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**Children Exposed to Domestic Violence:**

**Prevention Approaches with Mothers and Fathers**

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Children Exposed to Domestic Violence:

Prevention Approaches with Mothers and Fathers

Over the last two decades researchers, policy makers and practitioners have increasingly recognized that exposure to domestic violence may disrupt children’s experiences of consistent safety and care, and this disruption can lead to serious developmental difficulties, including emotional and behavioral problems and academic difficulties (Gewirtz & Edleson, 2007; Skopp, McDonald, Jouriles, & Rosenfield, 2007; Turner, Finkelhor & Omrod, 2006; Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006; Carlson, 2000; Scheeringa & Gaensbauer, 2000; Fantuzzo, Brouch, Beriama, & Atkins, 1997). Consequently, social interventions to help alleviate the traumatic effects of exposure to domestic violence on children are expanding (see Edleson, 2006; Groves, 2002; Lieberman & Van Horn, 2005; http://www.thegreenbook.info/). In this chapter the protective and risk factors that affect how children respond to adult domestic violence exposure are first examined. The focus is then on universal, selective and indicated prevention strategies aimed at minimizing risk factors and maximizing protective factors for children, with a specific focus on the role of parents.
Understanding Child Exposure to Domestic Violence

Defining Domestic Violence

The American Psychological Associations (APA) Taskforce on Male Violence Against Women defined interpersonal violence as, “Physical, visual, verbal, or sexual acts that are experienced by a woman or a girl as threat, invasion, or assault and have the effect of hurting her or degrading her and/or taking away her ability to control contact (intimate or otherwise) with another individual” (Koss, Goodman, Browne, Fitzgerald, Keita & Russo, 1994, p.xvi). One subcategory of interpersonal violence is relationship or domestic violence defined as “committed by one partner against the other in a relationship” (APA Intimate Partner Abuse and Relationship Violence Working Group, 2002). Note that Intimate Partner Violence (IPV) is the preferred, more precise terminology of the Centers for Disease Control and Prevention, recognizing that within the domestic setting there can also be child abuse, elder abuse, and animal abuse as forms of violence. For purposes of this chapter, the terms DV and IPV can be considered synonymous.

In recent years, there has been great debate about the relevance of gender to conceptualization of domestic violence, with some concluding that there exists “gender symmetry” in the experience of domestic violence in intimate relationships, i.e. that men’s experiences of violence in the domestic setting are the same as women’s (e.g. Dutton & Nicholls, 2005). However, as Hamby (2009) has pointed out, men commit over 90% of sexual violence, create higher levels of fear in their partners and injure and
murder their partners at much higher rates than do women. This is not to say that women do not commit violent acts against their partners, it is however at a much lower rate than men and appears to be less severe (Hamby, 2009). Stanko (2006, p. 549) identifies gender as vitally relevant to how domestic violence is conceptualized, spoken of, and challenged, noting that, “To lose sight and insight by ignoring how gender matters impoverishes any analyses of violence.”

Thus, in this chapter the focus is on the impact of domestic violence used by men against women but recognizing that a child’s exposure to any violence may have detrimental effects on his or her current physical and mental health as well as the child’s long-term development.

Defining Exposure

Several different terms have been used to define children’s exposure to adult domestic violence. The terms “witnesses” or “observers” of violence have frequently been used (Fantuzzo & Mohr, 1999; Kitzmann et al, 2003) but these terms are being replaced with an expanded terminology referring to child “exposure” to domestic violence. Exposure usually refers to a wide variety of experiences of children in homes where one adult is using violent actions to control another adult (Edleson, 2006; Fantuzzo & Mohr, 1999). For example, Kitzmann et al. (2003) expand the definition of witnessing violence to include hearing the violence and observing the aftermath of abuse, for example, bruises on their mother’s body or movement to a shelter. In some instances of exposure, children may respond by becoming
involved in the violent incident. Child involvement may vary from becoming actively involved in the conflict to distracting him or herself and the parents (Garcia O’Hearn, Margolin, & John, 1997; Peled, 1998). For example, children in homes in which violence was occurring were nine times more likely to verbally or physically intervene in parental conflicts than comparison children from homes in which no violence occurred (Adamson & Thompson, 1998). Similarly, based on the reports of 111 battered mothers, Edleson et al. (2003) found that 36% of the children frequently or very frequently yelled to stop violent conflicts, 11.7% frequently or very frequently called someone for help during a violent event, and 10.8% frequently or very frequently physically intervened to stop the violence.

In this chapter, child exposure will refer to this expanded range of child experiences. Exposure will be considered seeing, hearing and becoming involved in the violent incidents as well as experiencing the multiple events that both lead up to and follow violence in homes.

**Incidence of Exposure**

A 2008 national survey of 4,549 children ages birth to 17 found that 6.2% of American children were exposed to DV in the past year. The same survey found 16.3% of children of all ages were exposed to DV since birth but when asking older children with more life experience - those 14 to 17 years of age - over a third (34.6%) reported they were exposed to DV in their lifetime (Finkelhor, et al., 2009).

A study of police responses to DV in five U.S. cities found that younger children are more likely to be present than older children when police arrive at homes where DV
Children exposed to domestic violence may also be direct victims of physical and sexual maltreatment. Reviews examining the co-occurrence of documented child maltreatment and adult domestic violence revealed a 41% median co-occurrence of child maltreatment and adult domestic violence (Appel & Holden, 1998) with the majority of studies finding a 30% to 60% overlap (Edleson, 1999; Holden, 2003; Lee, Kotch, Cox 2004; McGuigan & Pratt, 2001).

It appears that large numbers of children are exposed to domestic violence each year and over their lifetimes which raises a question about the impact of this exposure on their child and adult development.

**Impact of Child Exposure**

Children can be harmed by exposure to violence even when they are not themselves direct targets of physical or sexual violence (e.g., Carlson, 2000; Rossman, Hughes, & Rosenberg, 2000). The co-occurrence of child exposure to domestic violence and other detrimental experiences like direct child maltreatment gives rise to a methodological challenge of separating out the impact of domestic violence exposure; many noted associations are thus
correlational and not established as direct effects of domestic violence exposure. Studies of children who are both victims of violence and exposed to parental violence show that each experience uniquely and independently contributes to behavior problems (Litrownik, Newton, Hunter, English & Everson, 2003). Children’s experiences and expectation of consistent safety and care may be disrupted and replaced by an environment characterized by instability and vulnerability (Gewirtz & Edleson, 2007). This disruption can lead to serious developmental difficulties, including emotional and behavioral problems and academic difficulties (Skopp, McDonald, Jouriles, & Rosenfield, 2007; Turner, Finkelhor & Omrod, 2006; Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006; Carlson, 2000; Scheeringa & Gaensbauer, 2000; Fantuzzo, Brouch, Beriama, & Atkins, 1997).

The impact of exposure to adult domestic violence has been well documented (see Edleson, 2006; Ehrensaft et al., 2003; Fantuzzo & Mohr, 1999; Jouriles et al., 1996; Kitzmann et al., 2003; Margolin & Gordis, 2004). The frequency of adult domestic violence in a home is highly associated with children’s behavioral problems, including externalizing behavior such as aggression and disobedience, and internalizing behavior such as depression, sadness and lack of self-confidence (Jouriles et al., 1996). In general, children exposed to domestic violence demonstrate lower cognitive functioning (Rossman, 1998) and reduced skills for resilience, including lower capacity in the areas of social competence, problem solving, autonomy and self-efficacy (Appel & Holden, 1998; Graham-Bermann & Edleson, 2001). In a review by Margolin and Gordis (2004), the consequences of being exposed to violence in a child’s home included both short- and long-term impacts on the child. Short-term impacts included aggression and
delinquency; emotional and mood disorders; posttraumatic stress symptoms such as exaggerated startle, nightmares, and flashbacks; health-related problems and somatic symptoms such as sleep disturbances; and academic and cognitive problems. Long-term impacts included an increased likelihood that a child will become either a victim or perpetrator of aggression later in life.

Overall, meta-analyses by Kitzmann, Gaylord, Holt, and Kenny (2003), Wolfe, Crooks, Lee, McIntyre-Smith, and Jaffe (2003) and Evans, Davies and DiLillo (2008) drawing from two decades of studies have shown children exposed to domestic violence exhibit significantly worse social and behavioral problems than children not so exposed, but the size of this effect is relatively small ($Z_r = .28$ in Wolfe et al., 2003). Exposed children were not, however, significantly different than children who were physically abused or who were both physically abused and exposed to violence (Kitzmann et al., 2003).

The harm of exposure to domestic violence begins even prior to birth. Estimates of the prevalence of violence against pregnant women vary widely. In an early review, Gazmararian, et al. (1996) synthesized findings across studies from 1963 to 1995 and found prevalence rates ranging from 0.9% to 20.1%. Campbell (2002) cited previous year prevalence estimates of 2.5% of pregnant women in the UK, 6% in Canada, 7% in South Africa, and 11% in Sweden. Violence that occurs during pregnancy can be seen as a form of exposure for the developing fetus because domestic violence during pregnancy causes harm not only to the woman being abused, but also to her baby. Among the potential consequences of violence during pregnancy are low birth weight
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(Campbell et al., 1999; Curry & Harvey, 1998; Fernandez & Krueger, 1999; Bullock & McFarlane, 1989; Parker, McFarlane, & Soeken, 1994; Rosen, Seng Tolman, & Mallinger, 2007; Sharps, 2007, Renker, 1999), premature labor (El Kady, Gilbert, Xing & Smith, 2005; Cokkinides, Coker, Sanderson, Addy & Bethea, 1999; Fernandez & Krueger, 1999; Shumway et al., 1999), miscarriage (Morland et al, 2008; Rachana, Suraiya, Hisham, Abdulaziz, & Hai, 2002; Jacoby, Gorenflo, Black, Wunderlich, & Eyler, 1999), fetal trauma (Connolly, Katz, Bash, McMachon & Hansen, 1997; Berrios & Grady, 1991), and fetal death (Webster et al., 1996). Additional studies confirm a positive association between domestic violence during pregnancy and delayed prenatal care (Dietz et al., 1997; Goodwin et al., 2000) and substance abuse (Bailey, 2007) which may increase risk for negative pregnancy outcomes. Physical and psychological abuse during pregnancy is also associated with increased risk of postpartum depression (Tiwari et al., 2008; Espinosa & Osborne, 2002), decreased breastfeeding (Lau and Chan, 2007; Silverman et al., 2006) and increased substance abuse, all of which may also confer subsequent risk for children (Kendall-Tackett, 2007).

Recent research on child exposure to trauma indicates that exposure to violence in childhood alters brain development and, particularly, that the abnormalities are more prominent if the traumatic exposure is early in life, severe and chronic (Perry, 2001). Young children’s exposure to domestic violence is thus particularly concerning because of the neurobiological changes that may occur and shape lifelong development and capacities. Specifically, traumatizing experiences may over-stimulate the neural pathways that control the fear response, leaving children in an ongoing heightened
state of fear or anticipation, even in the absence of traumatizing stimuli. Importantly, child physiology can rebound to relatively normal levels with restorative experiences. For example, reestablishing regular routines helps children to feel safe and promotes recovery (Blaufarb & Levine, 1972; Gordon & Wraith, 1993; Prinstein, LaGreca, Vernberg, & Silverman, 1996; Terr, 1994; Vogel & Vernberg, 1993).

Approximately half of children exposed to domestic violence are in the clinical range of internalizing behavioral problems (e.g., depression, anxiety, withdrawal) and externalizing behavioral problems (e.g., aggressive or delinquent behavior, impulsivity, hyperactivity), many with overlapping diagnoses (Grych, Jouriles, Swank, McDonald, & Norwood, 2000; McFarlane, Gross, O’Brien, & Watson, 2003). However, Graham-Bermann (2000) points out that many exposed children show no greater problems than children not so exposed. Several studies (Grych et al., 2000; Hughes & Luke, 1998; Sullivan et al., 2000) found that approximately half of the exposed children studied appeared similar to non-exposed children on a variety of measures. Given these varying impacts, a logical question is how does the differential presence of both protective and risk factors in children’s lives moderate the impact of violence exposure on a child’s development?

**Patterns of Risk and Protection for Battered Mothers and Their Children**

In examining how mothers may provide protection from or contribute to the risk their children experience from exposure to domestic violence, a number of factors may be considered. Maternal depression, parenting stress and aggressive parenting have
been shown to elevate children’s risk for developing internalizing and externalizing symptoms.

Depression is a characteristic response of children to disruptions in their social environment (Farruggia, Greenberger & Chen, 2006; Dawson, Hessl & Frey, 1994), but the greatest risk factor predicting depression and internalizing symptoms in children exposed to domestic violence is maternal depression. The majority of women who experience domestic violence have diagnosable levels of depression (Campbell, 2002), and studies have found an intergenerational connection of parent and child depression (Todd & Botteron, 2001; Goodman & Gotlib, 1999). Jarvis and Novaco (2006) found an association between maternal depression and internalizing symptoms in children following their stay in a domestic violence shelter. Morrel et al. (2003) studied a population of primarily African American children aged 4-6 and their mothers and found that the mother’s own depression mediated the relationship between maternal victimization and maternal reports of children’s internalizing symptoms. Similarly, Levendosky and Graham-Bermann (2001) found that maternal mental health predicted the adjustment of violence-exposed children. Jones, Forehand and Neary (2001) studied a diverse sample of children over the course of a two-year period and also found that maternal levels of depression prospectively predicted children’s development of depressive symptoms regardless of the quality of the parenting relationship.

Parenting effectiveness, including particularly the ability to parent well through stressful family circumstances, is a protective factor for children exposed to domestic violence. Mothers who reported lower levels of parenting stress and higher levels of
mastery reported that their children had significantly lower levels of externalizing behavior problems (Kalil, Tolman, Rosen & Gruber, 2003). Similarly, Boney-McCoy and Finkelhor (1996) found that strong parent-child relationships mitigated the effects of exposure to violence on children, though effects were not eliminated. Levendosky and Graham-Bermann (2001) reported that greater parenting effectiveness reduced the negative effects of violence on children’s internalizing and externalizing behavior problems. A series of other studies also found a connection between family conflict and child problems (see, for example, Rice, Harold, Shelton & Thapar, 2006; Morrel et al., 2003; Katz & Low, 2004).

**Patterns of Risk and Protection for Abusive Fathers and Their Children**

More data are available on battered mothers and their caregiving than on perpetrators and theirs. Unfortunately, at times the overreliance on data collected from and about battered mothers may lead to partial or inaccurate conclusions. For example, it may be that the perpetrator’s behavior is the key to predicting the emotional health of a child. By not collecting data about the perpetrators, we may incorrectly conclude that it is the mothers’ problems and not the perpetrators’ violent behavior that is creating negative outcomes for the children.

Several studies show that violent men directly impact the parenting of mothers. For example, Holden et al. (1998) found that battered mothers, when compared to other mothers, more often altered their parenting practices in the presence of the abusive male. Mothers reported that this change in parenting was made to minimize the men’s irritability. A survey of 95 battered mothers living in the community (Levendosky,
The relationship between the child and the adult perpetrator also appears to influence how the child is affected by exposure. A study of 80 mothers residing in shelters and 80 of their children revealed that an abusive male’s relationship to a child directly affects the child’s well-being, without being mediated by the mother’s level of mental health (Sullivan et al., 2000). Violence perpetrated by a biological father or stepfather was found to have a greater impact on a child than the violence of non-father figures (such as partners or ex-partners of the mother who played a minimal role in the child’s life).

Some research suggests that men who batter may be more likely to use negative child-rearing practices and less likely to use positive parenting (Holden & Ritchie, 1991; Fox and Benson, 2004). There is mixed evidence about whether they spend less time with their children. Holden & Ritchie (1991) and Sternberg, Lamb, Greenbaum, Dawud, Cortes & Lorey (1994) found abusive men were less involved with their children, but Fox and Benson (2004) found they did not differ from other fathers in time spent with their children. Abusive men may display more negative affect and anger towards their children (Holden, Stein, Ritchie, Harris & Jouriles, 1998; Margolin, John, Ghosh & Gordis, 1996). For example, in an observational study, Margolin and John (1997) found that men
who were abusive towards their partners were less supportive, warm and nurturing and used more power assertion towards their children.

It cannot be assumed that separation from an abusive father will end violence against the mother or mitigate the negative effects of children’s exposure to that violence. Domestic violence frequently continues after separation (Hardesty, 2002; Jaffe, Lemon, & Poisson, 2002; Fleury, Sullivan and Bybee, 2000; Liss & Stahly, 1993). Continuing threats and violence towards mothers can be a factor in child visitation (Sheeran & Hampton, 1999, Leighton, 1989). For example, Saunders, Sullivan, Tolman and Grabarek (2008) found that 43% of mothers involved in supervised visitation reported continued direct contact with their ex-partners, even though such contact was prohibited. Over a one-month period, of those who did not want this direct contact, 33% reported their ex-partners threatened them with violence or abuse, 61% reported threats involving their children, and 59% were stalked (Saunders, Sullivan, Tolman & Grabarek, 2008). Similarly, in an early Canadian study, one quarter of women reported threats by a perpetrator during child visitations (Leighton, 1989).

As Perel and Peled (2008) point out, the literature has generally focused solely on the negative aspects of batterers’ parenting. This tendency may obscure the potential for positive change that can prevent children’s subsequent exposure to violence and increase the probability of fathers’ positive influence upon their children’s well-being. Qualitative studies have begun to explore domestic violence perpetrators as fathers in richer detail. Interviews conducted by Fox, Sayers and Bruce (2001) revealed that recognizing the impact of their violence upon their children may motivate abusers
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Perel and Peled’s (2008) interviews with 14 men who were abusive toward their partners showed their attitudes toward parenting were basically positive, and that they worked toward being and considered themselves good fathers. However, they also identified constraints to their parenting, e.g. they believed their own experiences with their fathers did not properly prepare them for fatherhood.

This more complex picture of domestic violence perpetrators has also been supported by some quantitative research. Fox and Benson (2004), using U.S. national survey data, found domestic violence perpetrators spent as much time with their children and applied similar monitoring standards and actions as nonviolent men. However, as cited above, they also found that violent men were more likely to be punitive and less likely to use positive parenting behaviors when compared to non-abusive men. The promise of prevention strategies focused on violent fathers is explored later in this chapter.

Other Protective and Risk Factors

Additional protective and risk factors may impact the degree to which a child is affected by exposure. One likely factor that leads to differences in children’s experiences is the great variation in severity, frequency, and chronicity of violence. Other factors also play a role in children’s exposure and interact with each other creating unique outcomes for different children. For example, many children exposed to domestic violence are also exposed to other adverse experiences. In a study of 17,421 patients within a large health maintenance organization, Dube, Anda and their colleagues (Dube, Anda, Felitti, Edwards, & Williamson, 2002) found that increased
exposure to adult domestic violence in a child’s life was positively associated with increasing “adverse childhood experiences” such as exposure to substance abuse, mental illness, incarcerated family members and other forms of abuse or neglect. Problems associated with exposure vary based on gender and age of a child but not race or ethnicity (Carlson, 1991; Hughes, 1988; O’Keefe, 1994; Spaccarelli et al., 1994; Stagg, Wills, & Howell, 1989). For example, younger children appear to be more often present during domestic violence. Fantuzzo and colleagues (Fantuzzo, et al., 1997) examined data on police and victim reports of domestic assault incidents in five cities and found children ages 0 to 5 years were significantly more likely to be present during single and recurring domestic violence incidents. Interesting, the longer the period of time since exposure to a violent event also appears to be associated with lessening problems (Wolfe, Zak, Wilson & Jaffe; 1986).

**Summary**

The definitions of child exposure to domestic violence have expanded to include not just seeing but also hearing violence, becoming involved in violent events and experiencing additional events leading up to and following the outbreak of violence. Best estimates find millions of American children exposed to adult domestic violence in these varied ways every year. Research results suggest that such exposure may lead to negative behavioral, social and physiological developmental changes in a child’s life but that the effect of exposure is both moderated and mediated by a variety of risk and protective factors.
In this section, ways in which practitioners have addressed the needs of children exposed to adult domestic violence are reviewed, and how such exposure may be prevented in the first place is explored. There are many approaches to the prevention of domestic violence, prevention of children’s exposure to domestic violence, and intervention with exposed children, but the central focus here is on efforts that engage mothers or fathers and their children.

**Prevention Continuum**

A commonly accepted continuum of prevention (Chamberlain, 2008) includes *universal, selective,* and *indicated* prevention efforts. Prevention efforts with parents may be *universal*—aimed at improving parenting in the entire population and thus preventing domestic violence and exposure to it among other ills. Programs may alternatively be *selective* or targeted to parents at key transition points, for example, right before or after the birth of a child. Finally, programs may be *indicated*—directed to parents currently experiencing stressors such as domestic violence.

Little data exists on the effectiveness of programs at any of these prevention levels to reduce the exposure of children to domestic violence. Promising practices and what evidence does exist to support their adoption will be highlighted, and other possible preventive efforts will be considered where major gaps in existing services are identified.

[INSERT TABLE 1 HERE]
Universal Prevention Efforts

A key advantage of universal approaches to prevention is the large number of individuals who can be reached. Applied across a population, even an intervention that generates modest effects can have a widespread impact. Universal prevention programs involve changing social norms, behaviors, and policies that directly and indirectly contribute to domestic violence, and as such universal prevention is intrinsically part of a broad-based, long-term agenda. As the responsibility for violence prevention lies with the perpetrator, and mothers are more frequently the victims of domestic violence, the larger part of this discussion of universal prevention is dedicated to efforts focused on fathers.

Universal Prevention Programs. Universal prevention programs include both education and media programs. Education programs that can be considered primary prevention in the area of child exposure to domestic violence include both programs to promote positive parenting and programs to build relational skills such as effective communication and conflict management. Research demonstrates that parenting has a powerful effect on children’s well-being (for reviews, see Bornstein, 2002; Maccoby & Martin, 1983), that parenting can be improved through intervention programs (for reviews, see Brooks-Gunn, Berlin, & Fuligni, 2000; Brooks-Gunn, Fuligni, & Berlin, 2003; Brooks-Gunn, 2004), and that improving parenting contributes to enhanced outcomes for children (see review of meta-analyses of sensitivity and attachment interventions by Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003; also see studies by Barnett,
Universal parenting programs, by improving parenting practices and parental understanding of children’s developmental needs, can be seen as a mechanism for preventing child exposure to domestic violence. Brooks-Gunn and Markman (2005) note that parenting programs in the U.S. are typically targeted to poor families, and thus serve disproportionate numbers of minority families, whereas in several countries all new mothers receive a series of home visits after the birth of a child (Kamerman, 2000). Thus preventive effects of parenting programs are, on the whole, not distributed evenly across the population in the U.S.

Universal programs aimed at shifting beliefs and attitudes about violence and building communication and conflict resolution skills are another approach to preventing the onset of domestic violence and thus preventing child exposure. Several studies demonstrate the efficacy of school-based programs to prevent dating violence (e.g., Jaffe, Sudermann, Reitzel, & Killip, 1992; Weisz & Black, 2001; Wolfe et. al., 2003). Several longitudinal studies find that early conduct disorder/generalized violence predicts dating violence perpetration (Lavoi, et. al, 2002; Capaldi & Owen, 2001; Ehrensaft, et. al., 2003; Magdol, et. al., 1998; Brendgen, et. al, 2001), which suggests that prevention and intervention in the area of conduct problems can also be seen as preventive of dating violence.

There is little research on programs to prevent partner violence outside of school settings. One study of a community-based, communication and conflict management
skills program offered to couples planning to marry found that up to four years after program completion, participants reported better communication and less physical violence in their relationships compared to a control group; but by five year follow-up, the only lasting effect was in the area of men’s use of communication skills (Markman, Renick, Floyd, Stanley & Clements, 1993).

A number of promising community-based efforts in the U.S. to prevent domestic violence altogether (see, for example, Bowen, Gwiasda & Brown, 2004; Graffunder, et al., 2004; Mitchell-Clarke & Autry, 2004) have been discussed in the literature. In Australia, the state government of Victoria supports a state-wide media awards program aimed at influencing community attitudes toward violence against women by encouraging journalistic quality in the reporting and characterization of family violence (VicHealth, 2007).

**Universal Prevention with Mothers.** Victims of domestic violence do not bear responsibility for preventing the violence to which they are victim. Therefore, universal prevention with mothers builds awareness of personal rights within the context of a partner relationship, ability to recognize domestic violence, and knowledge of community resources. An example of such an effort was a collaboration with children’s museums across the U.S., the Ameriquest Mortgage Company and the Family Violence Prevention Fund that offered a program to "coach mothers in sound investments, encourage them to build and manage assets, and invest in their financial future...[The aim of the program is to reach out to mothers] in non-threatening settings and encourage their financial independence... [so that they] will have the tools they need to
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protect themselves and their children if family violence occurs" (FVPF, 2006). There is as yet no evidence to demonstrate benefits of this approach.

Programs of prenatal and infancy home visitation increasingly consider domestic violence prevention in comprehensive service provision (Olds, Hill, Mihalic, & O’Brien, 1998), and these are discussed elsewhere in this book.

Universal Prevention with Fathers. At the most universal level, numerous authors have noted that the conceptualization of fatherhood is changing (Marsiglio et al, 2000; Pleck and Pleck, 1997). Expectations for fathers’ roles seem to have shifted from ones emphasizing material support to more engaged roles. Fathers have probably benefited from this increased permission to develop close, emotionally satisfying relationships with their children, but a large gap remains between cultural support and clarity for fathers’ positive involvement with their children. Interventions that promote the positive involvement of fathers with their children may help to prevent both abuse of women and exposure of children to domestic violence. This is an emergent area of research and, to date, there exists limited evidence to support universal strategies targeting fathers. The authors are part of a team of researchers who are working to develop and test a series of interventions aimed at engaging expectant and new fathers in violence prevention. The project, titled the Global Research Program on Mobilizing Men for Violence Prevention, is a joint project of the Universities of Michigan, Minnesota and Washington (see http://www.mincava.umn.edu/mmvp/).

A number of efforts have emerged recently for engaging fathers in prevention of violence. Broadly construed, one approach has been to engage non-violent men as allies
to end domestic violence. These efforts can presumably help to reduce the risk of abuse by men who participate, but also change the culture that might support other men’s behavior. A number of authors have argued that male involvement in campaigns to end violence against women can undermine beliefs, attitudes and power relationships that support violence and transform the culture to support constructions of masculinity that lead to respectful and non-violent relationships with women (Crooks, Goodall, Baker & Hughes, 2006; Flood, 2005).

Crooks et al. (2007) have identified elements of universal prevention campaigns that are specifically directed towards fathers that can promote their effectiveness. First, programs should provide information to fathers that can help to improve their involvement and positive parenting participation. Second, campaigns should create motivation through group membership. Third, the campaigns should include specific skills that will help fathers take action.

The Family Violence Prevention Fund has sponsored two widely disseminated campaigns that contain these elements. The Founding Fathers campaign is aimed at recruiting men who explicitly denounce violence against women and children and promote a culture of respect by men towards women. One activity includes publishing an annual ad on Father’s Day in the New York Times demonstrating men’s concern about the issue of partner violence and soliciting additional participation by other men. An international registry of men who have supported the campaign is maintained. Participants are encouraged to take the campaign into their workplaces with brochures,
cards and other materials that can be distributed to raise awareness and engage others into joining the campaign.

Another prevention program developed by the Family Violence Prevention Fund is “Coaching Boys into Men”. It is a media campaign that uses public service announcements and other ads that promote the idea that men should deliver messages to boys that violence against women is unacceptable. A related program is the Coaching Boys Into Men leadership program for sports coaches that attempts to engage athletic coaches (many of whom are fathers themselves) into having conversations with their team members to promote respect for women and girls and erode support for violence as a defining characteristic of masculinity. The program distributes a “playbook” that provides a curriculum for presenting this information and finding teachable moments to promote these ideas. There is also a more structured weekly curriculum available and a newly developed Coaches’ Training Kit http://www.coaches-corner.org/. Coaches are encouraged to be involved in community outreach and other change efforts as well. Via a website, coaches have access to program materials and tips from fellow coaches on how to implement the program.

While formal evaluation of these programs has not been undertaken, FVP cites some support for the potential of such programs to influence public opinion and attitudes. A national telephone survey of 1,020 men, commissioned by the FVPF (Hart, 2007) demonstrated that a majority of men surveyed were aware of domestic violence as a problem (67% thought domestic violence was at least fairly common). Fifty-six percent believed they know someone who was involved in a domestic violence or sexual
assault situation, and 57% believed that they could make at least some difference in preventing domestic violence and sexual assault. Of fathers with children under 18, 64% said they could make at least some difference in prevention, and 83% believed they could promote healthy, respectful, nonviolent relationships among young people.

These survey findings point to the promise of primary prevention efforts to build upon men’s current beliefs and expand the number of men who believe that violence is a problem and that they can do something about it.

**Selective Prevention Efforts**

Selective prevention efforts target groups identified as being at elevated risk for becoming a victim or perpetrator of domestic violence. First selective prevention efforts with mothers will be discussed and then selective prevention efforts with fathers. Bridging the discussion of selective prevention with mothers and fathers, the period of pregnancy and new parenthood is identified as a critical time for targeted prevention with all parents.

**Selective Prevention by Screening Mothers in Healthcare Settings.** Although many victims of domestic violence do not seek treatment for acute injuries, many enter the healthcare system presenting with gynecological symptoms, gastrointestinal symptoms, or stress-related disorders (Campbell, 2002). These presenting problems are among a number of consistent, health-related risk markers exhibited by victims of domestic violence (Crowell & Burgess, 1996; Saunders, Hamberger, & Hovey, 1993). The consistency of these risk markers suggests an opportunity for medical professionals to selectively screen for domestic violence. Asking questions about violence can help to
identify new victims, assess the current level of safety of previously identified victims, and increase awareness of the problem of domestic violence among all patients.

Screening allows medical professionals to provide support and referrals to patients who reveal domestic violence, decreasing the likelihood of exposure of children to violence and reducing long-term health effects (Chrisler & Ferguson, 2006). Two studies have demonstrated that screening for domestic violence and providing a wallet-sized referral card to patients who report violence is associated with reduced physical violence over time compared to the level of violence reported at the time of the initial screening (McFarlane, Soeken, & Wiist, 2000; McFarlane, 2006). Research indicates that introducing protocols and screening tools, as many health care institutions have now done, increases identification and documentation rates of domestic violence in medical settings (Covington, et al, 1997; McLeer & Anwar, 1989; McFarlane, Parker, Soeken, & Bullock, 1992; McFarlane & Parker, 1994).

**Selective Prevention with Expectant and New Mothers.** When medical and other service providers meet with pregnant women, there is an opportunity to screen for domestic violence and to intervene if necessary to prevent the violence from occurring or progressing and to prevent subsequent child exposure to violence.

Macy et al. (2007) tracked physical, psychological and sexual abuse across the perinatal period. For women who had been physically abused prior to pregnancy, the first six months of pregnancy saw a sharp increase in risk for physical abuse. Importantly for prevention efforts, their results showed an increased risk of sexual and psychological abuse in the first month after birth, for women whose partners had not previously
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abused them either during pregnancy or before. Adolescent mothers are consistently at heightened risk for domestic violence, and at especially high risk for experiencing domestic violence during the postpartum period (Harrykissoon, Rickert, & Wiemann, 2002). Prevalence of violence was highest at three months' post partum (21%) and lowest at 24 months (13%); while 75% of mothers who reported violence during pregnancy also reported violence in the postpartum period, 78% of mothers who experienced violence during the first three postpartum months had not reported violence before delivery. These data point to the need for screening at multiple points since efforts aimed only at those known to be abusive prior to pregnancy would not be effective in preventing abuse that emerges postnatally.

Promising screening and violence prevention approaches integrated into existing services (such as home visiting programs and family planning programs) for women of childbearing age were recently identified (NACCHO, June 2008). Importantly, these programs screen for violence at least once during pregnancy and at least once during the postpartum period, as well as screening at times when a significant life change occurs (e.g., a death, job change, relationship change, or move). Screening rates have increased among those who receive home visiting services due to adoption of a shorter and more frequent screening protocol, and attention to sources of additional stress for families (NACCHO, June 2008). Another notable example is the Nurse-Family Partnership home visitation program. The program offers an array of services, and screening for domestic violence is embedded in an early, comprehensive risk assessment. Mothers-to-be who report domestic violence are provided with support
and referrals, and Olds et al. (2004) determined that two years after home visitation services had ended, nurse-visited women in Denver reported less domestic violence than comparison women who did not receive home visitation. However, a corresponding effect on domestic violence was not found in a study of women in Memphis, four years after cessation of home visiting services.

**Prevention with Expectant Fathers.**

As discussed above, preventing domestic violence during pregnancy is necessary for eliminating potentially harmful effects of exposure to the developing fetus during pregnancy and may also make subsequent violence exposure to infants and older children less likely as well. Men may have increased motivation for positive change during pregnancy and this may make efforts to prevent or stop domestic violence more effective. Additionally, this may be a key time to address issues such as positive partnering and parenting.

Despite these potentially beneficial outcomes, there do not appear to be any violence prevention programs specifically focused on expectant fathers that have established their efficacy through rigorous evaluations. However, other prevention efforts that have been used to promote positive transitions in this stage might be useful for reducing domestic violence as well. For example, parenting preparation might reduce stress which could increase the probability of subsequent partner or child abuse.
A number of efforts have, however, been developed to engage fathers who are at risk in various ways, e.g. adolescent fathers, unemployed, and those with a criminal history and some of these include expectant and new fathers among their targeted groups. One of the best known programs for fathers experiencing stressors is the Baltimore-based Responsible Fatherhood Program (Center for Urban Families, 2009). Participants in this program are primarily non-custodial fathers. Most are unemployed, have not graduated high school, and may have been involved in the criminal justice system and/or used illegal drugs. The program assists these low-income fathers with seeking employment, providing child support, steps to reduce recidivism, skills for effective parenting, and maintaining healthy relationships. While these fathers clearly are experiencing multiple stressors and have a number of risk factors, they do not participate in the program due to domestic violence or child abuse. However, BRFP actively works to identify domestic violence if it has occurred and motivate men to seek help for their abusive behavior if identified. They have established a cooperative relationship with a batterer intervention program at House of Ruth to provide cross-training and service referrals.

Another program that targets fathers at risk is the Con Los Padres program affiliated with the National Latino Fatherhood and Family Institute (NLFFI) of Bienvidios Family Services (Carillo & Tello, 2007; NLFFI, 2003). The program helps young and expectant fathers ages 16-25 to develop positive relationships with their children through 20 weekly classes. Case management services are available for young fathers who need additional support to develop appropriate interaction with their children. The
program screens for domestic violence and other forms of family and community

violence and can refer men to a more structured program that attempts to address
aggression. This aggression program is based on the principles of “Un Hombre Noble”- a
noble man. Un hombre noble is a man of “palabra” who keeps his word as the
foundation of respectful relationship with his children and others in his life. As the NLFFI
curriculum describes: “Through the process of sitting in a circle with other men who
collectively reflect the reality of their gifts and their baggage, men can begin to
acknowledge and accept that aggression and violence is not acceptable and realize it
causes irreparable damage to themselves and others” (NLFFI, 2003, p. cite, p. 43).

These programs in Maryland and California highlight the need for prevention
efforts to be culturally specific. This specificity may increase the probability of successful
engagement of fathers into the programs. Culturally specificity may also increase the
effectiveness of intervention by delivering messages that are more readily received by
participants but comparative studies are needed to confirm if these hypotheses are
correct.

These specific components aimed at mothers and fathers who are identified
through screening or already known to be aggressive towards family members or the
targets of such aggression leads to the final category of prevention, indicated efforts to
aid mothers, fathers and their children where domestic violence is known to have
occurred.

Indicated Prevention Efforts
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Chalk and King (1998) state that “In all areas of family violence, after-the-fact services predominate over preventive interventions...For domestic violence, interventions designed to treat victims and offenders and defer future incidents of violence are more common [than services aimed at prevention]” (p.291). In terms of intervening with children after intimate partner violence has already occurred, this indicated prevention may also be considered selective prevention, as it can reduce the possibility that those children will grow up to be perpetrators themselves. Children exposed as children are more likely to perpetrate intimate partner violence themselves as adults (Delsol & Margolin, 2004; Holtzworth-Munroe, Bates, Smutzler, & Sandlin, 1997). For example, Whitfield et al. (2003) found that, among 8,629 HMO patients studied, men exposed to physical abuse, sexual abuse and adult domestic violence as a child were 3.8 times more likely than other men to perpetrate domestic violence as adults.

Working with battered women and their children. As mentioned earlier, time away from violence was found to lessen the impacts of exposure (Wolfe, Zak, Wilson & Jaffe; 1986), thus providing a child and his or her primary caregiver with safe shelter and longer-term supports may end or limit future exposure and its negative impacts. Interventions for children exposed to domestic violence have been offered in shelters for over 30 years (Illinois Coalition Against Domestic Violence, 1996; New Jersey Coalition for Battered Women, 1992). Child-oriented programs recently have become more widespread in their availability in non-shelter, community settings, most often in the form of individual treatment for trauma (Groves, 1999; Silvern, Karyl, and Landis,
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Individual intervention with parent-child dyads (Van Horn, Best, and Lieberman, 1998), and separate group support and education programs for children and for their mothers (Graham-Bermann, 2000; Suderman, Marshall, and Loosely, 2000; Peled and Davis, 1995).

This section of the chapter will review evidence-based practices that have been found to improve outcomes for children exposed to domestic violence. Four specific intervention programs are reviewed about which much as been written. These intervention programs are seen as forms of indicated prevention in that they respond to exposed children but may also be view as primary prevention in that they may prevent exposure in the next generation of children.

*Child-Parent Psychotherapy.* Child-Parent Psychotherapy with Young Witnesses of Family Violence (CPP-FV) focuses on strengthening the parent-child relationship and repairing the damage done to the child’s developmental trajectory (Lieberman & Van Horn, 2005). CPP-FV is intended for early intervention, that is use with children five years old and younger, in situations where baseline physical safety has been established and domestic violence is not ongoing (Lieberman & Van Horn, 2005). Child-parent attunement is the bedrock of the treatment as CPP-FV views attachment as critical to both general healthy development and recovery from the trauma of exposure to domestic violence (Lieberman & Van Horn, 2005). The CPP-FV model integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach aimed at rebuilding the relationship between child and parent as well as restoring damage to the child's developmental and mental health.
progression incurred by the exposure to domestic violence. Treatment centers on three therapeutic goals: to improve the child-parent relationship, to help parent and child to more effectively modulate their feelings, and to help the parent better understand the child’s experience so that the parent can become more effectively protective (Lieberman & Van Horn, 2005). The CPP-FV model involves 12 months of weekly, hour-long, joint child-parent psychotherapy sessions. Typically sessions take place in an office playroom (in a clinical setting), but where it is safe, sessions may be held in the home.

Two studies have demonstrated the effectiveness of CPP-FV. Results of a study of 75 mother-child dyads, comparing the efficacy of CPP-FV with case management plus treatment as usual in the community, demonstrated significantly improved outcomes in the areas of children’s total behavior problems, traumatic stress symptoms, and diagnostic status, as well as mothers' avoidance symptoms, PTSD symptoms and general distress (Lieberman, Ghosh Ippen, & Van Horn, 2005). An investigation of the durability of improvement in maternal and child symptoms six months after termination of CPP-FV demonstrated the durability of effects on mothers’ general distress and children's total behavior problems (Lieberman, Ghosh Ippen, & Van Horn, 2006).

**Kids Club and Moms Parenting Empowerment Program.** The Kids Club and Moms Parenting Empowerment program is an intervention that includes both mothers who have experienced domestic violence and their children in treatment (Graham-Bermann, 1992; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007). The ten-session, manualized Kids Club intervention is described by Graham-Bermann (1992, 2007) as targeting children's emotional adjustment by addressing attitudes and beliefs
about families and violence, helping children to identify and process feelings associated with their experiences of violence, and enhancing children’s coping behaviors. Groups are age-graded and include boys and girls together. The program provides an environment for children to discover that they are not alone in their exposure to violence, to share their experiences, and to discuss the responsibility for and learn new strategies for coping with violence exposure. Activities designed to identify family strengths are incorporated, and only after relationships among group participants and leaders are well established do children’s group leaders allow for discussion of the specifics of violence in the family.

Concurrent with each children’s group, mothers meet in a separate group to share their experiences, concerns, and support related to parenting. Graham-Bermann & Levendosky (1992, 2007) describe the Moms Parenting Empowerment Program as a 10 session intervention based on goals of enhancing mothers’ social and emotional adjustment and improving mothers’ repertoire of parenting and disciplinary skills, and thereby reducing the behavioral and adjustment difficulties of their children.

An efficacy trial compared child-only intervention, child-plus-mother intervention, and a wait list, treatment as usual comparison group (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007). Participants consisted of 181 children ages 6-12 and their mothers exposed to domestic violence during the preceding year. Children showed the greatest improvement over time when the child and mother both participated in the intervention. Improvements were demonstrated for all three
measured outcomes: internalizing behavior problems, externalizing behavior problems, and change in attitude and beliefs.

*Child Witness to Violence Project.* The Child Witness to Violence Project (CWVP) at Boston Medical Center provides trauma-focused clinical intervention to children eight years old and younger who have been exposed to violence in their family or community. CWVP addresses disrupted attachment between parent and child, conflict between parent and child, parental lack of understanding of the impact of trauma on children, trauma associated with being a victim of domestic violence, and particularly maladaptive symptoms in the child (e.g. aggression, sleep disturbances, learning difficulties, and difficult peer relationships) (Groves & Gewirtz, 2006). Groves and Zuckerman (1997) identify three focal points in the work of CWVP: (1) reestablishing a sense of order and routine in the home, (2) explaining violent events to children, and (3) responding to children’s fears and worries in an honest and reassuring manner.

Principles of Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, et al.) and Child-Parent Psychotherapy (Lieberman, Van Horn, et al.) are integrated in the intervention model. CWVP recommends weekly sessions of 1-1.5 hours for at least five months (Groves, 2002). Services are typically offered in an outpatient clinic but in some cases home-based, and services are offered in English or Spanish.

Along with individual child psychotherapy and dyadic therapy, the intervention provides parent guidance, case management and advocacy. CWVP works in collaboration with domestic violence, law enforcement, child protection, and other community agencies to help families to secure safety, and receives referrals from
throughout the community. The CWVP offers a promising approach to intervention with trauma-exposed children as evidenced by clinical experience, but there are currently no published, peer-reviewed research studies for the model.

Supportive Advocacy with Mothers and Children. Some community-based support programs for battered women and their children also include an advocacy component. Sullivan, Bybee and Allen (2002) and McDonald, Jouriles, and Skopp (2006) have evaluated strengths-based support and advocacy interventions and determined that these programs effectively reduce the harmful effects of children's exposure to domestic violence. Sullivan, Bybee and Allen (2002) utilized a longitudinal, experimental design and over the course of eight months assessed (1) children's exposure to abuse and their self-competence and (2) maternal experience of abuse and maternal well-being. The experimental intervention involved advocacy for mothers and their children as well as a 10-week support and education group for the children. Study participants included eighty mothers and their children. Findings indicated that children in the experimental condition endorsed significantly higher self-competence in several domains compared to children in the control group, and mothers in the experimental condition demonstrated improvement in depression and self-esteem over time compared to mothers in the control group. McDonald, Jouriles, and Skopp (2006) evaluated a project to provide services to women and children upon their departure from a domestic violence shelter. Participating families had at least one child age 4-9 exhibiting clinical levels of conduct problems. At two years post-treatment, 15% of children in families who had received support and advocacy services exhibited clinical
levels of conduct problems, compared to 53% in the comparison condition. Mothers of children who had received the additional support also reported their children to be happier, to have better social relationships, and to have lower levels of internalizing problems versus the comparison condition.

**Summary.** The programs reviewed here show promise for intervening to prevent future domestic violence by working with battered mothers and their children who are already exposed to domestic violence.

**Working with men who batter and their children.** Applying these findings to prevention, domestic violence perpetrators would benefit from efforts to improve their parenting, especially in terms of decreasing punitive behavior and expression of negative affect. On the other hand, the evidence of these men’s involvement with and positive motivation for fathering supports the possibility that investment in fathering may be a positive motivation for cessation of domestic violence. Perel and Peled (2008) note that models of intervention with men who batter as fathers can be distinguished by the extent to which they see the issue of fathering as an end in itself or as an entry point into the men’s inner world and into other potential areas of change, such as the violent behavior. However these needn’t be mutually exclusive.

There are several examples of emerging programs specifically designed for training perpetrators to parent without violence, yet most of these have been established only the in last decade or so. These programs can be classified into two types: (1) parenting programs are supplementary sessions within existing batterer
intervention programs and (2) separate curricula that are offered to men once they have completed a traditional batterer intervention group curriculum.

One of the best documented programs is the Caring Dads program (Scott, Crooks and Kelly, 2006). Caring Dads uses a range of approaches including motivational interviewing, psychoeducation, cognitive-behavioral techniques, confrontation, and shame work. The program seeks to address four goals: (a) engaging men to examine their fathering by developing trust and motivation (b) increasing awareness and application of child-centered fathering; (c) increasing awareness of, and responsibility for, abusive and neglectful fathering and domestic violence; and (d) rebuilding children’s trust in the men’s fathering and planning for the future.

A preliminary evaluation of the Caring Dads program compared pre-to post intervention measures for 23 participants (Scott and Crooks, 2007). Using self-reports on the Parenting Stress Index (Abidin, 1995), fathers hostility, denigration, and rejection of child all decreased significantly, as did angry arousal to child and family situations. Self-reported partner abuse decreased but not significantly. They also attained a low attrition rate for participants (34 of 42 completed).

Another well-described and widely disseminated program is the Fathering After Violence (DVPF) program, developed by the Family Violence Prevention Fund (Arean and Davis, 2007). The curriculum is aimed for incorporation into existing batterer intervention programs and is based on exercise that: (1) create empathy for children’s experience of domestic violence; (2) identify behaviors that constitute positive modeling by fathers for their children, and support the mother’s parenting; and (3) increase
understanding of father’s roles in the process of repairing a damaged relationship with their children.

Fleck-Henderson (2004) conducted an initial evaluation of the Fathering After Violence program. Data was gathered on about 60 participants in three programs in the Boston area. Staff and participants’ self-reports provided some support that the curriculum was engaging and readily integrated into the batterer intervention program. The exercises appeared to result in improvements in the three goal areas noted above. Although attempts to contact partners were not very successful, the majority of those reached (about half) did report positively on the participants’ behavior towards their children and were positive about the program.

One prevention strategy for reducing children’s exposure to domestic violence may be limiting visitation rights of abusers. Screening might focus on high conflict divorces (Jaffe and Crooks, 2006). Targeting men who are already abusive may be viewed as a prevention strategy even if separation ends the exposure of violence for their existing children, because it is likely these men will have children from other partners in their past or future relationships and may continue to have contact with his children despite court orders to the contrary (Edleson & Williams, 2007).

The last decade has brought a growing recognition of the potential of interventions that directly focus on the prevention harm to children by promoting positive involvement of fathers in their children’s lives. However, this work has primarily been done in the context of programs that actively seek to end partner abuse and this remains a core condition for the reduction of the harm of exposure.
Conclusion

The findings reviewed in this chapter come from the growing but still small number of studies on children's exposure to intimate partner violence and the approaches that seek to prevent exposure and its subsequent harm. These findings provide a foundation for understanding the effects of exposure to domestic violence on children, the risk and protective factors that help to explain the extent to which exposed children experience negative developmental outcomes, and the important elements of appropriate, effective interventions to support children's recovery. The research work that has been done to date points to important directions for future research. Given that the early years of life are a period of rapid change in degree of cognitive, emotional and behavioral maturation, further study is indicated to evaluate if and how to effectively intervene with children at various ages, and how to modify manualized approaches (i.e. approaches to intervention that offer a prescriptive approach based on manuals and specialized training) to meet individual developmental needs. It is known that some trauma symptoms may only emerge long after the precipitating trauma; longitudinal studies are necessary both to evaluate long-term durability of treatment outcomes and to assess potential association between treatment and lifespan trauma symptoms.

Similarly, if the outcomes of universal prevention efforts are to come to fruition, both long-term investment in such approaches, as well as longitudinal research will be necessary. Enormous progress has been made in the past thirty years in identifying and addressing intimate partner violence as a social concern and threat to public health and
safety. Future work that further reduces the harm to adult survivors and their children, and promotes healthy and positive relationships between adult partners and between parents and their children will be welcome.


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Table 1. Prevention Continuum

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 5 years old</td>
<td>Programs with expectant and new parents to promote positive parenting, including home visiting and center-based programs.</td>
<td>Home visiting and community-based programs with families identified as high risk.</td>
<td>Home visiting and community-based programs with victims of domestic violence and their children, providing specialized services.</td>
</tr>
<tr>
<td>School-age children</td>
<td>School-based programs addressing violence awareness and prevention, mediation and conflict resolution skills.</td>
<td>School- or community-based intervention with children following signs of possible exposure; may include education or therapy.</td>
<td>Individual or group treatment, including crisis support, education and therapy. Appropriate treatment for indicated emotional or behavioral problems.</td>
</tr>
<tr>
<td>Adolescents</td>
<td>School-based program targeting violence prevention and conflict resolution skills AND programs with specific focus on prevention of dating violence.</td>
<td>School- or community-based intervention following signs of possible exposure; reinforce education about respectful adolescent dating relationships.</td>
<td>Individual or group treatment, including crisis support, education and therapy. Appropriate treatment for indicated emotional or behavioral problems.</td>
</tr>
<tr>
<td>Adults</td>
<td>Public education and media campaigns, challenging gender stereotypes and social norms that support domestic violence and attributing universal</td>
<td>Community-based intervention upon indication of possible exposure.</td>
<td>Multidisciplinary services to assist victim of chronic violence, inclusive of social support, medical treatment, police intervention legal advocacy,</td>
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<tr>
<td>responsibility for reducing violence.</td>
<td>counseling.</td>
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