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Differential Therapeutic Outcomes of Community-Based Group Interventions for Women and Children Exposed to Intimate Partner Violence

Paula T. McWhirter[1]

Abstract

Two community-based group therapies, emotion focused versus goal oriented, are compared among women exposed to intimate partner violence ($n = 46$) and their children ($n = 48$) aged between 6 and 12 years. A series of repeated measures analyses are employed to evaluate the effects of time from baseline to postintervention following random assignment. Main and treatment effects for women provide support for the relative effectiveness in increasing quality of social support in the emotion-focused intervention and in the reduction of both family conflict and alcohol use for the goal-oriented intervention.

Keywords

violence, family, community interventions, group therapy, child adjustment, intimate partner violence

[1]University of Oklahoma

Corresponding Author:
Paula T. McWhirter, 820 Van Vleet Oval, Norman, OK 73019
E-mail: paulamcwhirter@ou.edu

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Intimate partner violence (IPV) continues to be a major problem in American society. Women experience approximately 4.8 million intimate partner–related physical assaults and rapes annually, resulting in up to 1,500 deaths each year since 2005 (Tjaden & Thoennes, 2009; U.S. Department of Justice, 2009). The Center for Disease Control and Prevention's most comprehensive survey regarding IPV reveals that almost 1 in 4 women (23%) and 1 in 10 men (11.5%) report at least one lifetime episode of IPV. These rates increase among lower-income women (33.5%) and men (20.7%; household income less than US$15,000 annually; Centers for Disease Control and Prevention [CDC], 2008). The health-related costs of rape, physical assault, stalking, and homicide by intimate partners exceed US$5.8 billion each year, including direct medical and mental health care service expenses (nearly US$4.1 billion) and productivity losses (US$1.8 billion; CDC, 2003).

Slightly less than half of female victims of intimate violence live in households with children under age 12 (43%; Department of Justice, 2009). This places children at greater risk for witnessing traumatic violence and experiencing its outcome in the form of hearing narratives recounting the violent experience or viewing victim bruises, marks, swelling, or scars (Meltzer, Doos, Vostanis, Ford, & Goodman, 2009). Children present during instances of IPV are placed at further risk for inadvertently becoming direct targets of abuse (Alessi & Hearn, 2007). According to estimates, children are present during incidences of IPV at the rate of 10% to 20% each year (Carlson, 2000). Taken together, studies collectively suggest that between 3 and 10 million children witness some form of domestic violence annually (Roberts, 2007).

Consequences for children exposed to domestic violence range from internalizing to externalizing behavioral difficulties and include physical problems secondary to traumatic stress reactions (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007). In spite of these potentially broad and far-reaching consequences to children, studies addressing interventions for children exposed to IPV has been limited (Graham-Bermann et al., 2007; Meltzer et al., 2009). One reason for the limitation is that trauma in children may be frequently overlooked, inaccurately diagnosed instead as a number of mental health conditions, including depression, attention-deficit hyperactivity disorder, oppositional-defiant disorder, conduct disorder, generalized anxiety disorder, separation anxiety disorder, and reactive attachment disorder (Cook, Blaustein, Spinazzola, & van der Kolk, 2003).

Increasingly, however, family violence is recognized as a traumatic event in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury, or other threat to physical integrity of oneself or others (*DSM IV-TR*; *Diagnostic and statistical manual of mental disorders*

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[4th ed., text rev.], American Psychiatric Association [APA], 2000). Severe trauma is thought to result from prolonged or repeated exposures to violent events, not uncommon in situations of domestic violence (Cook et al., 2003). Repeated trauma of this nature can cause the nervous system to react in a constant state of alarm, which can result in posttraumatic stress disorder, compromising mental, emotional, and social functioning. Recent studies link serious health and social outcomes to previously traumatic experiences and suggest that trauma is far more prevalent than previously recognized. A longitudinal study that crosses child and adult development links a wide range of social (e.g., homelessness, prostitution, delinquency and criminal behavior, inability to hold a job) and health (e.g., heart disease, cancer, chronic lung disease, liver disease, skeletal fractures, HIV-AIDS) problems to cumulative and unaddressed trauma (Felitti et al., 1998).

The present study is designed to assess the clinical effectiveness to two community-based treatments to reduce family violence and increase psychosocial well-being of women and children previously exposed to IPV through addressing posttraumatic coping strategies. In accordance with participatory action research methodology (PAR; Kidd & Kral, 2005), intervention focus and measurement selection was conducted in collaboration with family homeless shelter service providers and residents who themselves had been exposed to IPV and were mothers of children who had witnessed domestic violence. The PAR team identified adaptive and nonadaptive coping as an area of primary importance in IPV survival for themselves and their children. Trauma victims employ a variety of coping mechanisms to address the negative effects of stress, including nonfacilitative coping strategies that yield positive immediate coping benefits, yet create longer-term difficulties with continued use, ultimately sabotaging trauma recovery. Some examples include substance abuse, violence victimization, family violence perpetration, self-isolation, and self-injury.

Three nonfacilitative coping mechanisms were identified by the PAR team: substance abuse, family violence perpetration, and self-isolation. Specifically, women reported consuming alcohol as a way to numb the physiological and psychological effects of violence, resulting in short-term relief of symptoms and longer-term potential for addiction. In addition, women indicated engaging in self-isolation in response to feelings of shame secondary to their abuse experiences. Women questioned their judgment in assessing their current relational interactions and in entering new relationships following experiences with IPV. Finally, women described short, yet distressing, outbursts directed toward their children resulting in temporary relief of their own stress with longer-term consequences in compromised family bonds.

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Although the PAR team requested treatment to address coping mechanisms, the team expressed a desire to assess each treatment intervention in terms of its overall ability to positively affect the lives of the women and children participants. This guided the PAR team's selection of outcome variables for the study that included measures thought to either directly or indirectly relate to the overall improvement of psychological health among women in areas related to coping: alcohol use (frequency of alcohol use, self-efficacy for discontinuing alcohol use, readiness to change alcohol use), family violence perpetration (family conflict, family bonding, and readiness to decrease violence in life), and self-isolation (quality of social support, depression). Child measures were selected to parallel the adult family and self-isolation measures and included family conflict, peer conflict, state of emotional well-being, and self-esteem.

Comparative interventions, emotion focused and goal oriented, were selected, and standardized treatment protocols were developed for this study. Cognitive behavioral interventions were included in both goal-oriented and emotion-focused interventions based on trauma theory that suggests that precortical cognitive processing is compromised following repeated exposure to trauma and should be addressed in posttrauma treatment protocols. The goal-oriented treatment integrated a full cognitive behavioral approach with components utilized in motivational Interviewing, due to its effectiveness in discontinuing a specific, identified behavior, such as a nonadaptive coping behavior (i.e., alcohol use, a negative parenting behavior, etc.). As such, it was hypothesized that this treatment would effectively decrease most nonadaptive coping mechanisms but that its affect would be less impactful on relationally based adverse coping (i.e., self-isolation).

Likewise, the emotion-focused treatment was selected to determine its efficacy in decreasing nonadaptive coping. The approach integrated cognitive behavioral process to educate and empower participants regarding relationships, emotions, and coping. A gestalt approach was employed to process the information in the relational context of the group. It was hypothesized that this treatment would be particularly effective at decreasing relationally based nonadaptive coping (i.e., self-isolation). In addition, due to the relational qualities of family bonding and family conflict, it was hypothesized that this intervention may yield positive results on these variables.

Although the interventions differed in content, they shared a strict structure that included separate group work (mother- and child-specific groups) followed by a joint family therapy group (mothers together with their children). The rationale underlying this shared structure was based on research demonstrating the relative effectiveness of comprehensive family approaches that

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incorporate interventions for child and parent together (Kumpfer & Alvarado, 2003; Serketich & Dumas, 1996) and revealing the relative effectiveness of family interventions (involving the child and mother together in therapy) over child-only therapy (Graham-Bermann et al., 2007). Structured group therapy was the shared modality selected due to its effectiveness in previous studies involving women and their children at high risk for exposure to violence (McWhirter, 2006; Panas, Caspi, Fournier, & McCarty, 2003; Wolfe, 2006).

Method

Participants

Women and their children residing in temporary family homeless shelters in a major Southwestern metropolitan area were recruited for participation in this study. Recruitment efforts included dissemination of information about the content and structure of the intervention via the shelters' social welfare worker and flyers posted throughout the area. Women included in the study reported a history of exposure to violence by an intimate partner within the year of study onset rated this relationship with a score of 15 or higher on the HITS tool of IPV and reported their child to be present during at least one incident of IPV within the past year. The HITS (hurt-insult-threaten-scream) tool was utilized as a screener for study inclusion due to is brevity and ease of use. The scale has shown good internal consistency (Cronbach's alpha = .80) and concurrent validity (r = .85) with the Conflict Tactics Scale verbal and physical aggression items (Sherin, Sinacore, Li, Zitter, & Shakil, 1998). Construct validity has been demonstrated in its ability to differentiate victims of IPV in a nonclinical population (Sherin et al., 1998). The appendix provides randomized clinical trial details (e.g., randomization sequence generation, allocation concealment, intervention implementation, etc.).

Women (n = 46) with a reported history of IPV and with a child witness (n = 48), aged between 6 and 12 years at the time of the study, were included as participants. Sample size was determined a priori based on the number of groups employed (2), expected effect size (large), preferred power (.95), and alpha level (Stevens, 2009). Family residents of the temporary family homeless shelters received age-appropriate child care (nursery, preschool, after school) and had meetings with a bachelor's level social welfare worker who provided community-based referral information. No other mental health services were available to study participants for the study duration.

All women participants reported a history of previous exposure to family violence. The overwhelming majority (89%) reported some form of abuse by

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an older parent or relative while growing up that included instances of physical (89%), emotional (80%), or financial (89%) abuse. Reported education included some high school (35%, $n = 15$), completed high school (30%, $n = 12$), some college (35%, $n = 15$), and one college-educated participant (2%, $n = 1$). Generally speaking, ethnicity reflected state proportions, including White (47%, $n = 21$), Latino (20%, $n = 9$), African American (16%, $n = 7$), Native American (11%, $n = 5$), and Asian American (2%, $n = 1$) women. The average age of the participants ranged from 18 to 47 years; the mean age across the sample was 30 years, which is likely a function of the inclusion criteria being that of a parent of a child aged between 6 and 12 years.

Design and Procedure

In this study, I utilized a multiple focused experimental construct validity design (Horan, 1995, 1999) which contrasts two treatment interventions that should produce significant changes on theoretically relevant measures and fail to produce significant changes on unrelated measures. Practical issues, service requirements, and, especially, ethical concerns precluded traditional standard treatment controls such as no treatment control, delayed treatment control, or cross-over control. Here, the two active treatments serve as high-demand control conditions for each other.

Mothers and their children were randomly assigned to one of two treatment condition: emotion focused or goal oriented. A computer-generated randomization list was drawn up by the author and given to the project manager responsible for allocating women into one of the two treatment condition based on the next available number. The code was revealed to the project manager once recruitment, data collection, and statistical analyses were complete. Group facilitators administering the interventions did not engage in participant allocation into treatment condition. Only the study statistician and data monitors saw unblinded data, but none had any contact with study participants.

Participants were blinded to treatment assignment for the duration of the study. In an attempt to equalize dose-effect exposure, conditions were matched in terms of structure and length. Women-only group met separately for 60 min and the children-only group for 45 min. Following a brief break, a cofacilitated 60-min joint family session involved children together with their mothers. Each group consisted of 4 to 5 participants with the subsequent cofacilitated joint groups consisting of 8 to 10 participants (children with their mothers). Groups met weekly for 5 weeks and were closed to new participants during

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this period of time. Groups were facilitated continually over the course of an academic year.

Treatment Conditions

Goal-oriented: women's group. The goal-oriented women's group drew largely on a cognitive behavioral approach with integration of components utilized in motivational Interviewing and the transtheoretical model. The intervention focused on increasing internally guided goal-oriented change. The emphasis on increasing intrinsic motivation for change was purposeful in that the women were living in temporary family shelters where many of the recent life changes experienced were imposed on them as a condition of continued stay. For example, women were required to find or maintain employment during their stay and were restricted from entering their apartment during regular business hours. Thus, for individuals managing a variety of externally imposed rules and regulations, attention to an internal focus on personal growth with the development of strategies for change was thought to be particularly beneficial.

Therefore, during initial meetings, the women were presented with information regarding adaptive and nonadaptive coping strategies. Participants were then encouraged to identify a nonadaptive coping strategy to work on changing as part of the treatment process. However, participants were also provided the option of identifying an adaptive coping strategy that they wanted to increase in their life. Thus, goals that women selected focused either on decreasing nonadaptive coping strategies or increasing adaptive ones. Goals were individualized and varied but generally fit into one of the following categories: relational (e.g., building more healthy bonds with their children or other family members, decreasing specific negative parental behaviors), personal (e. g., increasing awareness for personal feelings and reactions/behaviors related to feelings, learning more about own likes and interests as opposed to reliance on others for validation, decreasing self-isolation), functional (e.g., drink alcohol less frequently, follow through with practical needs of children with consistency).

Once a goal was selected, the remaining sessions involved conceptualizing practical steps, predicting and decreasing potential barriers, and developing specific strategies for change. During these sessions, facilitators were encouraged to focus on specific individual goals for each group member while emphasizing the group as a common source of support for all group members facing unique challenges in their change process. Facilitators were instructed to attend to building cohesion and trust during these sessions at the

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group level while guiding the women toward exploring and committing to specific goals for personal growth.

Goal-oriented: children's group. A companion goal-oriented intervention was created as a developmentally appropriate parallel intervention for children. Following the same approach and tenets as the women's group, children were encouraged to select a meaningful goal for change in their life. Discussion emphasized those aspects of life the children might be able to change and those that they are not responsible to change or were beyond their means. This discussion was designed to empower children to realize that although much is outside of the realm of their control, they do have the power to choose and change personal aspects of their life. The children were able to generate several possible changes they wanted to make, utilizing age-appropriate drama and art activities and visual aids. Many children selected goals related to behaviors that they felt were distressing to the grown-ups around them, such as sitting still in class, completing their homework, reduced arguing and complaining, or fighting less with their siblings. Children signed a contract verifying acceptance of their specific change goals.

Emotion-focused: women. The emotion-focused group was comprised of behavioral and gestalt therapeutic interventions. Each session was structured to include an initial cognitive behavioral psychoeducational segment that presented information that was then processed via a gestalt approach. Participants were encouraged to process congruent interactions in the "here and now" (Yalom & Leszcz, 2005) and were intentionally challenged to increase personal awareness and authentic interaction in the context of fostering healthy group relationships. The educational curriculum focused on healthy and nonhealthy relationships over one's lifetime and recognizing the influence of adaptive versus nonadaptive mechanisms in coping with abuse experiences. The attention to immediacy, "here and now" interactions, and relational personal awareness were considered likely to increase social support for these women.

These cognitive behavioral and gestalt therapeutic techniques were delivered in a sensitive milieu necessary to allow women to process information, thoughts, feelings, and behaviors in a setting that allowed for making behavioral changes. The five-session curriculum focused on the following: (a) exploring personal belief systems, especially concerning difficult experiences; (b) understanding the various forms of abuse; (c) understanding and expressing feelings; (d) recognizing healthy relationships; (e) and finding healthy ways to cope with stress.

Emotion-focused: children. A companion developmentally appropriate emotion-focused intervention was created for this study as a parallel intervention

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for children. Following the same approach and tenets as the women's group, children's group included age-appropriate strategies and techniques for (a) identification of upset feelings, concerns, worries, and fears associated with family transitions; (b) understanding, expressing, and integrating these feelings; (c) understanding behaviors of self and others as they relate to wants, needs, and feelings; (d) learning about abuse, recognize verbal and physical forms of abuse, and exploring strategies for keeping safe in abusive situations. Emphasis was placed on emotional awareness and expression. Activities and discussion centered on dealing with stress and strong emotions, dealing with family and peer pressure, identifying and making good friends, and handling interpersonal and familial conflict.

Joint family group for goal-oriented treatment and joint family group for emotion-focused treatment. Following work in separate groups, women and children were brought together to participate in a joint family group cofacilitated by two of the therapists, one from each separate group. The joint family group continued with the session theme that had been presented during separate (women and child) sessions of the same treatment modality (goal-oriented or emotion-focused). The content of the family group, either goal oriented or emotion focused, built on the theme initially presented during separate women's and children's groups. The theme was continued, in the context of the family group, with a summary of session theme and brief, age-appropriate, family-based presentation of information. This was followed by a related family-based activity and discussion. Group facilitators were provided direction to processing during group in ways that paralleled the theoretical intent initiated (whether goal-oriented or emotion-focused) during the previous separate group.

Therapists

Four (4) female therapists facilitated groups for this study: two masters-level licensed counselors, and two counselors-in-training (participating as part of a masters-level specialty practicum placement). Of the two masters-level licensed counselors, one cofacilitated both the women-only treatment conditions—goal oriented and emotion focused—and the other was a children's counselor and cofacilitated the children-only goal-oriented and emotion-focused interventions. Of the two counselors-in-training, one was a women's and one was a children's counselor-in-training, and they served as cofacilitators with the masters-level licensed counselors.

Therapists were trained to administer each treatment intervention utilizing treatment protocols developed for this project. Training was conducted over

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a period of 6 weeks, 2.5 hr weekly, for a total of 15 training hr. Therapists in both treatments received weekly supervision throughout the study to promote adherence to the treatment manuals. Training and supervision was conducted jointly by a counseling psychologist and a licensed professional counselor, each specializing in work with women and children exposed to IPV.

Measures

A battery of self-report measures was administered to women, children, and therapists approximately 1 week prior and following the 5-week group therapy intervention. The following instruments were selected by the PAR team as useful in investigating the relative effects of each therapeutic approach at baseline and posttreatment intervals.

Women's Measures

Family conflict. Family conflict was assessed utilizing the family attachment scale of the Student Survey of Risk and Protective Factors (Arthur, Hawkins, Catalano, & Pollard, 1998). It was a 3-item, self-report instrument measuring arguments within the family. Reliability of .83 was reported along with high concurrent validity with drug and alcohol use and youth delinquency (Arthur et al., 1998). Items were averaged yielding a range from 1 to 4, with high scores indicating high conflict. A Cronbach's coefficient of .87 was obtained from the study sample.

Family bonding. Family bonding was assessed utilizing the family attachment scale of the Student Survey of Risk and Protective Factors (Arthur et. al., 1998) It was a 4-item, self-report measure of family bonding that measures respondents closeness and ease in sharing thoughts and feelings with family members. Internal consistency of .74 was reported along with high concurrent validity with drug and alcohol use and youth delinquency (Arthur et al., 1998). Items were averaged yielding a range from 1 to 4, with high scores indicating high bonding. A Cronbach's alpha coefficient of .72 was obtained from the study sample.

Quality of social support. Social support was measured utilizing the 5-item Quality of Social Support Scale (Vandervoort, 1999) consisting of questions such as, "Overall, how satisfied are you with your relationship with your children?" with a 4-point response format, 1 = *very satisfied*, 2 = *satisfied*, 3 = *unsatisfied*, and 4 = *very unsatisfied*. Adequate reliability and validity have been reported for these measures (Vandervoort, 1999). Cronbach alpha obtained from this sample was .76.

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Depression. Depression was assessed by the Center for Epidemiologic Studies Depression Scale (CESD: Radloff, 1977). This is a 20-item self-report scale intended for the general population. Participants were provided instructions: "Please indicate how often you have felt this way during the past week by checking the appropriate space" for the following sample items—"I was bothered by things that usually don't bother me," "I felt hopeful about the future," and "I thought my life had been a failure"—utilizing a 5-point Likert-type response format ranging from 1 = *rarely or none of the time* (less than 1 day) to 5 = *most or all of the time* (5-7 days).

Adequate reliability and validity have been established for the CESD (Hann, Winter, & Jacobsen, 1999; Radloff, 1977, 1991), with Cronbach's alphas ranging from low .90s to high .80s. Cronbach's alpha for the current study sample was .93.

Self-efficacy. Self-efficacy expectations, the optimistic self-belief in one's own ability to perform novel or difficult tasks or cope with adversity in various domains of human functioning, were measured via the Generalized Self-Efficacy Scale (GSC; Schwarzer & Jerusalem, 1995). The 10-item scale was created to assess a general sense of perceived self-efficacy to predict coping with daily hassles as well as adaptation after experiencing all kinds of stressful life events. The measure can be useful in assessing adaptation after life changes, but it is also suitable as an indicator of quality of life at any point in time. Perceived self-efficacy facilitates goal setting, effort investment, persistence in face of barriers, and recovery from setbacks.

In samples from 23 nations, Cronbach's alphas on the GSC ranged from .76 to .90, with the majority in the high .80s. The current study sample yielded a Cronbach's alpha of .86. Criterion-related validity is documented in numerous correlation studies where positive coefficients were found with favorable emotions, dispositional optimism, and work satisfaction. Negative coefficients were found with depression, anxiety, stress, burnout, and health complaints.

Readiness ruler. The Readiness-to-Change/Confidence Ruler (Miller & Rollnick, 2002) is a measure used to elicit specific self-efficacy or belief or confidence in a person's ability to succeed at making a specific change. Participants are asked their level of confidence in their ability to change a specific behavior or activity. For the purposes of this study, participants were asked 3 items: "I am ready to decrease the amount of alcohol I consume," "I am ready to decrease violence I experience in my life," and "I am ready to make healing, healthy, therapeutic change in my life." Participants are asked to mark on a linear scale from 0 to 10 their current position in the change process from 1 = *not prepared for change* to 10 = *already changing*.

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In addition to participants, therapists were asked to rate from 0 to 10 each group participant using the following item based on the Readiness-to-Change/ Confidence Ruler and developed for the purposes of this study: "Indicate how ready is each client is to make healing, healthy, therapeutic change."

Adequate reliability and validity has been demonstrated for the Readiness Ruler (Blanchard, Morgenstern, Morgan, Labouvie, & Bux, 2003). Research has established that a person's expression of readiness to change a behavior is related to actual change, with high scores related to actual behavioral change and low scores predictive of an absence of change, for alcohol use, other drug use, and other behaviors. The measure's validity contributes to its applicability both clinically and experimentally (Blanchard et al., 2003).

Self-efficacy for discontinuing alcohol use. An additional single item was developed for this study as an additional assessment of self-efficacy specifically for alcohol use. The item, "How likely do you believe that some behavior of yours will be effective in stopping future alcohol or other drug use, should you choose?" utilized a 7-point Likert-type response format, with responses ranging from 1= *not at all likely* to 7 = *totally likely*. This item correlated highly with the Readiness-to-Change/ Confidence Ruler item regarding self-efficacy or confidence in changing alcohol use ($r = .97$).

Alcohol use. Alcohol use was assessed with a single item that has been utilized in many large-scale substance use survey research to assess current alcohol use (e.g., Flannery, Vazsonyi, Torquati, & Fridrich, 1994; McWhirter, Florenzano, & Soublette, 2002; Newcomb, Maddahian, & Bentler, 1986). The item elicits information using a 5-point, Likert-type response format. Participants indicate the extent to which the items describe themselves by circling *never*, *rarely*, *monthly*, *weekly*, and *daily* to the following question, "Currently, how often do you consume alcohol?" Adequate validity has been demonstrated for the item in assessing alcohol use (Flannery et al., 1994; McWhirter, 1998; Newcomb et al., 1986).

Children's Measures

Emotional barometer. Children's general psychological well-being was assessed visuographically, using the emotional barometer comprised of a figure that resembles a standard barometer or thermometer. Both prior to the group experience, and then afterward, children were asked to place a line at any point on the barometer figure to indicate current feelings ranging from smiling face, expressionless face, distressed face (located at the top, middle, and bottom or the barometer figure, respectively). Scores were measured on

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a 7-point scale utilizing a ruler to measure distance between pre- and post-treatment points.

Psychosocial measures. Children's peer conflict, family conflict, and self-esteem were each assessed with a single item developed for this study. Items were derived based on face validity and included, "I get along very well with other kids my age" (peer conflict), "I get along with my family" (family conflict), and "I feel very good about myself" (self-esteem) utilizing a 5-point Likert-type response format.

Results

Participants in the emotion-focused group (n = 1) and the goal-oriented group (n = 3) discontinued the intervention because they were relocated to a permanent living situation during the trial; consequently data from women (n = 46) and their children (n = 48) were available for the intention-to-treat analysis. All analyses performed were prespecified in the trial protocol, and totals included women randomly allocated to the emotion-focused (n = 22) and goal-oriented (n = 24) interventions. No adverse events secondary to participation in either treatment intervention were reported by participants or observed by treatment facilitators.

Preliminary 1-factor ANOVAs were conducted on dependent measures with alpha set at .05. These revealed no significant differences, providing some evidence of pretreatment equivalence: family conflict , $F(1, 46) = 2.20$, $p > .05$; family bonding, $F(1, 46) = 1.08$, $p > .05$; depression, $F(1, 46) = .2.22$, $p > .05$; quality of social support, $F(1, 46) = 2.70$, $p > .05$; Generalized Self-Efficacy Scale, $F(1, 46) = 1.82$, $p > .05$; Readiness Ruler, $F(1, 46) = 0.24$, $p > .05$; education, $F(1, 46) = 3.38$, $p > .05$; ethnicity, $F(1, 46) = 2.97$, $p > .05$; age, $F(1, 46) = 2.81$, $p > .05$.

Children's Groups

A series of 2 (treatment) x 2 (time) repeated measures analyses revealed main effects for state of emotional well-being, $F(1, 46) = 7.00$, $p < .05$, $\eta^2 = .13$; peer conflict, $F(1, 46) = 4.97$, $p < .05$, $\eta^2 = .16$; family conflict, $F(1, 46) = 22.27$, $p < .05$, $\eta^2 = .43$; and self-esteem, $F(1, 46) = 7.87$, $p < .05$, $\eta^2 = .24$. No treatment interaction effects were revealed. Children in both treatment conditions reported decreases in family conflict and increases in state of emotional well-being, peer conflict, and self-esteem. Means and standard deviations at pre- and post-treatment are presented on Table 1.

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Table 1. Means and Standard Deviations Pretreatment and Posttreatment: Children's Measures

Time	Emotional barometer	Peer conflict	Family conflict	Self-esteem
Goal oriented				
Pretreatment				
M	4.25	2.33	2.73	1.36
SD	1.11	1.23	1.28	0.63
Posttreatment				
M	4.76	1.60	1.03	1.93
SD	1.41	0.74	0.43	1.27
Emotion focused				
Pretreatment				
M	4.48	2.23	2.71	1.31
SD	1.04	1.30	1.40	0.63
Posttreatment				
M	5.00	1.16	1.06	2.00
SD	1.22	0.86	0.42	1.22

Women's group: main effects. Repeated measures ANOVAs revealed overall time effects as well as treatment interaction effects for depression, $F(1, 44) = 12.02$, $p < .05$, $\eta^2 = .22$; family bonding, $F(1, 44) = 23.61$, $p < .05$, $\eta^2 = .35$; self-efficacy, $F(1, 44) = 20.23$, $p < .05$, $\eta^2 = .32$; readiness to decrease violence, $F(1, 44) = 23.61$, $p < .05$, $\eta^2 = .35$; women's report of readiness to make meaningful therapeutic change, $F(1, 44) = 11.10$, $p < .05$, $\eta^2 = .20$; and facilitators' report of readiness to make meaningful therapeutic change, $F(1, 44) = 13.59$, $p < .05$, $\eta^2 = .24$. Gains were found on all measures in the expected direction, such that women in both groups reported decreases in depression and increases in family bonding and self-efficacy. Increases were also reported for the readiness indicators, including readiness to decrease violence and increase both self-reported and facilitator-reported readiness to make meaningful therapeutic change.

Main and treatment interaction effects. Main and treatment interaction effects were revealed for family conflict with greater decreases reported in the goal-oriented intervention, $F(1, 44) = 28.75$, $p < .05$, $\eta^2 = .40$ (main); $F(1, 44) = 4.10$, $p < .05$, $\eta^2 = .09$ (interaction); and quality of social support with greater increases reported in the emotion-focused intervention, $F(1, 44) = 18.68$, $p < .05$, $\eta^2 = .30$ (main) and $F(1, 44) = 5.88$, $p < .05$, $\eta^2 = .12$ (interaction). These results suggest that participants in both groups demonstrated decreased family conflict and improved quality of social support; however, significantly

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greater reduction in family conflict was reported among women who participated in the goal-oriented intervention compared to those participated in the emotion-focused intervention, and significantly greater increases in social support was reported among women who participated in the emotion-focused intervention compared to those who participated in the goal-oriented condition. These findings suggest that the specific treatments result in predicted outcome and lend support to the importance of tailoring interventions to meet needs of individual women following exposure to IPV.

Alcohol Use Variables

Main effects were revealed for self-efficacy for discontinuing alcohol use, $F(1, 46) = 4.29$, $p < .05$, $\eta^2 = .09$, and readiness to change alcohol consumption, $F(1, 46) = ,13.32$ $p < .05$, $\eta^2 = .23$. However, both main, $F(1, 46) = 76.18$, $p < .05$, $\eta^2 = .63$, and treatment effects, $F(1, 46) = 5.00$, $p < .05$, $\eta^2 = .10$, were revealed for the women's reports of current alcohol use. The findings suggest that women in both treatments reported increased self-efficacy for discontinuing alcohol use and increased readiness to change alcohol consumption. Beyond that, the women in the goal-oriented group reported a decrease their use of alcohol pre- to post-group intervention. Means and standard deviations at pre- and post-treatment for all women's study variables are presented on Table 2.

Discussion

Findings indicate gains on all measures in expected directions. Children in both groups reported decreases in family and peer conflict and increases in state of emotional well-being and self-esteem. Women in both groups reported decreases in depression and increases in family bonding and self-efficacy. Gains were also reported for the readiness indicators, including increases in readiness to decrease violence and increases in both self-reported and facilitator-reported readiness to make meaningful therapeutic change.

In addition to these main effects, some key variables yielded both main and treatment interaction effects among women participants. Women in both groups demonstrated decreased family conflict and improved quality of social support; however, significantly greater decreases in family conflict were reported among goal-oriented participants and significantly greater increases in social support were reported among emotion-focused participants. Similarly, main and interaction effects also were revealed for reported alcohol use. Women in both treatments reported increased self-efficacy for discontinuing

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Table 2. Means and Standard Deviations at Pretreatment and Posttreatment: Women's Measures

Time	Family conflict	Family bonding	Quality of social support	Depression	Self-efficacy
Goal oriented					
Pretreatment					
M	2.80	1.66	0.73	3.60	3.17
SD	0.95	1.89	0.88	0.54	0.48
Posttreatment					
M	1.14	3.34	2.21	3.09	3.45
SD	1.44	0.99	0.68	0.80	0.64
Emotion focused					
Pretreatment					
M	2.14	2.48	1.00	3.62	3.34
SD	1.10	1.81	1.56	0.60	0.37
Posttreatment					
M	1.39	3.63	2.92	3.37	3.76
SD	1.21	0.86	0.43	0.85	0.58

Time	Readiness confidence ruler: alcohol	Readiness confidence ruler: violence	Readiness confidence ruler: therapeutic change	Self-efficacy: alcohol use	Alcohol use
Goal oriented					
Pretreatment					
M	10.69	10.41	6.86	4.25	2.03
SD	0.44	0.73	3.99	1.49	0.58
Posttreatment					
M	10.34	3.82	8.18	4.84	0.55
SD	0.37	5.18	3.53	1.68	0.74
Emotion focused					
Pretreatment					
M	10.79	9.17	7.46	4.57	1.80
SD	0.33	3.62	3.91	1.16	0.35
Posttreatment					
M	10.01	5.17	8.42	5.48	0.92
SD	0.32	5.29	3.40	1.62	0.77

alcohol use and increased readiness to change alcohol consumption. However, only women in the goal-oriented group reported a significant decrease in their reported use of alcohol. This suggests that, in contrast to emotion-focused group participants, goal-oriented participants realized their aspirations for not drinking.

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The methodological design is important to consider in contextualizing these findings. Alternative treatments (i.e., active treatment controls) were employed in favor of no treatment control or wait list control. The control condition selected for this experimental design is the most ethically responsive, given the high needs and transient nature of the population. The group therapy modality employed across interventions likely contributed to the overall positive results revealed by the main effects. Yalom's common therapeutic factors—cohesion, universality, instillation of hope, and so forth—inherent in the group modality may be primarily responsible for shared curative effects across the two treatment modalities (Yalom & Leszcz, 2005). As such, common therapeutic factors are just as likely as the specific treatment approaches to account for treatment effectiveness for shared gains across the two treatments. However, the common factors argument does not account for treatment specific findings, which were theoretically consistent with the given intervention employed. Specifically, women participants in the goal-oriented group reported significantly greater decreases in alcohol use and realizing personal goals to decrease use, compared to those in the emotion-focused group. Those in the emotion-focused compared to the goal-oriented group reported significantly greater increases in social support, pointing to the social support benefits of emotion-focused interventions. These differential findings are treatment driven and thus provide substantial evidence (i.e., assay sensitivity) supporting the validity of the control conditions employed within this experimental design.

As previously mentioned, measures were selected in collaboration with the PAR team that included family homeless shelter service providers and residents who themselves had been exposed to IPV and were mothers of children who had witnessed domestic violence (Kidd & Kral, 2005). Based on the vulnerability of their children exposed to IPV, the PAR team strongly urged that assessment of child participants be kept to a minimum. Selection of short measures for the child participants is supported by literature addressing internal and external consequences to children following domestic violence exposure (Evans, Davies, & DiLillo, 2008). Specifically, children in transition from postviolence exposure may answer long instruments with less accuracy and reliability, secondary to compromised attention and concentration. Further rationale for the use of single-item measures was based on measurement studies revealing high correlations between single-item and multiple-item measures. Specifically, high correlations were found for single-item versus multiple-item measures of attitudes, beliefs, and perceptions (Gardner, Cummings, Dunham, & Pierce, 1998), depression, symptom severity, psychosocial depression, cognitive and social impairment due to

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depression, and quality of life (Zimmerman et al., 2006). In addition, a high correlation was revealed comparing the Rosenberg Self-Esteem Scale with a single-item measure of self-esteem (Robins, Hendin, & Trzesniewski, 2001). Although these studies involve measures designed for use with adults, they provide some evidence for the reliability and validity of single-item self-report measures in clinical the evaluation of outcomes.

All measures for the adult women participants consisted of multiple items, with the exception of the Readiness Ruler, designed specifically as a single-item measure for use in practice to empirically assess clinical effectiveness. Selection of this theory-driven measure was purposeful, given the goal-oriented intervention's emphasis on the construct of per the transtheoretical model (Miller & Rollnick, 2002). This single-item, multiple-choice format yielded a correlation of .91 for stage classifications between single-item and multiple-item ratings of the same construct (Cook & Perri, 2004).

Multifaceted Interventions Following IPV Exposure

Results of this study suggest that both the emotion-focused and goal-oriented programs investigated hold some promise for reducing negative outcomes following IPV exposure among women and their children. Regarding the children's data, gains were found on all measures in the expected direction for children regardless of the treatment group to which they were assigned. Specifically, children in both groups reported increases in state of emotional well-being, peer conflict, self-esteem, and reduced family conflict. Child participants fundamentally responded in positive ways to both interventions. The results of this study are congruent with studies that demonstrate the efficacy of family-based interventions involving the child with his or her mother following IPV (Graham-Bermann et al., 2007). These multicomponent approaches involving mothers together with children have found greater success in improving attitudes about violence and reducing aggression among children after IPV exposure (Graham-Bermann et al., 2007; Kumpfter & Alvarado, 2003).

Considerations in Interventions Following IPV Exposure

Considering that 60% to 65% of change within psychotherapy occurs within initial (first-seventh) sessions, with only an additional 5% to 10% increase in therapy outcomes after 6 months and an additional 5% to 10% increase after a year of therapy (Miller, Duncan, & Hubble, 2004) points to the importance of practice guided by outcome research. This is particularly the case with

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transient populations, such as women and children who have survived IPV. The differential outcomes of the two interventions studied provide a basis for a defined or tailored approach to meet unique presenting needs of women following exposure to IPV.

Previous research examining the relationship between substance use and family violence calls for integrated approaches to addressing concomitant family violence and alcohol issues (Bennett & O'Brien, 2007; McWhirter, 2007). These studies suggest that women engage in substance use as a non-adaptive mechanism to self-regulate fluctuations in mood and to avoid psychological distress associated with victimization. By way of example, after 6 months of coordinated services for women with co-occurring substance abuse and intimate partner victimization, women who reported decreased substance use simultaneously reported higher self-efficacy and increased fear of realistic consequences of domestic violence (Bennett & O'Brien, 2007). Frequency and severity of use may go underreported in an attempt to protect against loss of child custody, potentially limiting therapists' ability to address these issues meaningfully. This is a complex interplay of family conflict and substance use issues. Based on preliminary findings of the current study, practitioners may wish to consider goal-oriented approaches when intervening among women experiencing concomitant substance use and family violence.

Other women may be deeply affected by isolation, a mechanism utilized by abusers to maintain power and control over their partners in perpetuating the cycle of violence. These women may experience long periods of physical seclusion and emotional loneliness as a part of their IPV experience. Women presenting with these concerns or those who self-isolate as a form of non-adaptive coping may benefit from immediate interventions that emphasize emotion-focused group therapies.

The multiplicity of concerns and symptoms experienced by women and children subsequent to IPV exposure demands further development and research involving effective practice-based community interventions designed to better meet the needs of this high-risk population. Investigations of evidenced-based interventions for women and children exposed to IPV are in beginning stages of development (Graham-Bermann et al., 2007). Previous studies reveal the effectiveness of comprehensive family approaches that incorporate interventions for child and parent together (Kumpfer & Alvarado, 2003; Serketich & Dumas, 1996) and of family interventions (involving the child and mother together in therapy) over child-only therapy (Graham-Bermann et al., 2007). It is hoped that the current study provides a contribution to this emerging field by contextualizing coping strategies in IPV treatment for women and their children.

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Appendix

CONSORT Statement 2001—Checklist ✓

Items to include when reporting a randomized trial

PAPER SECTION And topic	Item	Descriptor	Reported on Page #
TITLE & ABSTRACT	1	How participants were allocated to interventions (e.g., "random allocation", "randomized", or "randomly assigned").	1, 2
INTRODUCTION Background	2	Scientific background and explanation of rationale.	3-5
METHODS Participants	3	Eligibility criteria for participants and the settings and locations where the data were collected.	5-6
Interventions	4	Precise details of the interventions intended for each group and how and when they were actually administered.	6-10
Objectives	5	Specific objectives and hypotheses.	4
Outcomes	6	Clearly defined primary and secondary outcome measures and, when applicable, any methods used to enhance the quality of measurements (e.g., multiple observations, training of assessors).	10-14
Sample size	7	How sample size was determined and, when applicable, explanation of any interim analyses and stopping rules.	5
Randomization—Sequence generation	8	Method used to generate the random allocation sequence, including details of any restrictions (e.g., blocking, stratification)	6
Randomization—Allocation concealment	9	Method used to implement the random allocation sequence (e.g., numbered containers or central telephone), clarifying whether the sequence was concealed until interventions were assigned.	6
Randomization—Implementation	10	Who generated the allocation sequence, who enrolled participants, and who assigned participants to their groups.	6
Blinding (masking)	11	Whether or not participants, those administering the interventions, and those assessing the outcomes were blinded to group assignment. If done, how the success of blinding was evaluated.	6

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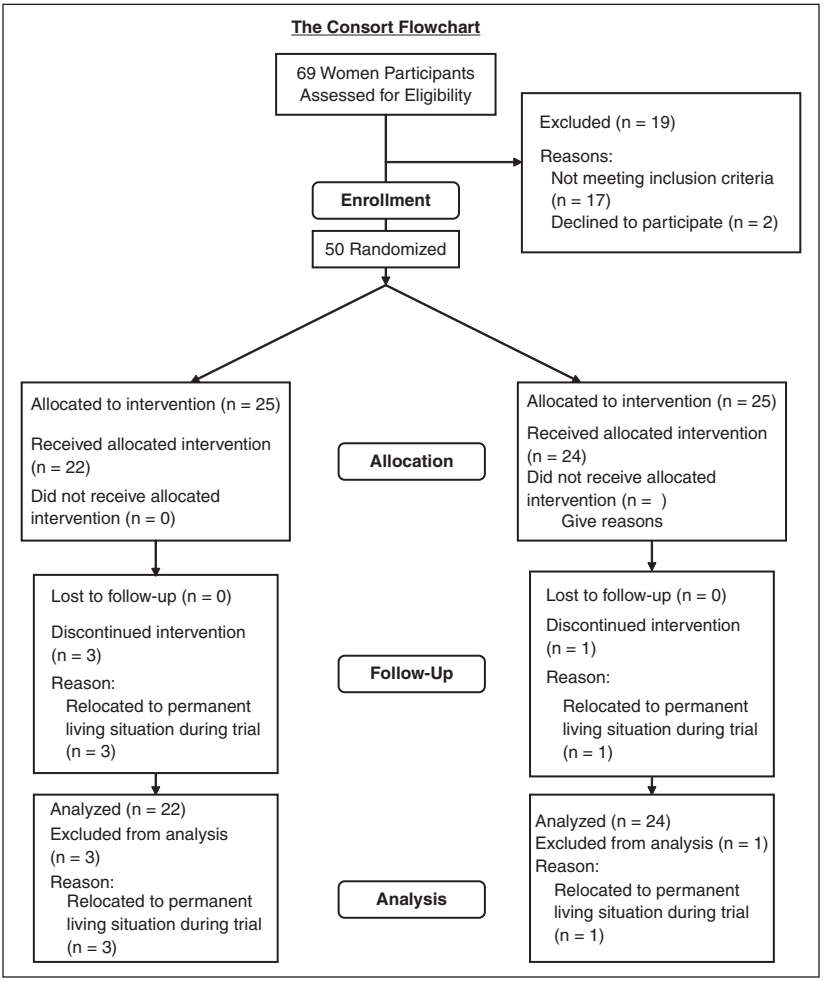
Appendix (continued)

PAPER SECTION And topic	Item	Descriptor	Reported on Page #
Statistical methods	12	Statistical methods used to compare groups for primary outcome(s); methods for additional analyses, such as subgroup analyses and adjusted analyses.	15-17
RESULTS Participant flow	13	Flow of participants through each stage (a diagram is strongly recommended). Specifically, for each group report the numbers of participants randomly assigned, receiving intended treatment, completing the study protocol, and analyzed for the primary outcome. Describe protocol deviations from study as planned, together with reasons.	37
Recruitment	14	Dates defining the periods of recruitment and follow-up.	7
Baseline data	15	Baseline demographic and clinical characteristics of each group.	5-6, 15
Numbers analyzed	16	Number of participants (denominator) in each group included in each analysis and whether the analysis was by "intention-to-treat." State the results in absolute numbers when feasible (e.g., 10/20, not 50%).	15
Outcomes and estimation	17	For each primary and secondary outcome, a summary of results for each group, and the estimated effect size and its precision (e.g., 95% confidence interval).	35
Ancillary analyses	18	Address multiplicity by reporting any other analyses performed, including subgroup analyses and adjusted analyses, indicating those prespecified and those exploratory.	15
Adverse events	19	All important adverse events or side effects in each intervention group.	15
DISCUSSION Interpretation	20	Interpretation of the results, taking into account study hypotheses, sources of potential bias or imprecision, and the dangers associated with multiplicity of analyses and outcomes.	18-24
Generalizability	21	Generalizability (external validity) of the trial findings.	20-21
Overall evidence	22	General interpretation of the results in the context of current evidence.	23-24

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Appendix (continued)



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Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the authorship and/or publication of this article.

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Bio

Paula T. McWhirter, PhD, is a professor of counseling psychology in the Department of Educational Psychology at the University of Oklahoma. She researches the efficacy and effectiveness of counseling interventions for children, youth, and family across settings and cultures. She has authored grants, resulting in more than half a million dollars in funding, to investigate the efficacy of services provided to children and families who have experienced domestic violence and chemical dependency. She is a Fulbright scholar and completed her dissertation on intervention strategies with high-risk youth while working at a school-based community mental health center in Santiago, Chile. She completed her masters and doctoral degrees in counseling psychology from Arizona State University. She holds postdoctoral fellowships in statistics and research methodology from the National Institute of Drug Abuse Research Center at the University of California at Los Angeles and in clinical neuropsychology at Good Samaritan Regional Medical Center in Phoenix, Arizona. She has served as adjunct faculty in the counseling and clinical psychology programs at Arizona State University and at the University of Notre Dame. Prior to accepting her current position at the University of Oklahoma, McWhirter served as clinical director for a comprehensive provider of behavioral health services for more than 1000 Medicaid eligible children and their families, directing all aspects involving clinical policies, objectives, and initiatives and providing counseling consultation and supervision.

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