed to improve accessibility and efficiency and reduce the cost of treatment for young children experiencing posttraumatic stress symptoms. All steps are usually completed in 12 to 16 weeks. TF-CBT is one of the most widely used treatments for young children experiencing trauma. While TF-CBT has been adapted for children exposed to domestic violence, no information was available about adapting Stepped Care-TF-CBT for CEDV. In Step One, six weeks in length, there are three in-office therapist-directed sessions which include orientation, psychoeducation, and relaxation techniques. The remaining treatment is parent-led, therapist-assisted treatment at home with weekly telephone support, web-based resources including video demonstrations and handouts, and 11 parent-child meetings using a parent-child workbook called "Stepping Together." The "Stepping Together" workbook includes components on stress management techniques, behavior management, and skill-building activities such as identifying emotions and recognizing reactions to trauma.

If the child responds to Step One, it is followed by a parent-led maintenance phase to facilitate open communication between the children and parent/caregiver and reinforce use of the tools learned in Step One. Children who need more treatment progress to more intensive care with Step Two: standard TF-CBT for young children, which includes reviewing psychoeducation on trauma, relaxation strategies, affect modulation, cognitive coping, trauma narrative, and enhancing safety.

A small open trial with children ages 3 to 6 years old demonstrated reductions in traumatic stress symptoms for children who completed Step One; outcomes were maintained at the three month follow-up.⁴² A randomized controlled clinical trial comparing Stepped Care TF-CBT to standard care TF-CBT is underway.

ii. Online Evidence-based Practice Registries

Baseline Scan

Six interventions for children experiencing different types of trauma, including CEDV, were identified through our baseline scan of registries for evidence-based practices, as well as through 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 in domestic violence shelters. Three of the five 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.

Update Scan

The update of the national scan of evidence-based practice registries yielded 17 interventions for CEDV that had not previously been identified. With one exception—GroupTreatment for Children Affected by Domestic Violence (DV)—the interventions addressed many different types of trauma including CEDV. Five interventions specifically addressed complex trauma. Many of the interventions identified during the update scan of evidence-based practice registries have been evaluated with at least one randomized controlled trial. A majority of the interventions are designed to work with caregivers and children. A number of the interventions, including programs like Parenting with Love and Limits (PLL) and Real Life Heroes: Resiliency-Focused Treatment for Children with Traumatic Stress (RLH) have a strong emphasis on strengthening the parent-child relationship. PLL can be used as an alternative to residential placement for youth as well as with youth returning home from out-of-home placement.

Ten of the interventions can be delivered –in part or entirely — at home. Two of the interventions that can be implemented in the home, Attachment and Biobehavioral Catch-Up (ABC) and Celebrating Families! (CF!), can be delivered by paraprofessionals. CF! works with families recovering from substance abuse that are at high risk for domestic violence and/or child abuse. Homebuilders, a home-based intervention, provides intensive family reunification services for families with children who are at high risk for out-of-home placement or have been placed out of the home. Early Pathways (EPP), another home-based program, is designed to treat and prevent disruptive behaviors in young children exposed to trauma. Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) is a strengths-based intervention designed for families that use coercive parenting strategies including corporal punishment. Honoring Children, Making Relatives (HC-MR*) is a cultural translation, transformation, and enhancement of Parent-Child Intervention Therapy (PCIT) for Native American and Alaska Native children. PCIT was reviewed in the baseline scan in 2012.

Eight interventions can be implemented in schools. Two of these interventions, Bounce Back: Elementary School for Childhood Trauma and Support for Students Exposed to Trauma (SSET), are modifications of Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), an evidence-based intervention that was identified in the baseline scan. SSET, designed for middle schools, can be delivered by school staff (Support for Students Exposed to Trauma/ SSET). Both Bounce Back and SSET are designed specifically for schools. Another intervention designed specifically for schools is Safe Harbors Program: School-Based Victim Assistance and Violence Prevention Program. There are five interventions that can be implemented in a variety of settings, including schools: Child-Centered Play Therapy (CCPT), Cue-Centered Treatment (CCT), Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/ NST), Integrative Treatment of Complex Trauma for Adolescents (ITCT-A), and Trauma and Grief Component Therapy for Adolescents (TGCT-A). Safe Harbors works with children from 6 to 21 years old. CCPT, a play-based mental health intervention, works with children from 3 to 10 years old. STAIR/NST and ITCT-A focus on multi-traumatized adolescents while CCT works with youth from 8 to 18 years old who have experienced chronic exposure to violence/ trauma. TGCT-A, another intervention for adolescents that can be implemented in schools, has a component that addresses the interplay between trauma and grief.

Another adolescent-focused intervention is Streetwork Project which works with homeless and street-involved youth. This intervention addresses a wide range of types of trauma including gang violence, community violence, terrorism, bias crimes, teen relationship violence, and exposure to domestic violence. See Table 2 for a complete listing of the additional interventions identified during the update scan of evidence-based practice registries.

Table 2. Interventions Identified by Update Scan of EB-Practice Registries

Attachment and Biobehavioral Catch-Up (ABC)
Bounce Back: Elementary School for Childhood Trauma
Celebrating Families (CF!)
Child-Centered Play Therapy (CCPT)
Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)
Early Pathways (EP)
Group Treatment for Children Affected by Domestic Violence (DV)
Homebuilders
Honoring Children, Making Relatives (HC-MR)
Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)
Parenting with Love and Limits (PLL)
Real Life Heroes: Trauma & Resiliency-Focused Treatment of Children with Traumatic Stress (RLH)
Safe Harbors Program
Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST)
Streetwork Project
Support for Students Exposed to Trauma: School Support for Childhood Trauma (SSET)
Trauma and Grief Component Therapy for Adolescents (TGCT-A)

Descriptions of the six interventions identified by the baseline national scan of evidence-based practice registries and the 17 additional interventions identified during the update national scan are described below. Organized alphabetically, an asterisk (*) following the name of an intervention indicates that it was identified during the update of the national scan conducted in 2017.

Attachment and Biobehavioral Catch-Up (ABC)*, which is based on attachment theory and also stresses neurobiology, has three core interventions. The first intervention, recognizing that children experiencing early trauma often behave in ways that push caregivers away, helps caregivers to re-interpret these behavioral signs and learn how to respond with nurturing care. The second intervention helps caregivers to learn how to provide a responsive, predictable environment that builds children's behavioral and self-regulatory capacities. The third intervention focuses on caregivers to help them recognize and change their own behaviors that can be overwhelming, frightening or triggering to a young child.

Primary types of trauma addressed by ABC included neglect, abuse, and domestic violence. The intervention, delivered in ten one-hour weekly sessions at home or in shelter settings, is video-taped.

Parent coaches, who receive two to three days of training and one year of supervision, can deliver the intervention. ABC was developed primarily for families with a child from birth to twenty-four months old, from low-income African American, Hispanic and non-Hispanic White families and has been used in single parent and multigenerational families. ABC has been implemented in Spanish, Norwegian, German, and Russian; the ABC manual is only available in English and Spanish. In a randomized clinical trial with children at risk for neglect who were involved with Child Protective Services, children receiving the ABC intervention showed more typical cortisol production, with higher wake-up cortisol levels and a steeper diurnal slope (morning to evening) than children receiving usual care in the control group.⁴³ Children who received the ABC intervention had significantly lower rates of disorganized attachment (32%) and higher rates of attachment (52%) than children in the control group.⁴⁴ The effect size for sensitivity changes is as large in community settings as in laboratory trials.⁴⁵

Bounce Back: An Elementary School Intervention for Childhood Trauma* is an adaptation of the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) program. A cognitive-behavioral, skills-based group intervention, Bounce Back is designed for elementary school children exposed to traumatic events including exposure to community, family, and school violence. The intervention is delivered by a mental health clinician in weekly group sessions and two to three individual sessions over a ten week period. Available in Spanish, Bounce Back has been used in schools with children from a variety of ethnic and socioeconomic backgrounds. In group sessions, children learn and practice identifying feelings, relaxation techniques, problem-solving, and conflict resolution, while building social support. During individual sessions, children complete a trauma narrative they can share with a parent/caregiver. Bounce Back includes up to three parent education sessions during which parents learn the skills that their children are learning.

Bounce Back was evaluated in a randomized controlled trial with a culturally diverse group of first through fifth graders.⁴⁶ Compared to the delayed intervention group, children who received Bounce Back demonstrated significant improvements in parent- and child-reported posttraumatic stress and child-reported anxiety over the three month intervention. The first intervention group maintained or showed additional improvement at the three month follow-up after the intervention was completed. The delayed intervention group demonstrated significant improvements in parent- and child-reported posttraumatic stress, depression and anxiety after receiving the Bounce Back intervention.

Celebrating Families (CF!)* is a family-inclusive and trauma-informed skill-building program that applies a cognitive behavioral therapy (CBT) model with families recovering from substance abuse that are at high risk for domestic violence and/or child abuse. CF! provides sixteen weekly instructional sessions devoted to a particular theme, including communication, making

healthy choices, feelings and defenses, and anger management. Meetings start with a family meal. Parents and children then meet in separate group sessions. After group sessions, parents and children reunite for a 30-minute activity to practice what has been learned. Appropriate for children ages 0 to 17 years old, CF! can be delivered by paraprofessionals, with clinical supervision, in a wide range of settings, including community agencies, residential and outpatient treatment services, schools, faith-based organizations, and social services. A culturally adapted version of CF! in Spanish is called Celebrando Familias!

In a one-group pretest/posttest evaluation study, parents in early recovery from substance abuse were recruited from two community-based organizations and one residential treatment center to receive the CF! intervention.⁴⁷ After the sixteen week CF! intervention, parents reported more positive parenting, greater involvement with children, better parenting skills, more effective parenting, and increased supervision of their children. They also reported lower alcohol and drug use. Parents receiving CF! indicated that there was greater family cohesiveness, better communication, less family conflict, and more family strengths/resilience following the intervention. Parents in the CF! intervention also reported less depression for themselves and their children.

In another one-group pretest/posttest study using child welfare system data, families receiving CF! were compared with families receiving services from Family Treatment Drug Court (FTDC) or a traditional child welfare case plan.⁴⁸ Family reunification happened sooner for parents receiving CF! and FTDC. The CF! and FTDC intervention groups also had higher rates of reunification compared to families receiving the traditional child welfare case plan.⁴⁸

Sparks and colleagues (2013) compared the results of the two one-group pretest/posttest studies to determine if CF! was as effective with Hispanic as non-Hispanic families.⁴⁹ Hispanic families receiving CF! showed as much or more improvement for outcome measures as non-Hispanic families.

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. A [fact sheet on CARE](#) can be found at the National Child Traumatic Stress Network's website on empirically supported treatments and promising practices.⁵⁰

Child-Centered Play Therapy (CCPT)* is a developmentally responsive, play-based mental health intervention that utilizes play—the natural language of children — as well as therapeutic relationships to provide a safe, consistent and therapeutic environment in which a child can experience full acceptance, empathy and understanding from the counselor, and process inner feelings and experiences through play. Delivered by a CCPT-trained mental health provider, settings for CCPT included outpatient clinics, schools, community agencies and hospitals. CCPT was created to address a wide range of symptoms associated with traumatic experiences, including exposure to domestic violence. Appropriate for children ages 3 to 10 years old, CCPT is typically provided over 15-20 weeks in individual play sessions. An adaptation of CCPT for schools is provided twice weekly for 8 weeks. CCPT can be offered in small groups. CCPT resources have been translated into Chinese, Japanese, Korean, Mandarin and Russian.

Results from randomized controlled trials of CCPT include the following findings:

- Children receiving CCPT had lower anxiety scores compared to the control group at posttest⁵¹
- Children in the CCPT intervention had lower teacher-reported aggressive behaviors compared to the waitlist control group at posttest⁵²
- Children in the CCPT intervention group had higher composite academic achievement compared to the students in the waitlist control group at posttest⁵³

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.⁵⁴ 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.⁵⁵

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 demonstrated a 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 experienced 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.⁵⁶ 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.

Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): Empowering Families Who Are At Risk for Physical Abuse* is a strengths-based therapy program for caregivers and children in families where caregivers engage in a continuum of coercive parenting strategies including corporal punishment. Grounded in cognitive behavioral therapy, CPC-CBT utilizes many elements from CBT models used with families and also incorporates elements from motivational, family systems, and trauma and developmental theories. The four essential components of CPC-CBT are engagement and psychoeducation, effective coping and skill building, family safety, and abuse clarification. Delivered by mental health professionals in individual or group family sessions over a period of sixteen to twenty weeks, CPC-CBT is appropriate for families with children ages 3 to 17 years old. Settings for CPC-CBT include in the birth family home, community agencies, and outpatient clinics. This intervention has been implemented with families that speak only Spanish. CPC-CBT resources are available in English, Spanish, and Swedish.

In a randomized controlled trial, parents and children who received CPC-CBT were compared to parents who received cognitive behavior therapy while their children participated in other activities such as games or art.⁵⁷ Parents were referred from local child protective service agencies, prosecutors' offices, and health fairs. At posttest, children in the CPC-CBT intervention group had lower posttraumatic stress disorder (PTSD) symptoms, while their parents had higher scores for positive parenting compared to the comparison group.

A clinical trial comparing CPC-CBT to treatment-as-usual is nearing completion in Sweden.

Early Pathways Program (EPP)* is a home-based, parent-child therapy program designed to treat and prevent disruptive behaviors in young children (ages 1 to 5 years old) experiencing trauma, including child abuse and neglect, and exposure to domestic violence. EPP is usually delivered by human services professionals with a master's degree over a period of eight to sixteen weeks. The five key program components of EPP are:

1. Strengthening the parent-child relationship through child-led play
2. Maintaining developmentally appropriate expectations of children, and using cognitive methods for calmly and thoughtfully responding to disruptive behaviors
3. Using positive reinforcement to strengthen prosocial behavior, improve home routines and strengthen parent supervision to provide a more predictable and safer home for young children

4. Using time-limited strategies (time-out, redirection, ignoring) for reducing disruptive behaviors

5. Using trauma-informed strategies for children exposed to trauma

Early sessions focus on parent-child relationships and later sessions focus on discipline strategies. Trauma-informed strategies have been infused throughout the program. The primary focus of this program is serving children from diverse families living in poverty. EPP can be delivered in the adoptive home, the birth family home, foster/kinship care settings, and community agencies. Caregiver handouts are written at a 3rd to 4th grade reading level to accommodate academic skills of caregivers, and EPP is available in English and Spanish. EPP provides free training online.

Several evaluations have been conducted including randomized controlled trials that demonstrated the following outcomes:

- Parents who received the EPP intervention reported significantly fewer concerns with their child's challenging behavior compared with parents in the wait-list control group at posttest^{58, 59,60,61}
- At posttest, children in the intervention group had fewer trauma symptoms⁶¹
- Parents who received the EPP intervention reported less frequent use of verbal and corporal punishment and more frequent use of positive, nurturing activities compared with parents in the wait-list control group at posttest^{58,59,60}
- At posttest, children in the intervention group had significant improvement in overall psychological, social, and occupational/school functioning compared with those in the wait-list control group⁵⁸

Group Treatment for Children Affected by Domestic Violence is a therapist-delivered, group intervention for children and parents who do not use violence. Consisting of topic-driven modules that are delivered in 44 weekly sessions, this group treatment addresses a wide range of topics, including coping, communication, thoughts, feelings and behaviors, and blame/responsibility. Mindfulness exercises, movement therapy, music, and art are integrated into this trauma-focused treatment. Group sessions address implications of domestic violence in gay and lesbian families, and spiritual and religious issues related to domestic violence and recovery from trauma. Children and parents attend weekly parallel group sessions with similar content. This intervention is designed for multiservice agencies that offer a wide range of services to clients.

Homebuilders is designed for families with one or more children who are at imminent risk of out-of-home placement or have been placed outside the home and need intensive services to reunify with the family. These families are usually experiencing problems such as child abuse and neglect, family violence, juvenile delinquency, mental illness, and/or substance abuse. Within 24 hours of referral to Homebuilders, participating families receive services in the home from therapists. Services include cognitive behavioral treatment, motivational interviewing, social skills, parent training, social support services (examples include assistance with transportation, budgeting, household maintenance, and repair), extensive interagency treatment planning, and family advocacy. The program engages families by delivering services in their natural environment at times when they are most receptive to learning and enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require activities related to reintegrating the child into the home and the community such as enrolling a child in school or helping a child connect with clubs, sports, and other community groups.

Homebuilders' services are appropriate for children from birth to 18 years old. The intervention is delivered by master's level therapists in three to five 2-hour sessions weekly for 4 to 6 weeks with two aftercare booster sessions in the six months following referral. The goals of Homebuilders is to reduce child maltreatment, family conflict and child problem behaviors, while teaching families the skills they need to prevent out-of-home placement, or to successfully reunify caregivers with their children. Homebuilders is available in multiple languages based on the needs of the population at a program site.

Results from three evaluation studies are reported here. In a randomized controlled study, families were selected from foster care caseloads to receive Homebuilders type intensive services or routine reunification services as part of an overall out-of-home care plan.⁶² In families receiving Homebuilders, 96.5% of the children returned home by the 12-month follow-up assessment compared with 52.9% of the children in the control group.

In another randomized trial by Evans and colleagues, families presenting at emergency rooms were randomized to three different interventions: Homebuilders model, an enhanced version of Homebuilders (called Enhanced Home-Based Crisis Intervention) or Crisis Case Management (a less intensive model that did not include clinical treatment services at home).⁶³ Children in the intervention groups receiving more intensive services (Homebuilders and Enhanced Home-Based Crisis Intervention) showed statistically significant gains in family cohesiveness.

In a study by Kirk and Griffith, children who received intensive family preservation services (Homebuilders model) in 51 of 100 counties in North Carolina were compared with similar

children in the same counties who did not receive intensive services. The families in the comparison group received typical agency services.⁶⁴ Children in the intervention group receiving intensive family preservation services (Homebuilders model) were 21% less likely to experience a placement within 12 months compared to the comparison group of families receiving typical agency services.

Honoring Children, Making Relatives (HC-MR)* embeds the practices of Parent-Child Intervention Therapy (PCIT) into a framework that supports American Indian and Alaska Native traditional beliefs and parenting practices that regard children as being the center of the Circle. Live skill coaching is a core strategy used in PCIT. Online video consultation is used in remote, real-time coaching sessions with families to overcome issues of distance, isolation, and time constraints.

To integrate an Indigenous worldview and Indigenous practices, a translation, transformation, and enhancement of PCIT was conducted. Core values that were incorporated include that a child was received by all relatives and affected by all interactions around them, that a caregiver's responsibility was to cultivate the positive nature of the child with honor and respect, that discipline was teaching self-control and the rules of life versus punishment, and also avoiding and adapting jargon and technical aspects of PCIT that may be overwhelming or offensive to American Indian and Alaska Native caregivers.⁶⁵ Tribal language can be used to describe components of this modified version of PCIT.

HC-MR addresses issues of implementation with limited license professionals/ reservation-based therapist trainees in rural and isolated communities in its curriculum to facilitate delivery on rural reservations and tribal settings. The types of trauma addressed by HC-MR include physical abuse, domestic violence, and limited parenting skills due to boarding school experience. Appropriate for children ages 3 to 7 years old, the length of the intervention is 12 to 16 weeks.

HC-MR is part of the Indian Country Child Trauma Center's work to transform evidence-based treatment models, called the Honoring Children series, in conjunction with the National Child Traumatic Stress Network. HC-MR has been implemented with multinational Latinos, multigenerational African Americans and Cambodians, in addition to American Indian and Alaska Native children.

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)* is an assessment-driven, multi-component, flexible treatment for multi-traumatized adolescents based on individualized, periodic assessment of the client's needs and stressors. ITCT-A is based on developmentally appropriate, culturally adapted approaches that can be applied in multiple

settings including outpatient clinics, schools, inpatient and residential care, and the juvenile justice system. Treatment modalities include relational/attachment-oriented, cognitive therapy, exposure therapy, mindfulness skills development, affect regulation training, trigger management, social advocacy, identity development, and psychoeducation. ITCT-A can be delivered in individual or group therapy with collateral and family therapy approaches integrated into treatment.

A key feature of ITCT-A is continuous monitoring of treatment effects over time, using the Assessment-Treatment Flowchart (ATF-A). In addition to evaluating adolescent's symptomology, the ATF-A assesses socioeconomic status, culture, ongoing level of support systems and coping skills, family and caretaker relationships, attachment issues, and functional self-capacities. A client's social and physical environments are considered as well as the presence of new stressors, changes in family financial and housing status, and the potential danger from revictimization through exposure to community violence.

ITCT-A is delivered by therapists in 16 to 36 sessions. In addition to complex trauma, ITCT-A is used to treat youth between the ages of 12 and 21 years old who have experienced physical abuse, sexual abuse, emotional abuse and neglect, community violence, domestic violence, medical trauma, traumatic loss, or parental substance abuse. Developed to be responsive and sensitive to cultural differences as well as the effects of poverty and social marginalization, ITCT-A is used by programs serving diverse clientele from different socioeconomic and ethnic backgrounds. This treatment has been tailored for homeless youth, unaccompanied immigrant minors, LBGT youth, and youth exploited by the sex industry. Adapted ITCT-A tools are also available in Spanish.

In a one-group, pretest/posttest study, children and youth living in an economically deprived environment received ITCT-A over a period of 3 to 8 months.⁶⁶ At the end of the intervention, compared to pretest scores, there were significant reductions in anxiety, depression, posttraumatic stress, anger, dissociation and sexual concerns as a function of time in treatment.

Parenting with Love and Limits (PLL)* combines group therapy, family therapy and family trauma treatment within one continuum of care. The PLL model teaches families, with children from 10 to 18 years old, to restore the parental hierarchy, reestablish healthy communication patterns, and restore family attachments. PLL is designed to move families progressively through the stages of readiness to change while keeping youth from penetrating deeper into systems outside of the home. It can be used as an alternative to residential placement for youth as well as with youth returning home from placement outside of the home. PLL can be implemented by a

service provider with a master's level counseling degree in a wide range of settings, including an adoptive home, a birth family home, community agencies, foster/kinship care, outpatient clinics, and residential care facilities. A combination of multifamily and individual family therapy sessions are provided over a period of 3 to 6 months. PLL is intended for hard-to-reach parents, caregivers with youth who are at risk for out-of-home placement, and families with youth returning from an out-of-home placement. The types of problems addressed with children and adolescents include severe emotional and behavioral problems, domestic violence, substance abuse, depression and suicide ideation. PLL resources are available in English, Spanish, and Dutch.

PLL was evaluated with a quasi-experimental design: youth receiving PLL were compared to youth receiving treatment-as-usual in a mental health care system.⁶⁷ Youth in the PLL intervention group returned at lower rates to outpatient treatment, crisis services and inpatient hospitalization compared to youth in the treatment-as-usual group. In another quasi-experimental design evaluation, youth transitioning from residential placement to the community were compared to youth who received standard probation aftercare services after 18 months of the implementation of PLL.⁶⁸ Youth in the PLL intervention group had lower rates of rearrest recommitment, felony adjudications, and felony arrests compared to control youths. In a quasi-experimental design evaluation by Karam and colleagues, moderate- to high-risk youth who received the PLL intervention had significantly fewer police contacts, and improved parent-reported behavior compared to the treatment-as-usual control group.⁶⁹

Real Life Heroes: Resiliency-Focused Treatment for Children with Traumatic Stress

(RLH)* provides practitioners with easy-to use tools including a life storybook, multi-sensory creative arts, mindfulness, yoga, and “improv” activities to engage children and caregivers in trauma treatment. RHL helps practitioners to reframe referrals based on pathologies and blame into a shared ‘journey,’ and ‘pathway’ to recovery that focuses on restoring (or building) emotionally supportive and enduring relationships and promoting development of self-regulation skills for children and caregivers. The life storybook, built around the metaphor of heroes, provides a structured, phase-based approach to engage children and caregivers to rebuild safety, hope, attachments, skills, and resources to help children with traumatic stress, complex PTSD and trauma recovery. Creative arts activities are utilized to develop affect recognition and regulation skills, concentration, mindfulness and to replace shaming and dysfunctional beliefs with confidence and constructive beliefs. The RLH format includes an activity-based workbook and session rituals which provide an easy-to-learn and transferable structure that allows children and caregivers to continue trauma treatment if they move between programs or practitioners, and includes primary roles for residential counselors, parents, resource parents, mentors, and other caring adults.

Core components of RHL include: psychoeducation on traumatic stress for children, caregivers and other service providers; activities to foster attunement and trust with caring adults; development of social support; development of skills for affect recognition and management; trauma processing; desensitization to triggers; and sharing an organized life story that includes a past, present and future. RLH is provided in weekly sessions for six to eighteen months by a psychologist or social worker. While it was developed to address many different types of trauma, including exposure to domestic violence, there is a particular emphasis on complex Posttraumatic Stress Disorder (PTSD). Appropriate for children (6-12 years old), as well as adolescents with delays in social, emotional and cognitive functioning, it can be implemented in a variety of settings, including the home, mental health clinics and residential care. RLH has been used in child welfare programs, and with children who have had multiple placements. RLH is available in English and Chinese.

In a one-group pretest/posttest study, children (ages 8 to 15 years old) received the RLH intervention.⁷⁰ The children were involved in child welfare and behavioral health programs and were primarily from low socioeconomic status, mixed urban-rural backgrounds and had severe trauma histories. From baseline to four months, children demonstrated significant reductions in child self-reports of trauma symptoms and reduced problem behaviors reported on caregiver checklists. At twelve month follow-ups, there was a significant reduction of child trauma symptoms reported by parents and increased security/attachment over time.

In another study, children with experiences of multiple traumas and significant levels of traumatic stress, recruited from seven child and family/child welfare and behavioral health programs, were compared to a group of children receiving trauma-informed treatment-as-usual.⁷¹ Children receiving RLH demonstrated statistically significant reductions in trauma symptoms and behavior problems compared to the treatment-as-usual comparison group.

Safe Harbor Program: School-Based Victim Assistance and Violence Prevention

Program* uses a multi-pronged approach to help students (ages 6 to 21 years old), parents, and schools cope with violence, victimization, and trauma. The intervention uses a combination of targeted and school-wide strategies to address violence at the individual, interpersonal and social context/environmental levels. A key component of the program is a ten-lesson trauma education/violence prevention curriculum called PEARLS (People Empowered About Real Life Situations). Safe Harbor was designed to address multiple forms of trauma including domestic violence, teen dating violence, community violence, gang violence, and child abuse. Traumatized students are offered individual counseling and individual follow-up. There is also individual follow-up with students receiving the curriculum. A “safe harbor” room is created

at schools to provide a low-stigma, easy access point for students who need support. Group activities help to reinforce the curriculum and core messages on leadership, empowerment and developing social-emotional skills, and alternatives to violence. The program provides staff training and encourages parental involvement. A school-wide antiviolence campaign along with the curriculum helps to reach all students and change beliefs, attitudes, and values to promote violence prevention.

There are three resources that have been created to support the program: the PEARLS curriculum, an implementation manual, and the “Facilitator’s Guide to the PEARLS curriculum.” Training, which can range from six hours to three days, is available. Two evaluations are qualitatively described in the National Child Traumatic Stress Network’s review of the Safe Harbor Program. A pilot study in schools in two different states indicated increases in students’ self-confidence, improved ability to control anger, and resolve conflicts non-violently, and better problem-solving.⁷² Other outcomes included decreases in students’ fighting and bullying. A three-year evaluation with schools in New York State indicated improvements in conflict resolution skills. Students also demonstrated better social control and more opposition to gang violence.⁷²

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.⁷³ 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 traumas, 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 received only 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.

Skills Training in Affective and Interpersonal Regulation for Adolescents (STAIR-A & STAIR/NST)* is a skills-based cognitive behavioral therapy (CBT) intervention designed to improve emotional regulation and interpersonal and social problems among adolescents exposed to multiple traumas. STAIR-A and STAIR/NST are implemented by therapists. STAIR-A and STAIR/NST were designed to promote resilience and reduce symptoms among adolescents who have experienced multiple traumas, including physical and sexual abuse, community violence, domestic violence, and sexual assault. It is appropriate for youth ages 12 to 21 years old.

The STAIR component targets social and emotional competency building. Key interventions include emotional regulation skills, social skills development, positive self-definition exercises, and goal setting and achievement. There are three versions of STAIR-A: Inpatient (three session version serves as support and bridge for other services upon discharge), Individual (eight to ten sessions in outpatient settings), and Group (ten to twelve sessions for school-based settings). STAIR/NST is a two-module treatment that includes STAIR as described above plus a second phase of six individual sessions that focus on the emotional processing of trauma in detail within the context of developing a positive life narrative and future plan.

STAIR-A was evaluated in a pilot study utilizing a matched assessment-only comparison group designed with racial/ethnic minority adolescent girls.⁷⁴ STAIR-A was delivered in a 16-week school-based group format. At posttest, compared to girls in the comparison group, girls who received the STAIR-A intervention reported:

- Less severe levels of depression
- Fewer feelings of nervousness, worry and fear, as well as a reduced tendency to be overwhelmed by problems
- Less stress and tension in personal relationships, fewer feelings of being excluded socially, and better perceptions of social relationships and friendships with peers
- Higher levels of internal locus of control

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 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 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

The Streetwork Project*, based in New York City, uses a harm reduction philosophy that focuses on building trust and self-esteem to empower youth to change their high-risk behaviors. The program provides counseling, stabilization, and case management with an emphasis on enhancing individuality for homeless, street-involved youth. Types of trauma addressed include community violence, gang violence, domestic violence, teen relationship abuse, homicide, child abuse, bias crimes, and terrorism. The Streetwork Project has been implemented in drop-in centers and treatment settings and is appropriate for youth from thirteen to twenty-three years of age.

All clients are assigned a primary counselor who assists them in accessing services and obtaining referrals as needed. Clients received two counseling days weekly. Free services include legal, medical, and psychiatric care, long-term counseling, individual and group therapy, advocacy, case management, help in obtaining identification, emergency and transitional housing, GED preparation and support, help in obtaining Medicaid and other benefits, hot meals/bag lunches, showers, clothing, wellness activities (including acupuncture, yoga, and nutritional counseling), HIV prevention counseling, parenting groups, drop-in groups and the opportunity to socialize in a safe, non-judgmental setting.

No evaluation data was available at the time of this review. A fact sheet about the Streetwise Project can be found at the National Child Traumatic Stress Network's website for empirically supported treatments and promising practices.⁷⁵

Support for Students Exposed to Trauma (SSET)* is a nonclinical adaptation of the Cognitive Behavioral Intervention for Trauma (CBITS) program for high schools. SSET is a school-based intervention for middle-school students (ages 10-16) who are experiencing posttraumatic stress disorder (PTSD) symptoms. The goals of SSET are to reduce PTSD symptoms and improve functioning by providing a variety of skill-building techniques to reduce problems with anxiety/nervousness, withdrawal or isolation, depressed mood, acting out in school and impulsive or risky behavior. The types of traumatic events addressed by SSET including witnessing or being a victim of family, school or community violence, being in a natural or man-made disaster, being in an accident or fire, and experiencing moderate to severe PTSD symptoms. SSET was developed and tested in middle schools serving diverse, multicultural, and multilingual students.

SSET is delivered by school teachers and counselors in a ten lesson-plan format with a small group of students (usually 6-10 students), using the same core cognitive-behavioral elements that are used in CBITS. The group leader acts as a “coach” to help students acquire and practice new skills effectively. Group leaders are required to work with a clinician who can provide consultation as needed. Key components covered in the lesson plan are learning about common reactions to trauma (psychoeducation), practicing relaxation skills, identifying maladaptive thinking and learning ways to challenge those thoughts (cognitive coping), learning problem solving skills, building social support, and processing the traumatic event.

SSET was evaluated in a pilot study using a randomized controlled trial design.⁷⁶ Middle school students (predominantly Hispanic 6th & 7th graders) who participated in SSET immediately (between baseline and 3-month follow-up assessment) were compared to students who participated in SSET on a delayed schedule (between the 3-month and 6-month follow-up assessment). To be eligible for the study, students had to have experience with severe violence in the past year and current symptoms of PTSD of moderate severity. Preliminary results from this pilot study indicated that compared to the wait-list control group, students in the SSET intervention group at the three-month follow-up had:

- Significant reductions in depressive symptoms
- Significantly fewer behavior problems compared to students
- Reduced posttraumatic stress symptoms, but the difference was not statistically significant

Trauma and Grief Component Therapy for Adolescents (TGCT-A)* is a modularized, assessment-driven, flexibly tailored treatment program for trauma-exposed and traumatically bereaved older children that can be delivered in individual or group sessions. Designed to meet the complex needs of youth in order to deal with the interplay between trauma and grief, TGCT-A is organized into four modules. Treatment modules and sessions within modules are selected according to a client's needs, strengths, circumstances, and informed wishes. The four modules are:

- Module I includes psychoeducation on traumatic stress and grief reactions, core skills for emotion regulation, dealing with trauma and loss reminders, social support
- Module II provides guidelines for facilitating narrative construction and sharing of trauma/loss experiences
- Module III provides a customized approach to grief based on assessment of a youth's multidimensional grief profile; skill training and therapy are provided depending on the mix of separation distress, existential/identity distress or circumstance-related distress
- Module IV promotes developmental progression, planning for upcoming stressors, and consolidates treatment progress

TGCT-A is delivered by a master's level mental health professional in a range of settings, including community agencies, hospitals, outpatient clinics, residential care facilities, schools, and juvenile justice facilities. Weekly sessions are provided over a period of 12 to 26 weeks. The types of trauma addressed include community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events. TGCT-A is appropriate for youth from 12 to 20 years old. It has been implemented in settings that serve diverse populations of youth in low income urban and suburban communities and with incarcerated youth. TGCT-A is available in English and Bosnian; there are plans to translate TGCT-A into Spanish.

TGCT-A was evaluated in a randomized controlled trial with war-exposed and predominantly ethnic Muslim secondary students in Bosnia who reported severe symptoms of posttraumatic stress disorder (PTSD), depression or maladaptive grief and significant impairment in school or relationships.⁷⁷ The group intervention was conducted in a school setting. Students in the intervention group received TGCT-A and a classroom-based psychoeducation and skills

intervention while the comparison group received only the classroom-based psychoeducation and skills intervention. Only the treatment group (TGCT-A) experienced significant reductions in maladaptive grief reactions at the end of the intervention.

Semistructured focus groups were conducted to evaluate the effectiveness of TGCT-A with war-exposed youth in Bosnia and Herzegovina.⁷⁸ Students' overall perceptions of TGCT-A were positive. Perceived outcomes by students and group leaders included acquisition of coping skills and attitudes, willingness to advocate for peers and improved interpersonal relationships.

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 specialists 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, who were 10-18 years old, indicated reductions in PTSD avoidance/numbing symptoms, posttraumatic thoughts, and negative coping. Youth also reported increased hope and self-efficacy skills.

iii. Direct Inquiry

Ten interventions were identified through direct inquiry during the baseline national scan. 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.

One intervention (Trauma Smart) was identified through direct inquiry during the follow-up national scan in 2017. This intervention, identified with an asterisk (*), was categorized as an innovative and emerging practice for families experiencing domestic violence.

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 were identified in the baseline scan and one research-informed intervention was identified during the update scan in 2017 (identified by an asterisk). The four interventions identified through direct inquiry are described below.

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 the mental health clinician can do a strengths-based family assessment when needed. 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 Mom's 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 who have been exposed 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, such as 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.

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 (as well as 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. Parent survivors 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.⁷⁹ 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.⁸⁰

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, the 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 is offered to children 3-12 years old. Parent survivors 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 posttest 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.

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 pretest/posttest comparison study of the Community Group Program for Children and Mothers' Exposed to Woman Abuse was conducted with 17 mothers and 14 children.⁸¹ 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.⁸² 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 being

less frustrated. 92% 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*.⁸³ 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 understand why their children should be part of the children's group, that victims—like 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 pretest-posttest comparison study of Northnode was conducted with children receiving clinical services from nine different social service agencies who completed the 12-week intervention.⁸⁴ 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. 56% of the caregivers reported they had enough information about the children's group while 46% felt they did not have as much information as they would have liked.

Innovative and Emerging Practices with Families Experiencing Domestic Violence

The first three of the four interventions described below, identified during the baseline scan for this review, are innovative and emerging practices to work with parents on issues related to domestic violence. Caring Dads works directly with fathers who have exposed their children to domestic violence and other forms of abuse. Christians as Family Advocates-CAFA Parenting Program offers separate parenting classes for parents who use violence and parent survivors affected by domestic violence. Connections integrates intervention for domestic violence, substance abuse, and parenting. Trauma Smart, a trauma-informed model for working with children that started in early education settings, was identified in the update of the national scan.

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 mistreating 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 and non-violent co-parenting with children's mothers, recognize the impact of their abusive behaviors, and to connect men with other service providers to help their children be safe and recover from trauma. To ensure safety and freedom from coercion for the domestic violence victims and their 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, 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 posttest scores for 23 fathers.⁸⁵ At the end of the intervention, fathers' levels of hostility, denigration, rejection of their children, and anger arousal to child and family situations had decreased significantly compared to before the intervention. A larger pre- and posttest comparison study was conducted with 98 fathers.⁸⁶ 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 used 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.⁸⁷ 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.

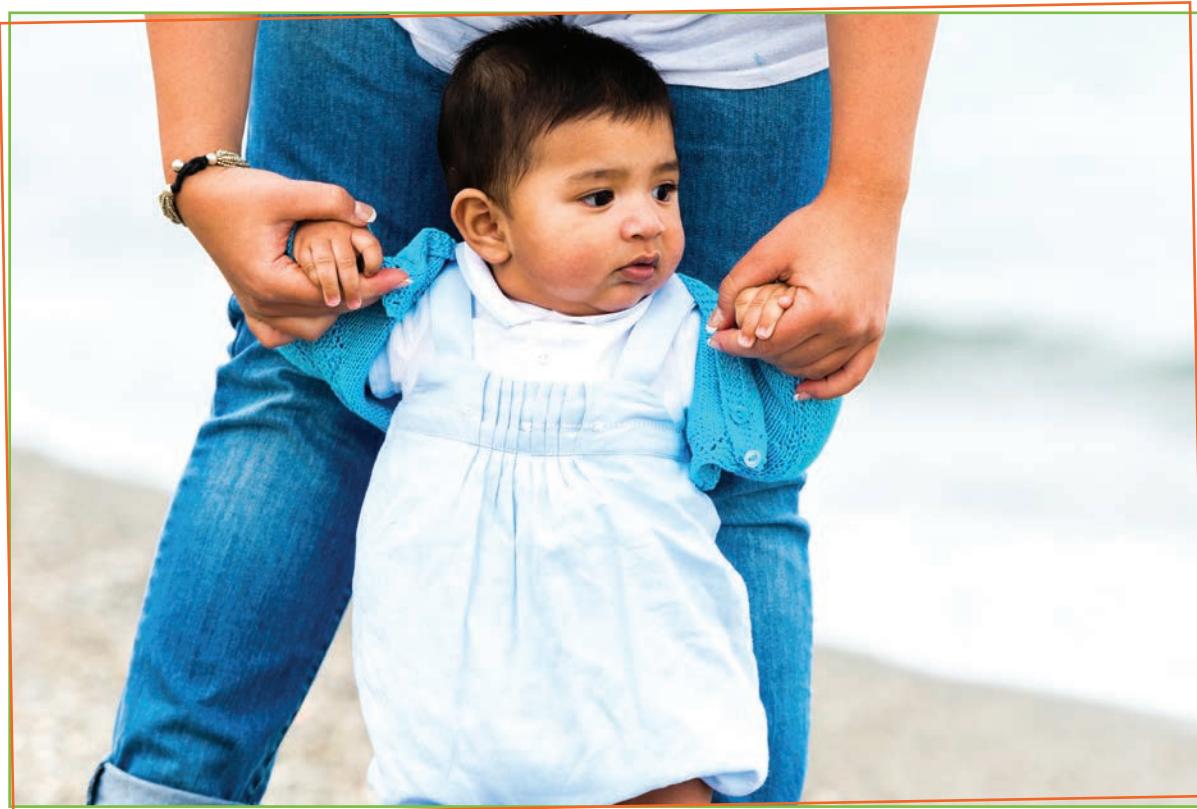
Connections is offered in six sessions and is delivered concurrently to mothers with other interventions, including substance abuse treatment, mental health counseling, child care, parenting services, domestic violence advocacy. Goals of the intervention include increasing maternal knowledge about the 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 the following in mothers: increased ability to resist substance use relapse, decreased symptoms of depression and anxiety, increased empathy and appropriate expectations for children, and decreases in levels of parenting distress (Margaret Leslie, written communication, Nov 6, 2010).

Trauma Smart* is a model that is being implemented primarily in early learning settings to build the internal capacity of organizations to support children impacted by trauma. Started in Head Start programs in Missouri, the model has expanded to early education, child care settings, and some primary schools in other states. Trauma Smart integrates education, mental health, and overall child well-being into one model using a trauma-informed approach that is based

on four pillars: staff resilience and skill building, mastery of classroom strategies, parenting engagement, and skill building and response for children with high needs. The model is grounded on the principles of Attachment, Regulation, and Competency (ARC). Core elements include extensive training, classroom level coaching and consultation for teachers, parent engagement and skill building to implement Trauma Smart practices at home, and trauma informed practices and therapeutic intervention (ARC) as needed with children.

Evaluation of Trauma Smart is underway in several locations. Findings from a pretest/posttest one-group evaluation of children receiving Trauma Smart in a Head Start program demonstrated significant improvements in children's:⁸⁸

- Teacher-reported ability to pay attention
- Teacher-reported externalizing behaviors and oppositional defiance
- Parent-reported children's externalizing behaviors, internalizing behaviors and attention/hyperactivity



V. DISCUSSION

Literature Review

The literature review for the baseline scan identified five interventions designed or modified for CEDV. Four of these CEDV-specific interventions were evaluated with randomized controlled trials and were featured in two or more registries for evidence-based practices. All five of these interventions work concurrently with parent survivors and their children. Only one intervention works with children beyond 12 years old or the 8th grade. Improving parenting skills and children's social and emotional skills are common characteristics of interventions that specifically address CEDV.

Two of the four interventions identified during the follow-up national scan of the literature review were designed or modified for CEDV. One publication identified in the follow-up describes a randomized trial comparing two different community-based group interventions for women and children exposed to domestic violence. The other intervention, which uses play therapeutically, has been modified for women and children exposed to domestic violence, and evaluated in two qualitative studies. Whereas most of the CEDV-specific interventions identified by the national scans work with young children, the play-based intervention works with children up to 18 years old. Both of the CEDV-specific interventions address parenting skills and children's social and emotional development, as was noted for the CEDV-specific interventions identified in the baseline scan literature review.

The length of CEDV-specific interventions identified in the baseline and update scans of the literature review varied from five weeks to one year of treatment. It is encouraging that there are several relatively brief interventions for CEDV that have been shown to be effective. These interventions are diverse in their applications ranging from a home visitation program to a trauma-focused cognitive behavioral intervention adapted for domestic violence shelters. The addition of a play-based therapeutic intervention adds a new dimension to promising practices for CEDV.

Of the four interventions for children exposed to violence/trauma (including, but not limited to, CEDV), one is school-based, one is an extensively evaluated behavioral family interaction intervention that uses live parent coaching, one is designed to work with youth experiencing chronic exposure to violence/trauma, and one is a two-step approach to a cognitive behavioral health intervention adapted for domestic violence shelters that is focused on treating symptoms of posttraumatic stress. It is noteworthy that the two-step approach was developed to reduce cost and improve access and efficiency. All of these interventions have been or are in the

process of being evaluated with at least one randomized controlled trial, are delivered by mental health professionals, and are relatively brief.

Evidence-based Practice Registries

The baseline scan of evidence-based practice registries identified six interventions, three of which are targeted to traumatized adolescents. The number of registries/publications on evidence-based practices that included a given intervention ranged from one to three, demonstrating the variability that occurs between registries in reviewing and evaluating 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 can be implemented in community-based, nonclinical settings such as domestic violence shelters, homes, schools, and residential treatment facilities.

The 17 interventions identified in the update scan of evidence-based practice registries reflects some interesting trends since the baseline scan was conducted. First and foremost is the expansion of the number of interventions for traumatized children. Many interventions cover a very broad range of types of trauma including community violence, gang violence, sex trafficking, and homelessness. Domestic violence is frequently included in these broader descriptions of the types of trauma addressed. Chronic exposure to violence/trauma, experiencing multiple forms of trauma and complex trauma are noted in several of the descriptions of these interventions. Additionally, as was the case with the baseline scan, the follow-up scan identified a number of interventions that work with adolescents. One of these interventions focuses on the intersection of exposure to domestic violence and homeless youth, which is an extremely marginalized population.

As was observed with the CEDV-specific interventions identified in the initial literature review, most of the interventions identified in the update scan of evidence-based practice registries work with parents/caregivers and children. Improving parenting skills, understanding the effects of trauma, and strengthening parent-child relationships were consistent themes for interventions working with younger children, and some of the youth-focused interventions.

Several interventions discussed the importance of self-regulation and developing coping skills. Mindfulness, relaxation techniques, yoga, creative arts activities, and other skills for emotional regulation are key strategies noted in several interventions. One program has developed a life storybook for children and youth that uses the metaphor of heroes. This interactive resource

is designed so that it can be used with multiple agencies, service providers, and caregivers to enhance continuity of care.

While most of the newly identified interventions are delivered by mental health professionals, there are two interventions that can be implemented by paraprofessionals. The range of settings was even broader than what had been observed in the baseline scan. An impressive number of interventions were designed for or had been modified for implementation in schools. The importance of school-based settings to reach more children experiencing trauma has gained considerable visibility in the past several years. More than half of the interventions identified in the update scan could be delivered in the client's home. Other settings included residential care, in-patient settings, drop-in centers, and community-based mental agencies. Several of the interventions targeted to adolescents can be implemented in juvenile justice facilities. There are also a number of interventions that extend their services past 18 years of age into early adulthood.

The 17 additional interventions are diverse in their approaches. In addition to the play-based intervention identified in the update scan of the literature review, another play-based therapeutic intervention was identified in the follow-up scan of evidence-based practice registries. Two interventions focus on family reunification: a sensitive and complex issue that was not addressed in interventions identified during the baseline scan. One of these interventions provides rapid access to intensive services including basic support services such as transportation and budgeting, while the other intervention works with families that are at risk for or have had a child placed outside of the home.

Several interventions are available in Spanish and some have been translated into multiple languages. Celebrating Families! (CF!) has a modified version for Spanish-speaking-only families. As part of a larger project to develop a series of American Indian and Alaska Native transformations of evidence-based treatment models, Parent-Child Interaction Therapy (PCIT) has been culturally adapted/translated into a framework that supports American Indian and Alaska Native traditional values, and parenting practices. Since these interventions were identified through evidence-based practice registries, nearly all are supported by evaluation data. Many have been evaluated with randomized controlled trials. The other most common evaluation design was a pretest/posttest design.

Direct Inquiry

The baseline direct inquiry with key informants identified an additional 10 interventions for children exposed to violence and their families. A number of these interventions can be delivered by nonclinical service providers or through 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; a third combines an evidence-based practice with emerging practices. All but one of the interventions has done some type of program evaluation, usually a pre and posttest comparison design with encouraging results. There are two interventions that focus entirely on working with parents: one with fathers who use violence and the other works separately with parents who use 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 was identified by direct inquiry during the follow-up scan. Implemented primarily in early learning programs, the intervention works with children that have experienced a wide range of different adversities and difficulties, including exposure to domestic violence.

Insights and Trends

Our findings indicate that a multi-pronged approach is essential to identify the increasingly diverse range of services for CEDV. Most interventions specifically designed or adapted for CEDV were identified by literature review in the baseline and follow-up national scans. Interventions for trauma that include CEDV as one of the types of trauma addressed have rapidly increased in number, as reflected in the follow-up scan. These interventions are usually identified through searches of online evidence-based practice registries.

A broad range of interventions for CEDV were identified by direct inquiry during the baseline scan, including CEDV-specific interventions, interventions addressing multiple types of trauma (including CEDV), and interventions for caregivers. A broader methodology for direct inquiry was used during the baseline scan. The modified methodology used for direct inquiry during the follow-up scan identified only one intervention, suggesting that the more extensive outreach that was conducted during the baseline scan may be preferable. With increased accessibility and availability of information online, it is important to consider how the search strategies used in the national scan should be expanded to identify resources such as apps and web-based interventions that are unlikely to be captured by the current three-pronged approach.

An important strength that emerged during the national scan is more rigorous evaluation of interventions for CEDV. There are CEDV interventions 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. The increase in the sharing of evaluation findings should encourage advocates and others to consider how they can communicate to external audiences their work. 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 design.

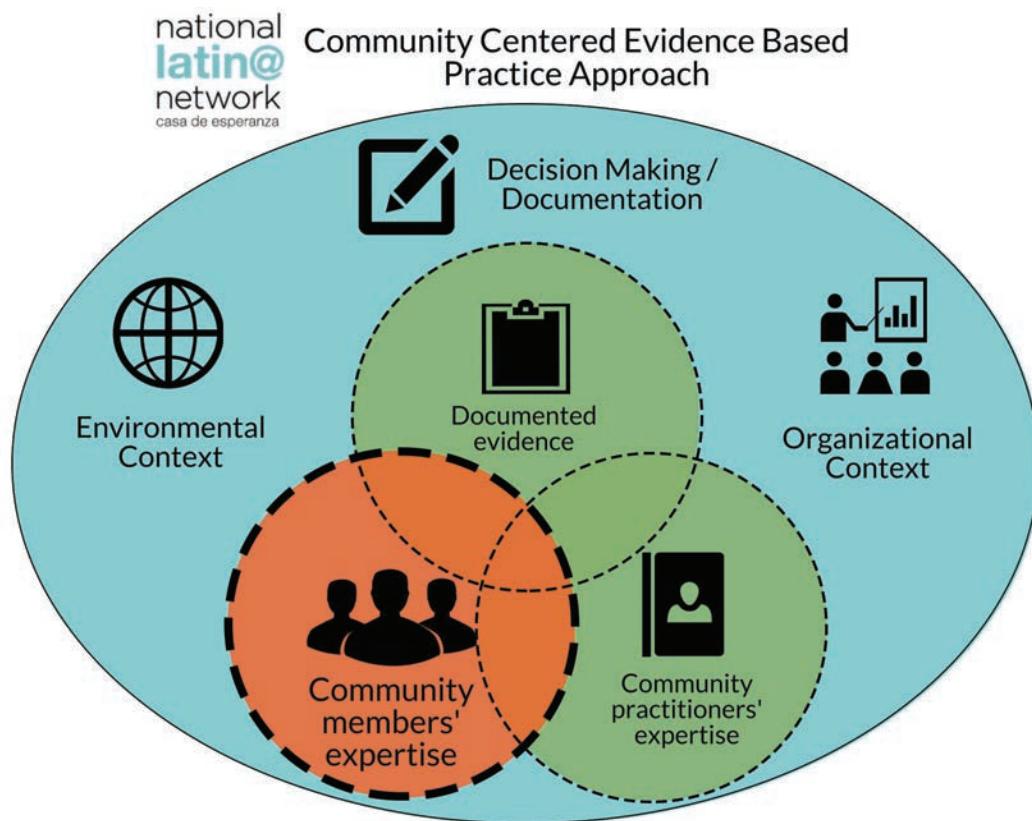
Funding for evaluation and particularly participatory evaluation should target practices that have not yet been documented and disseminated to the field broadly. Program developers and advocates may find opportunities to partner with other community agencies and universities in order to conduct evaluation of community-based services. There are several interventions in this review that have been evaluated with one randomized controlled trial. While these interventions have been replicated in other locations, evaluation has not been replicated. A persistent limitation in the evaluation of interventions for CEDV is that follow-up to assess whether outcomes were sustained after the intervention ended was usually limited to a few months. While long-term follow-up is often challenging and costly, funders should allocate funding for this purpose.

In order to fully meet the diverse needs of families, the field must expand and shift resources to culturally specific national, state and local organizations to develop and evaluate interventions tailored specifically for marginalized populations. A number of the interventions involve interagency collaboration, creative partnerships, and diverse settings to reach families and children. Examining interventions may provide additional ideas about innovative partnerships and funding opportunities that involve multiple systems to promote a trauma-informed, coordinated community response. Advocates should consider as potential partners entities that work with many of the same families that advocates also serve, even when they have not previously worked together. The proliferation of school-based programs is one example: many domestic violence shelters have connections with schools in their communities and may be able to collaborate on trauma-informed services, training, and funding opportunities. By educating other service providers about how domestic violence can affect service delivery, advocates may be able to find common ground to coordinate services, ensure that safety considerations are being incorporated into service delivery in other settings, and identify strategies for cost-sharing. Another example of 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.

While progress had been made to develop and evaluate interventions to meet the needs of families, many gaps remain. Programs should consider expanding the CDC model of evidence based decision making that was discussed previously to consider the Community-centered evidence-based practice, (CCEBP) approach developed by Casa de Esperanza⁸⁹. (see figure 2) This approach prioritizes culturally relevant evidence grounded in the voices of community

members. By expanding traditional approaches to evidence based practice to emphasize community expertise, the CCEBP offers a different understanding of what is considered evidence based practice in the domestic violence field. Incorporating this approach could greatly enhance programs efforts to collect cultural-specific information from their community; furthering their understanding of what programs or interventions would be most effective. There is considerable emphasis across interventions on working with families from different cultural backgrounds. Many of the interventions have manuals and resources that have been translated into one or more languages however knowledge is limited into how interventions are also being adapted for cultural congruency. Advocates who are working with families from different cultural backgrounds or who have special needs should 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 better understand the unmet and emerging needs in rural, marginalized, and culturally diverse communities. More rigorous evaluation of interventions targeted at diverse populations in community-based settings is needed. If programs and interventions are not culturally relevant to the individuals and families they work with, there may be negative implications that include increased drop out rates, the possibility of causing more harm than good, and misused resources due to the ineffective nature of the interventions. Similar to the importance of ensuring that programs and services for survivors of domestic violence are trauma-informed and based in the context of domestic violence, it is crucial that organizations partner with their different communities to adapt interventions to reflect their nuanced realities and meet their specific needs.⁸⁹ Additional funding should also be allocated for cultural translations of best practices, especially with marginalized populations including communities of color, immigrant, LGBTQ, tribal and rural populations. Funding should also be targeted to support the development and evaluation of models that are specifically designed by and for marginalized communities and not just the adaptation of mainstream models. Additionally, the CCEBP approach prioritizes participatory and mixed-method approaches as sources of evidence and can enhance the adoption of these methods in evaluation and research. Because the timeline to submit 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.

Figure 2, Community-Centered Evidence-Based Practice Approach (CCEBP)



(Serrata, J. V., Macias, R. L., Rosales, A., Hernandez-Martinez, M., Rodriguez, R., & Perilla, J. L., 2017)

Most of the interventions are provided by mental health clinicians or therapists. There is no way of knowing whether these service providers had previous training on trauma-informed care or training on domestic violence. There are several programs that can be delivered by nonclinical staff, including domestic violence advocates, parent coaches, and teachers. 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 control 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. Celebrating Families! is implemented by paraprofessional parent coaches. CARE, a modification of PCIT, can also be implemented by domestic violence advocates. Honoring Children-Making Relatives (HC-MR), an adaptation of PCIT for American Indian and Alaska Native children, includes content in its curriculum to address challenges faced by limited-license professionals and reservation-based therapist trainees in rural and isolated communities.

All of the interventions were specifically designed to address CEDV, and a majority of the other interventions serving children exposed to violence/trauma, work concurrently with children, and parents/caregivers. A guiding principle based on evidence-based practices for CEDV is the importance of dual advocacy for mothers and children exposed to domestic violence. Simultaneous treatment of mothers and their children appears to be an effective approach to service delivery that also provides opportunities to coordinate and enhance safety considerations. One of the interventions identified in the update of the national scan, *Celebrating Families!*, addresses the co-occurrence of domestic violence and substance abuse. A persistent gap in the field of trauma-informed services for families experiencing domestic violence is interventions that address co-occurring mental health issues.

There is an emerging trend in both CEDV-specific interventions and interventions for exposure to violence/trauma (including CEDV) to enhance parenting skills and provide psycho-education about the impact of exposure to violence and other adversities on children. Trauma-informed parenting interventions have been developed for parents who use violence and coercion with an intimate partner, parents who are victims of domestic violence, and victimized parents with substance abuse problems. Learning more about these programs can help advocates promote trauma-informed parenting with their clients and enhance existing parenting programs that they may work with. As advocates work to meet the needs of their clients and communities, parenting programs may also provide opportunities for collaboration and partnership.

Many of the interventions use multi-modal approaches that combine more than one type of treatment or offer a range of treatment options based on an assessment of the client's current needs and circumstances. There is a strong emphasis on social-emotional learning, skill development, and mind-body techniques. Interventions are often provided as a combination of individual and group sessions for caregivers and children. Components of psychoeducation on trauma and empowerment training are frequently integrated with cognitive behavioral therapy.

VI. CONCLUSION

Using a three-pronged methodology, a total of 55 evidence-based and promising practices for CEDV were identified by the baseline and follow-up national scans. We know more than ever before about effective strategies to work with children exposed to domestic violence and other adversities. 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 informed decisions about the services they offer. The multi-pronged methodology used in the national scan has been essential to identify interventions for CEDV across the continuum of evidence. 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 and other forms of trauma.

While we intentionally developed an approach that would be more comprehensive and inclusive, a significant limitation to this national scan is that there are likely a number of community-based and emerging practices that have been missed. This is especially apparent in the update scan, which identified only one intervention by direct inquiry, even though direct inquiry identified several community-based and emerging practices during the baseline scan. The methodology for direct inquiry of the update scan was modified to request information from program developers and researchers associated with interventions identified during the baseline scan. Returning to a broader approach that includes outreach to CEDV subject matter experts and practitioners—the methodology used in the baseline scan—is recommended for future updates. In the future, it is recommend that organizations that serve culturally-specific and marginalized communities also help to capture programs that are currently “hidden” from mainstream research. Program developers and researchers who are associated with a specific intervention may not be familiar with new and emerging practices that are happening in community settings. As previously noted, it is also possible that ongoing pressures to focus on proven strategies and evidence-based practices has limited opportunities to develop, support, and evaluate community-based initiatives and emerging practices.

Given the number of new interventions identified during the update scan, particularly interventions that have been reviewed in evidence-based practice registries, periodic updates of the national scan are recommended. Conducting participatory research with culturally diverse communities, including listening sessions with community members as emphasized by the CCEBP approach, can increase the pool of programs considered evidence-based that

are culturally inclusive and have a robust understanding of the impacts of structural violence and sociopolitical contexts.⁹⁰ There should also be ongoing discussions with CEDV subject matter experts, practitioners, and community partners to brainstorm strategies to identify community-based and emerging practices in future updates of the national scan.

The results from the national scan has been compiled into the dynamic online resource, [Promising Futures, Best Practices for Serving Children, Youth and Parents Experiencing Domestic Violence](#). The website highlights the expanding database of models that aims to help advocates and other service providers identify interventions and strategies 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.

The growing emphasis on trauma-informed interventions that address multiple types of trauma is clearly supported in the findings from the update of the national scan. The majority of interventions identified in the update address many types of trauma, including CEDV. Some specifically address the effects of multiple types of co-occurring trauma, chronic exposure, and complex trauma. With growing awareness of how CEDV is strongly correlated with other adverse childhood experiences (ACEs), trauma-informed interventions that address multiple forms of trauma will help to meet the needs of children living with domestic violence and other adversities. As we learn more about the intersections between domestic violence and other childhood adversities, advocates, and other service providers should consider emerging opportunities to work collectively on grant applications, cross-training, and service delivery.



VII. REFERENCES

- ¹Turner HA, Finkelhor D, Ormrod R, Hamby SL. Infant Victimization in a Nationally Representative Sample. *Pediatrics*. 2010;126:44-52.
- ²McDonald R, Jouriles EN, Ramisetty-Mikkler S, Caetano R, Green CE. Estimating the Number of American Children Living in Partner-Violent Families. *Journal of Family Psychology*. 2006;20(1):137-142.
- ³Finkelhor D, Turner H, Shattuck A, Hamby SL. Prevalence of Childhood Exposure to Violence, Crime and Abuse. Results from the National Survey of Children's Exposure to Violence. *JAMA Pediatrics*. 2015;169(8):746-754.
- ⁴Bair-Merritt MH, Blackstone M, Feudtner C. Physical Health Outcomes of Childhood Exposure to Intimate Partner Violence: A Systematic Review. *Pediatrics*. 2006;117:e278-e290.
- ⁵Kitzmann KM, Gaylord NK, Holt AR, Kenny ED. Child Witnesses to Domestic Violence: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*. 2003;71(2):339-352.
- ⁶Choi J, Jeong B, Polcari A, Rohan ML, Teicher MH. Reduced fractional anisotropy in the visual limbic pathway of young adults witnessing domestic violence in childhood. *Neuroimage*. 2012;59(2):1071-9.
- ⁷Graham-Bermann SA, Seng J. Violence Exposure and Traumatic Stress Symptoms as Additional Predictors of Health Problems in High-risk Children. *Journal of Pediatrics*. 2005;146(3):349-354.
- ⁸Campbell JC, Lewandowski LA. Mental and Physical Health Effects of Intimate Partner Violence on Women and Children. *Psychiatric Clinics of North America*. 1997;20(2):353-374.
- ⁹Hurt H, Malmud E, Brodsky NL, Giannetta J. Exposure to Violence: Psychological and Academic Correlates in Child Witnesses. *Archives of Pediatric Adolescent Medicine*. 2001;155:1351-1356.
- ¹⁰U.S. Department of Justice and U.S. Department of Health and Human Services. 2011. *Evidence-Based Practices for Children Exposed to Violence: A Selection from Federal Databases*. Washington, DC.

¹¹National Child Traumatic Stress Network. 2010. *Domestic Violence and Children: Questions and Answers for Domestic Violence Project Advocates*. Los Angeles, CA and Durham, NC: National Center for Child Traumatic Stress.

¹²Edelson JL, in consultation with Nissley B. 2006. *Emerging Responses to Children Exposed to Domestic Violence*. Harrisburg, PA; VAWNet, of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Retrieved July 13, 2013, from: <http://vawnet.org>

¹³Puddy RW & Wilkins N. 2011. *Understanding Evidence Part 1: Best Available Research Evidence: A Guide to the Continuum of Evidence of Effectiveness*. Atlanta, GA: Centers for Disease Control and Prevention.

¹⁴De Arellano MA, Ko SJ, Danielson CK & Sprague CM. 2008. *Trauma-informed Interventions: Clinical and Research Evidence and Culture-specific Information Project*. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

¹⁵U.S. Department of Justice and U.S. Department of Health and Human Services. 2011. *Evidence-Based Practices for Children Exposed to Violence: A Selection from Federal Databases*. Washington, DC.

¹⁶Cicchetti D, Rogosch, FA, & Toth SL. Fostering secure attachment in infant maltreating families through preventive interventions. *Development and Psychopathology*. 2006;18:623-650.

¹⁷Cicchetti D, Toth SL, Rogosch FA. The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development*, 1999;1: 34-66.

¹⁸Toth SL, Maughan A, Manly JT, Spagnola M, Cicchetti D. The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Developmental Psychopathology*. 2002;14: 877-908.

¹⁹Lieberman AF, Van Horn PJ, & Ghosh Ippen C. Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2005;44(12):1241-1248.

²⁰Lieberman AF, Ghosh Ippen C, Van Horn PJ. Child-Parent Psychotherapy: Six month follow-

up of a randomized control trial. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2006; 45(8):913-918.

²¹McWhirter PT. 2011. Differential Therapeutic Outcomes of Community-Based Group Interventions for Women and Children Exposed to Intimate Partner Violence. *Journal of Interpersonal Violence*. 26(12), 2457-2482.

²²Graham-Bermann SA, Banyard V, Lynch S, DeVoe ER. Community-based intervention for children exposed to intimate partner violence: An efficacy trial. *Journal of Consulting and Clinical Psychology*. 2007; 75(2):199-209.

²³Graham-Bermann SA, Howell KH, DeVoe E. Mediators and moderators of change in adjustment following intervention for children exposed to intimate partner violence. *Journal of Interpersonal Violence*. 2011;26(5):1815-1833.

²⁴Graham-Bermann SA, Kulnarni MR, Kanukollu S. Is disclosure therapeutic for children following exposure to traumatic violence? *Journal of Interpersonal Violence*. 2011;26(5):1056-1076.

²⁵Jouriles EN, McDonald R, Rosenfield D. et al. Reducing conduct problems among children exposed to intimate partner violence: A randomized clinical trial examining effects of Project Support. *Journal of Consulting and Clinical Psychology*. 2009;77(4):705-717.

²⁶MacMillan KM, Harpur LL. An examination of children exposed to marital violence accessing a treatment intervention. *Journal of Emotional Abuse*. 2003;3(3/4): 227-252.

²⁷Siu, A.F.Y. Theraplay in the Chinese world: An intervention program for Hong Kong children with internalizing problems. *International Journal of Play Therapy*, 2009; 18(1), 1-12.

²⁸Siu, A.F.Y. Effectiveness of Group Theraplay® on enhancing social skills among children with developmental disabilities. *International Journal of Play Therapy*, 2014;23(4), 187-203.

²⁹Dodd LW. Therapeutic Groupwork with Young Children and Mothers Who have Experienced Domestic Violence. *Educational Psychology in Practice*, 2009; 25(1), 21-36.

³⁰Bennett LR, Shiner SK, Ryan S. Using Theraplay in Shelter Settings with Mothers and Children Who Have Experienced Violence in the Home. *Journal of Psychosocial Nursing*, 2006; 44(10), 39-48.

³¹Cohen JA, Mannarino AP, Knudsen K. Treating sexually abused children: One year follow-up of a randomized controlled trial. *Child Abuse and Neglect*. 2005; 29:135-145.

³²Cohen JA, Deblinger E, Mannarino AP. A multisite randomized controlled trial for multiply traumatized children with sexual abuse-related PTSD. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2004;43(4):393-402.

³³Deblinger E, Stauffer LB, Steer RA. Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their non-offending mothers. *Child Maltreatment*. 2001; 6:332-243.

³⁴Cohen JA, Mannarino AP, Iyengar S. Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence. *Archives of Pediatric and Adolescent Medicine*. 2011;165(1):16-21.

³⁵Stein BD, Jaycox LH, Kataoka SH, et al. A mental health intervention for schoolchildren exposed to violence. *JAMA*. 2003;290(5):603-611.

³⁶Morsette A, Swaney, G, Stolle D, Schulberg D, van den Pol R & Young M. Cognitive Behavioral Intervention for Trauma in Schools (CBITS): School-based treatment on a rural American Indian reservation. *Journal of Behavior Therapy and Experimental Psychiatry*. 2009; 40(1):169-178.

³⁷Kataoka SH, Stein BD, Jaycox LH et al. A school-based mental health program for traumatized immigrant children. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2003;42:311-318.

³⁸Carrion V.G. 2016. *Cue-centered therapy for youth experiencing posttraumatic symptoms: A structured multimodal intervention, therapist guide*. New York. Oxford University Press.

³⁹Carrion VG, Kletter H, Weems CF, Rialon Berry R & Rettger JP. Cue-Centered Treatment protocol for children exposed to interpersonal violence: A school-based randomized trial. *Journal of Traumatic Stress*. 2013; 26, 654-662.

⁴⁰Chaffin M, Solovksy JF, Funderburk B, Valle LA, Brestan EV et al. Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*. 2004;72(3):500-512.

⁴¹Borrego J, Gutow M, Reicher S, Barker C. Parent-child interaction therapy with domestic violence populations. *Journal of Family Violence*. 2008;23:495-505.

⁴²Salloum A, Robst J, Scheeringa MS, Cohen JA Wang W, Murphy T, Storch EA . Step One Within Stepped Care Trauma-Focused Cognitive Behavioral Therapy for Young Children: A Pilot Study. *Child Psychiatry and Human Development*. 2014;45(1), 65-77.

⁴³Bernard K, Dozier M, Bick J, Gordon MK. Intervening to enhance cortisol regulation among children at risk for neglect: Results of a randomized controlled trial. *Developmental Psychopathology*. 2015;27(3):829-841.

⁴⁴Bernard K, Dozier M, Bick J, Lewis-Morrarty E, Lindheim O, Carlson E. Enhancing attachment organization among maltreated children: results of a randomized clinical trial. *Child Development*. 2012;83(2):623-636.

⁴⁵Caron, E., Weston-Lee, P., Haggerty, D., & Dozier, M. Community implementation outcomes of Attachment and Biobehavioral Catch-up. *Child Abuse and Neglect*. 2016;53:128-137.

⁴⁶Langley AK, Gonzalez A, Sugar CA, Solis D, Jaycox L. Bounce Back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *Journal of Consulting and Clinical Psychology*. 2015;83(5):853-865.

⁴⁷Lutra Group. 2006. Year One (FY '05-06) Evaluation report for Celebrating Families! Grant summary. Retrieved from www.celebratingfamilies.net/PDF/YearOneEvaluationReport.pdf

⁴⁸Quittan GA. 2004. An evaluation of the impact of the Celebrating Families Program and Family Drug Treatment Court on parents receiving Family Reunification Services. *Unpublished master's thesis*, San Jose State University, San Jose, California.

⁴⁹Sparks, SN, Tisch R, Gardner M. Family-centered interventions for substance abuse in Hispanic communities. *Journal of Ethnicity in Substance Abuse*. 2013; 12(1):68-81.

⁵⁰National Child Traumatic Stress Network. Child Adult Relationship Enhancement (CARE) Fact Sheet. Downloaded January 18, 2018 at
http://nctsn.org/nctsn_assets/pdfs/promising_practices/CARE_fact_sheet_3-20-07.pdf

⁵¹Stulmaker HL & Ray. Child-centered play therapy with young children who are anxious: A controlled trial. *Child and Youth Services Review*. 2015;57:127-133.

⁵²Bratton SC, Ceballos PL, Sheely-Moore AI, Meany-Walen K, Pronchenko Y, Jones LD. Head Start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy*. 2013;22(1):28-42.

⁵³Blanco PJ & Ray DC. Play therapy in elementary schools: A best practice for improving academic achievement. *Journal of Counseling and Development*. 2011;89(2):235-243.

⁵⁴Groves B. 2002. *Children who See Too Much: Lessons from the Child Witness to Violence Project*. Boston: Beacon Press.

⁵⁵Child Witness to Violence Project, Boston Medical Center. *Shelter from the Storm: Clinical Intervention with Children Affected by Domestic Violence*. Retrieved on January 6, 2011 from: <http://www.childwitnessstoviolence.org>

⁵⁶Berkowitz SJ, Stover CS, Marans SR. The Child and Family Traumatic Distress Intervention: Secondary prevention for youth at risk of developing PTSD. *Journal of Child Psychology and Psychiatry*. 2010, Sept 24; doi:10.1111/j.1469-7610.2010.02321.

⁵⁷Runyon MK, Deblinger E, Steer RA. Group cognitive behavioral treatment for parents and children at-risk for physical abuse. *Child and Family Behavior Therapy*. 2010;32(2):196-218.

⁵⁸Fung MH & Fox RA. The culturally-adapted Early Pathways program for young Latino children in poverty: A randomized controlled trial. *Journal of Latina/o Psychology*. 2014; 2(3):131-145.

⁵⁹Harris, SE, Fox, RA, & Love, JR. Early Pathways therapy for young children in poverty: A randomized controlled trial. *Counseling Outcome Research and Evaluation*, 2015; 6: 3-17.

⁶⁰Harris, SE, Fox, RA, & Holtz, CA Screening for significant behavior problems in young children living in poverty. *Journal of Child and Family Studies* 2016;25: 1076-1085.

⁶¹Love, JR & Fox, RA. Home-based parent child therapy for young traumatized children living in poverty: A randomized controlled trial. *Journal of Child and Adolescent Trauma*, 2017;10(2): 1-11.

⁶²Fraser MW, Walton E, Lewis RE, Pecora PJ, Walton WK. An experiment in family reunification: Correlates of outcomes at one-year follow-up. *Children and Youth Services Review*. 1996;18(4/5):335-361.

⁶³Evans ME, Boothroyd RA, Armstrong MI, Greenbaum PE, Brown EC, Kupfinger AD. An

experimental study of the effectiveness of in-home crisis services for children and their families: Program Outcomes. *Journal of Emotional and Behavioral Disorders*. 2003;11(2):92-102.

⁶⁴Kirk RS, Griffith DP. Intensive family preservation services: Demonstrating placement prevention using event history analysis. *Social Work Research*. 2004;28(1):5-18.

⁶⁵Bigfoot DS & Funderburk BW. Honoring Children, Making Relatives: The cultural translation of Parent-Child Interaction Therapy for American Indian and Alaska Native families. *Journal of Psychoactive Drugs*. 2011;43(4):309-318.

⁶⁶Lanktree CB, Briere J, Godbout N, Hodges M, Chen K, Trimm L, Adams B, Maida A, Freed W. Treating multitraumatized, socially marginalized children: Results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma*. 2012; 21:813-828.

⁶⁷Sterrett-Hong EM, Karam E, Kiaer L. Statewide implementation of Parenting with Love and Limits Among Youth with Co-Existing internalizing and externalizing functional impairments reduces return to service rates and treatment costs. *Administration and Policy in Mental Health*. 2017;44(5):792-809.

⁶⁸Early KWS, Chapman SF, Hand GA. Family-focused reentry services: A quasi-experimental design evaluation of recidivism outcomes. *Journal of Juvenile Justice*. 2013;2(2):1-22.

⁶⁹Karam EA, Sterrett EM, Kiaer L. The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using Parenting with Love and Limits. *Family Process*. 2017;56(2):331-347.

⁷⁰Kagan R, Douglas AN, Hornik J, Kratz SL. Real Life Heroes pilot study: Evaluation of a treatment model for children with traumatic stress. *Journal of Child and Adolescent Trauma*. 2008; 1(1):5-22.

⁷¹Kagan R, Henry J, Richardson M, Trinkle J, LaFrenier, A. Evaluation of Real Life Heroes treatment for children with complex PTSD. *Psychological Trauma: Theory, Research, Practice and Policy*. 2014; 6(5):588-596.

⁷²National Child Traumatic Stress Network Fact Sheet. Safe Harbor Program: School-Based Victim Assistance and Violence Program Fact Sheet.

⁷³Najavits LM, Gallop RJ, Weiss R. Seeking Safety therapy for adolescent girls with PTSD and substance use disorder: A randomized, controlled trial. *Journal of Behavioral Health Services and Research*. 2006;33(4):453-463.

⁷⁴Gudino OG, Leonard S, Cloitre M. STAIR-A for Girls: A pilot study of a skills-based group for traumatized youth in an urban setting. *Journal of Child & Adolescent Trauma*. 2016;9(1):67-79.

⁷⁵National Child Traumatic Stress Network. Streetwork Project Fact Sheet. Downloaded January 18, 2018 at: http://www.nctsnet.org/sites/default/files/assets/pdfs/promising_practices/StreetworkProject_fact_sheet_3-20-07.pdf

⁷⁶Jaycox LH, Langley AK, Stein BD, Wong M, Sharma P, Scott M, Schonlau M. Support for students exposed to trauma: A Pilot study. *School Mental Health*. 2009;1(2):49-60.

⁷⁷Layne CM, Saltzman WR, Poppleton L, Burlingame GM, Pasalic A, Durakovic E, Music M, Campara N, Dap N, Arslanagic B, Steinberg AM, Pynoos RS. Effectiveness of a school-based group psychotherapy program for war-exposed adolescents: A randomized controlled Trial. *Journal of American Academy of Child and Adolescent Psychiatry*. 2008;47(9): 1048-1062.

⁷⁸Cox J, Davies DR, Burlingame GM, Campbell JE, Layne CM, Katzenbach RJ. Effectiveness of a trauma/grief-focused group intervention: a qualitative study with war-exposed Bosnian adolescents. *International Journal of Group Psychotherapy*. 2007;57(3):319-345.

⁷⁹Cunningham A, Hurley P. 2007. "A Full and Candid Account": Using Special Accommodations and Testimonial Aids to Facilitate the Testimony of Children. London ON: Centre for Children & Families in the Justice System.

⁸⁰Child Witness Project. 1993. *Three Years After the Verdict: A Study of the Social and Psychological Adjustment of Child Witnesses Referred to the Child Witness Project*. London ON: London Family Court Clinic.

⁸¹Rodger SC. *Evaluation of the Community Group Program for Children Exposed to Women Abuse, Preliminary Report, Summary*. Unpublished manuscript. Contact srodrger2@uwo.ca

⁸²Sudermann M, Marshall L, Loosely S. Evaluation of the London (Ontario) Community Group Treatment Programme for Children Who Have Witnessed Woman Abuse. *Journal of Aggression, Maltreatment & Trauma*. 2000; 3(1):127-146.

⁸³Bentley L, Lehmann P, Marshall L, Rabinstein S, Sudermann M, Loosely S, Milos L. *Group Treatment for Children Who Witness Woman Abuse, A Manual for Practitioners*. Children's Aid Society, London, Ontario, Canada.

⁸⁴Lennett J. 2005. *Evaluation of Clinical Services for Children Affected by Domestic Violence: Lessons Learned and to be Learned*.

⁸⁵Scott KL, Crooks CV. Preliminary evaluation of an intervention program for maltreating fathers. *Brief Treatment and Crisis Intervention*. 2007;7(3):224-238.

⁸⁶Scott KL, Lishak V. Interventions for maltreating fathers: statistically and clinically significant change. *Child Abuse and Neglect*. 2012;36:680-684.

⁸⁷Leslie, M. (ed.). 2007. *Substance use, violence and mothering: BTC's Connections Project*. In The Breaking the Cycle Compendium Vol. 1: The Roots of Relationship (pp 101-112). Toronto: Mothercraft Press. Available on-line at http://www.mothercraft.ca/assets/site/docs/resource-library/publications/BTC_Compendium_Rev.Ed_Jul.2011.pdf

⁸⁸Holmes C, Levy M, Smith A, Pinne S, Neese P. A Model for Creating a Supportive Trauma-Informed Culture for Children in Preschool Settings. *Journal of Child and Family Studies*. 2015;24(6):1650-1659.

⁸⁹Serrata, J. V., Macias, R. L., Rosales, A., Hernandez-Martinez, M., Rodriguez, R., & Perilla, J. L. (2017). *Expanding evidence-based practice models for domestic violence initiatives: A community-centered approach*. Psychology of violence, 7(1), 158.

⁹⁰Serrata, J. V., Macias, R. L., Rosales, A., Hernandez-Martinez, M., Rodriguez, R., & Perilla, J. L. (2017). *Expanding evidence-based practice models for domestic violence initiatives: A community-centered approach*. Psychology of violence, 7(1), 158.

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