The Promotion of Well-being among Children Exposed to Intimate Partner Violence: A Systematic Review of Interventions

Natasha E. Latzman, Cecilia Casanueva, Julia Brinton, & Valerie L. Forman-Hoffman

Submitted to the Coordinating Group of:

- [x] Crime and Justice
- [ ] Education
- [ ] Disability
- [ ] International Development
- [ ] Nutrition
- [x] Social Welfare
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- [x] No
- [ ] Yes
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Children and adolescent’s exposure to intimate partner violence (IPV), or domestic violence, is a pervasive public health problem. An estimated 8 to 15 million children in the United States (Hamby, Finkelhor, Turner, & Ormrod, 2011; McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006) and 275 million children worldwide are exposed to IPV each year (Pinheiro, 2006). The consequences of exposure can be severe and long-lasting. Research has linked IPV exposure in childhood to impaired neurological, physiological, and psychosocial functioning that contribute to a wide-range of health consequences. Indeed, IPV exposure has been associated with reduced cognitive ability and educational achievement (Kitzmann et al., 2003), under-immunization (Bair-Merritt, Blackstone, & Feudtner, 2008), and both psychological (e.g., posttraumatic stress, depression, aggression; Davies, Evans, & DiLillo, 2008) and physical health problems (e.g., ischemic heart disease, obesity; Felitti et al., 1998). These negative developmental sequalae appear to be evident across nations and cultures; for example, the link between IPV exposure and future physical and/or sexual victimization has been found in studies conducted in the United States, China, South Africa, Colombia, India, Egypt, the Philippines, and Mexico; see Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002).

Documentation of the immense magnitude and burden of children’s exposure to IPV has been met with an increased interest in the development of intervention strategies to protect this vulnerable population and promote well-being. Interventions for children exposed to IPV were initially developed in the late 1980s and 1990s and predominately focused on provision of general support; they were available only in battered women’s shelters or from agencies providing services to victimized women (see Graham-Bermann & Hughes, 2003 for a review of early programming). More recently, theory-driven psychosocial programs serving children exposed to violence have been developed and established in other venues (e.g., school-based mental health clinics, outpatient psychotherapy settings). A recent scan identified 23 unique programs designed to improve outcomes for children exposed to IPV currently being implemented across the United States, with at least 8 of these programs having been subject to one or more rigorous evaluations, including randomized controlled trials (Chamberlain, 2014). To date, however, no systematic review has been conducted to synthesize the state of this burgeoning literature and provide recommendations for research and practice.
The proposed systematic review will therefore fill an important gap. Our **primary goal** is to systematically examine the available evidence for the effectiveness of psychosocial interventions for promoting well-being following children’s exposure to IPV. Here we use a broad definition of psychosocial interventions, as used by the Institute of Medicine of the National Academies, to include a wide variety of services (e.g., assessment, psychological counselling, group interventions, and education and support services that include a psychological and/or social component) that emphasize psychological and/or social factors rather than biological factors (England, Butler, Gonzales, 2015). Our **secondary goal** is to examine whether interventions with particular characteristics (modality, theoretical orientation, and setting) are more effective than others in promoting well-being. Through this process, we aim to identify gaps in the current scientific literature and highlight important areas for future research to build the evidence base.

**OBJECTIVES**

Our review seeks to answer three main questions:

1. Are psychosocial interventions targeting children who have been exposed to intimate partner violence (IPV) effective at promoting well-being? Specific domains of well-being include:
   a. Mental and behavioral health (e.g., posttraumatic stress symptoms, depressive symptoms; anxiety symptoms, adjustment problems, disruptive, aggressive, and delinquent behavior)
   b. Other development and school-based functioning (e.g., cognitive development, academic achievement, social skills, executive functioning)

2. Are interventions with particular characteristics more effective than others in promoting well-being among children exposed to IPV? Specific intervention characteristics include:
   a. Modality (e.g., individual, family-based)
   b. Theoretical orientation/approach (e.g., cognitive-behavioral, interpersonal)
   c. Type of setting (e.g., domestic violence shelter, outpatient clinic).

**EXISTING REVIEWS**

To date, no previous authors have attempted to synthesize results of empirical evaluations of interventions designed to promote well-being following exposure to IPV in childhood. Several literature scans, critical reviews and systematic reviews have been conducted in related areas, however. For example, Futures without Violence (Chamberlain, 2014) recently released a scan of interventions designed for children exposed to IPV. The scan was focused on programs based in the U.S., and the authors did not systematically review and synthesize the results of empirical evaluations. Wethington et al. (2008) reviewed a range of interventions intended to reduce psychological harm from traumatic events—broadly
defined—among children, adolescents, and young adults. This review did not separate out children's exposure to IPV from other types of trauma exposures (e.g., car accidents). Further, in 2013, two systematic reviews were commissioned by the Agency for Healthcare Research and Quality (AHRQ) Effective Healthcare Program (both of which were co-authored by researchers on the current proposal). In the first, Goldman and colleagues (2013) conducted a comparative effectiveness review of interventions addressing child maltreatment, and in the second, Forman-Hoffman and colleagues (2013) conducted a comparative effectiveness review of interventions for children exposed to nonrelational traumatic events (e.g., accidents, natural disasters). Both of these reviews excluded evaluations of programs designed for children exposed to IPV, given the different nature of the trauma, resulting system responses, and intervention settings. For example, children exposed to IPV may not have access to resources traditionally offered to children engaged with the child protection system. Further, due to their own victimization, mothers experiencing IPV may be less able to provide support and stability to their own children (Lieberman & Van Horn, 2008); in fact, research indicates that mothers return to IPV perpetrators a mean of five times before permanently ending the abusive relationships (Sullivan & Bybee, 2011).

Based on our expertise, scan of the extant literature, and overviews describing intervention approaches (Graham-Bermann & Howell, 2011), we expect to fully code 20-30 studies. We anticipate that the majority of studies included in our review will target school-aged children (e.g., Graham-Bermann, 2002; Jouriles, et al., 2001; Sullivan et al., 2002), with relatively fewer studies examining programs that target adolescents (age 12 years and older).

**INTERVENTION**

We plan to include any type of psychosocial intervention where the primary or secondary aim is the promotion of child well-being following exposure to IPV. Included interventions must involve provision of psychosocial services to the exposed child; psychosocial interventions are defined broadly to include a wide variety of services (e.g., assessment, psychological counselling, group interventions, and education and support services) that emphasize psychological and/or social factors rather than biological factors. Interventions may be psychological in nature, such as psychotherapies of various orientations (e.g., cognitive-behavioural or interpersonal therapy) and/or social in nature (e.g., peer support services) (England et al., 2015). Interventions that focus services solely on the child’s caregiver (i.e., services provided to only women at domestic violence shelters) will be excluded. However, we will include interventions that are multicomponent in nature and target both the child and risk factors related to the child’s parent(s) or family environment. Interventions can occur in any setting, provided they include a psychological and/or social component; including but not limited to domestic violence shelters or service organizations, schools, outpatient clinics, or hospitals. For example, Kid’s Club and Mom’s Empowerment (Graham-Berman, 2000) is a psychosocial program delivered in a broad range of settings
(e.g., community-based agency, outpatient mental health clinic) both within the U.S. and abroad. It includes both parenting programs and groups for children exposed to IPV that focus on building social, emotional and coping skills.

There are a number of interventions which are designed for children exposed to trauma, broadly defined (e.g., child maltreatment, witnessed community violence, car accidents). In these interventions, children may or may not have been exposed to IPV. For example, Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), is a school-based psychosocial program delivered to children exposed to violence, including but not limited to intimate partner violence (Kataoka et al., 2013). If results are not reported for children who have been exposed to IPV (at least, but not limited to) then we will not include the study in our review.

**POPULATION**

The specific population of interest is children and adolescents aged 0 to 17 years who have been exposed to IPV. Studies will be included if >50% of the study population is in the age range of 0 to 17 years. We will use a broad definition of exposure to IPV that includes a child seeing, hearing, or otherwise being exposed (e.g., exposed to the aftermath such as helping a parent with injuries) to IPV (physical, sexual, emotional/psychological, stalking) between caregivers or a caregiver and a current or former spouse partner. We will exclude studies with children broadly identified as “at risk” for exposure (e.g., have experienced other types of victimization other than IPV exposure). Our review will be international in scope and we will not apply any restrictions related to nationality, language or cultural background, although we will code and consider study country/population’s Human Development Index (HDI).

**OUTCOMES**

The proposed review will examine outcomes related to child well-being. Any program implemented with IPV-exposed children aged 0 to 17 that intended to address these well-being outcomes (whether as a primary or secondary outcome) will included in the present review.

- Mental and behavioral health (including but not limited to posttraumatic stress symptoms, depressive symptoms, anxiety symptoms, disruptive, aggressive, and delinquent behavior)
- Other development and school-based functioning (including but not limited to cognitive functioning, academic achievement, and executive functioning)
**STUDY DESIGNS**

We plan to identify and assess experimental and quasi-experimental designs where the primary or secondary aim is the promotion of well-being following child exposure to IPV. Only studies that have a well-defined control group will be included (e.g., wait-list control, treatment-as-usual). Designs may include, for example, randomized controlled trials, quasi-randomized controlled trials where participants choose assignment, or propensity score matched groups. Pre-post designs without any comparison group and studies presenting only qualitative data will be excluded. Risk of bias will be assessed using the Cochrane Risk of Bias tool for each study (Higgins et al., 2008); the strength of evidence will be graded according to criteria defined by Owens and colleagues (2010), which incorporates risk of bias, consistency, directness, and precision of the evidence for each outcome.

**REFERENCES**


**REVIEW AUTHORS**

**Lead review author:** The lead author is the person who develops and co-ordinates the review team, discusses and assigns roles for individual members of the review team, liaises with the editorial base and takes responsibility for the on-going updates of the review.

**Name:** Natasha E. Latzman, PhD  
**Title:** Research Psychologist  
**Affiliation:** RTI International
ROLES AND RESPONSIBILITIES

• Content: Natasha Latzman, Cecilia Casanueva

• Systematic Review Methods: Natasha Latzman, Cecilia Casanueva, Valerie Forman-Hoffman

• Statistical Analysis: Natasha Latzman, Valerie Forman-Hoffman

• Information Retrieval: Natasha Latzman, Julia Brinton, Valerie Forman-Hoffman

The team will be led by Principal Investigator Natasha Latzman, who has substantive expertise in violence and victimization, child and adolescent mental health, and evaluation research. She has training in systematic review methodology and will lead the project, including ensuring all milestones are met on time, developing the protocol, overseeing the literature retrieval, participating in analysis, and leading the development of the final paper. She will be supported by Cecilia Casanueva, an expert in IPV and child maltreatment, who will contribute to coding, synthesis and report writing; Julia Brinton, an experienced social science analyst, who will contribute information retrieval, database management, citation screening and coding; and Valerie Forman-Hoffman, an expert in review methodology and statistical analysis, who serve as senior advisor, providing input on all stages of the review process, including data extraction, assessing bias and quality, and conducting analyses.

FUNDING

We received funding under the Jacobs Foundation (in partnership with the Campbell Collaboration) call for proposals, Better Evidence for Children and Youth.

POTENTIAL CONFLICTS OF INTEREST

None of the researchers involved in the team present conflicts of interest to note.

PRELIMINARY TIMEFRAME

• Date you plan to submit a draft protocol: 28 October 2016
Date you plan to submit a draft review: 1 October 2017

Below is a proposed timeline for the review:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Anticipated Deadline</th>
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<tbody>
<tr>
<td>Submit title registration to Campbell Collaboration</td>
<td>28 July 2016</td>
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<tr>
<td>Submit protocol proposal to Campbell Collaboration</td>
<td>25 October 2016 (within 3 months of approval of title)</td>
</tr>
<tr>
<td>Receive protocol reviews</td>
<td>10 November 2016 (estimated)</td>
</tr>
<tr>
<td>Submit revised protocols based on reviews</td>
<td>10 December 2016</td>
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<tr>
<td>Conduct systematic literature search</td>
<td>1 February 2017</td>
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<tr>
<td>Conduct abstract screening</td>
<td>10 March 2017</td>
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<tr>
<td>Conduct literature retrieval</td>
<td>15 April 2017</td>
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<tr>
<td>Conduct study eligibility screening and begin coding</td>
<td>1 May 2017</td>
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<tr>
<td>Complete coding, begin analysis</td>
<td>1 August 2017</td>
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<tr>
<td>Submit draft review to Campbell Collaboration</td>
<td>20 October 2017 (within 1 year of approval of protocol)</td>
</tr>
<tr>
<td>Submit final review to Campbell Collaboration</td>
<td>15 December 2017</td>
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**AUTHOR DECLARATION**

**Authors’ responsibilities**

By completing this form, you accept responsibility for preparing, maintaining, and updating the review in accordance with Campbell Collaboration policy. The Coordinating Group will provide as much support as possible to assist with the preparation of the review.

A draft protocol must be submitted to the Coordinating Group within one year of title acceptance. If drafts are not submitted before the agreed deadlines, or if we are unable to contact you for an extended period, the Coordinating Group has the right to de-register the title or transfer the title to alternative authors. The Coordinating Group also has the right to de-register or transfer the title if it does not meet the standards of the Coordinating Group and/or the Campbell Collaboration.

You accept responsibility for maintaining the review in light of new evidence, comments and criticisms, and other developments, and updating the review every five years, when substantial new evidence becomes available, or, if requested, transferring responsibility for maintaining the review to others as agreed with the Coordinating Group.

**Publication in the Campbell Library**
The support of the Coordinating Group in preparing your review is conditional upon your agreement to publish the protocol, finished review, and subsequent updates in the Campbell Library. The Campbell Collaboration places no restrictions on publication of the findings of a Campbell systematic review in a more abbreviated form as a journal article either before or after the publication of the monograph version in *Campbell Systematic Reviews*. Some journals, however, have restrictions that preclude publication of findings that have been, or will be, reported elsewhere and authors considering publication in such a journal should be aware of possible conflict with publication of the monograph version in *Campbell Systematic Reviews*. Publication in a journal after publication or in press status in *Campbell Systematic Reviews* should acknowledge the Campbell version and include a citation to it. Note that systematic reviews published in *Campbell Systematic Reviews* and co-registered with the Cochrane Collaboration may have additional requirements or restrictions for co-publication. Review authors accept responsibility for meeting any co-publication requirements.

I understand the commitment required to undertake a Campbell review, and agree to publish in the Campbell Library. Signed on behalf of the authors:

Form completed by: Natasha E. Latzman Date: 25 July 2016