# Family Violence Research, Assessment and Interventions:

## *Looking Back, Looking Ahead*

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# Foreword

For over a decade, the Center for the Study of Traumatic Stress (CSTS) and its Family Violence and Trauma Project has supported the research goals of the Family Advocacy Program (FAP) of the U.S. Army. We at the CSTS are pleased to introduce a benchmark of this work, *Family Violence Research, Assessment and Intervention: Looking Back, Looking Ahead,* to readership invested in the health, welfare and resilience of Soldiers and Families.

*Family Violence Research, Assessment and Intervention: Looking Back, Looking Ahead* is a collection of interviews that have appeared in *Joining Forces Joining Families*, a newsletter published by the CSTS to foster research knowledge and practice among the FAP professional community. This newsletter regularly features an interview with a renowned scholar and practitioner on an important topic concerning family violence and child maltreatment. *Family Violence Research, Assessment and Intervention: Looking Back, Looking Ahead* features many of these interviews along with a background discussion of the interviewee's research and methodologies.

Since the start of Operation Iraqi Freedom and Operation Enduring Freedom, many military families from the active Army component, Army National Guard and Army Reserve have experienced multiple deployments, combat injury, and loss of life. These stressors disrupt family routines, affect parenting and undermine a family's sense of safety — factors that often lead to family and relationship dysfunction.

*Family Violence Research, Assessment and Intervention: Looking Back, Looking Ahead* presents a wealth of scientific approaches that are relevant and applicable to working with populations at risk for family maltreatment. In light of the present interest in bridging military and civilian health and mental health care to reach soldiers and families who live in communities throughout the United States, this book can enrich clinical care and advocacy, and contribute to the health and resilience of Army Soldiers and Families in wartime and peacetime.

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# Introduction

*Family Violence Research, Assessment and Intervention: Looking Back, Looking Ahead* is a product of the Center for the Study of Traumatic Stress (CSTS) and its Family Violence and Trauma Project (FVTP). The CSTS is part of the Department of Psychiatry of Uniformed Services University of the Health Sciences. The CSTS serves as the academic arm and a component site of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

For over a decade, the FVTP has addressed the prevalence and trends of spouse and child maltreatment in the U.S. Army. One important means of communicating relevant and current research information to the Army has been through publication of a newsletter, *Joining Forces Joining Families.* This newsletter informs Army leadership and the Army's Family Advocacy Program of the scientific and medical aspects of family maltreatment.

In *Family Violence Research, Assessment and Intervention: Looking Back, Looking Ahead,* we present a collection of interviews that took place during 2004 through 2010. The interviews are with 15 prominent scholars and practitioners who have conducted significant spouse and child maltreatment research emphasizing prevention and intervention. A companion piece describing the background of their research is also included. A number of scholars have been interviewed again for this book adding research and clinical care insights for the practitioner as well as the researcher. Importantly, the implications of their work stretch beyond violence to topics such as parenting, assessment of functioning, neuroscience, home visiting, research methodologies, and others.

We hope that *Family Violence Research, Assessment and Intervention: Looking Back Looking Ahead* will be a valuable resource for family health and mental health practitioners in both our military and civilian communities, and that it will encourage continued research and best practices to prevent, mitigate and foster recovery around family violence, child maltreatment and spouse abuse.

James E. McCarroll, PhD
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# Contributors

**Sandra T. Azar, PhD**: Dr. Azar is a clinical psychologist and a Professor of Psychology at The Pennsylvania State University where she teaches and conducts research. She received her PhD in psychology from the University of Rochester in 1984. Her distinguished career includes membership on the editorial board of numerous scientific journals and she has received many federal grants from the U.S. and Canada. Her research interests include child abuse and neglect, gender and aggression, parenting, family interactions, developmental aspects of self–control, adolescent depression, and legal processes and families. Currently, her work centers on the relation between cognitive processes and parenting, particularly under adverse conditions such as poverty and parental disability.

**Lee W. Badger, PhD, MSW**: Prior to her retirement in 2008, Dr. Badger was Professor and Nicholas J. Langenfeld Endowed Chair in Social Research at the Graduate School of Social Service at Fordham University, New York City. She received her MSW (1977) and PhD (1987)degrees from the University of Alabama. Before moving to New York, she served for many years on the faculties of the University of Alabama Medical and Social Work schools. For over twenty–five years, she focused her research on the recognition and treatment of mental disorders, particularly depression, and the development and testing of psychosocial interventions in primary care. Her more recent focus has been on the patterns, types, and consequences of intimate partner violence, especially within the United States Army. An author of over 40 articles, monographs, and book chapters, she has received research support from, among others,the National Institute of Mental Health, the John D. and Catherine T. MacArthur Foundation, and the United States Department of Education FIPSE program.

**William R. Beardslee, MD**: Dr. Beardslee is the Director of the Baer Prevention Initiatives, Chairman Emeritus of the Department of Psychiatry at Children's Hospital in Boston, and Gardner Monks Professor of Child Psychiatry at Harvard Medical School. He is a Senior Scientist at the Judge

Baker Children's Center in Boston. Dr. Beardslee has directed the Preventive Intervention Project, a ten year study of response to public health preventive interventions for families facing depression. Dr. Beardslee serves on the Carter Center Task Force on Mental Health, and served on the Institute of Medicine's Board of Children, Youth and Families, and on two of its committees: the Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, and the Committee on Depression, Parenting Practices, and the Healthy Development of Young Children. He has received many awards for his work including the Blanche F. Ittleson award for outstanding published research contributing to the mental health of children, the Catcher in the Rye Award for Advocacy for Children, and the Agnes Purcell McGavin Award for Prevention of Mental Disorder in Children, all from the American Psychiatric Association. He received the Irving Philips Award for Prevention, from the American Academy of Child and Adolescent Psychiatry. He is the author of over 150 articles and book chapters and two books.

Dr. Beardslee is the Director of the Baer Prevention Initiatives, Chairman Emeritus of the Department of Psychiatry at Children's Hospital in Boston, and Gardner Monks Professor of Child Psychiatry at Harvard Medical School. He is a Senior Scientist at the Judge Baker Children's Center in Boston. Dr. Beardslee has directed the Preventive Intervention Project, a ten year study of response to public health preventive interventions for families facing depression. Dr. Beardslee serves on the Carter Center Task Force on Mental Health, on the Institute of Medicine's Board of Children, Youth and Families, and on two of its committees: the Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, and the Committee on Depression, Parenting Practices, and the Healthy Development of Young Children.He has received many awards for his work including the Blanche F. Ittleson award for outstanding published research contributing to the mental health of children, the Catcher in the Rye Award for Advocacy for Children, and the Agnes Purcell McGavin Award for Prevention of Mental Disorder in Children, all from the American Psychiatric Association. He received the Irving Philips Award for Prevention, from the American Academy of Child and Adolescent Psychiatry. He is the author of over 150 articles and book chapters and two books.

**Jacquelyn C. Campbell, PhD, RN, FAAN**: Dr. Campbell is the Associate Dean for Faculty Affairs/Professor, at the Johns Hopkins University. Dr. Campbell's research on family violence and violence against women has included risk factor assessment for intimate partner homicide, abuse during pregnancy, marital rape, physical and mental health effects of intimate

partner violence, prevention of dating violence, and interventions to prevent and address domestic violence. She has been the principal investigator on numerous federal grants and served on the congressionally appointed U. S. Department of Defense Task Force on Domestic Violence. Her research results have been used for health policy recommendations to state, national, and international organizations. Dr. Campbell, a member of the National Institute of Medicine, is the recipient of the 2006 Pathfinder Award for Nursing Research from the Friends of the National Institute of Nursing Research. Dr. Campbell has authored and co–authored more than 250 articles and book chapters, as well as written and edited seven books on battered women and family violence.

**Howard Dubowitz, MD**: Dr. Dubowitz is Professor of Pediatrics and the Director of the Center for Families at the University of Maryland Medical School in Baltimore, Maryland. He received his medical training at the University of Cape Town, South Africa, completed an internship in Israel, a pediatric residency at Boston City Hospital, and a fellowship in child abuse and neglect at Children's Hospital, Boston. Dr. Dubowitz, who holds a Master of Science degree in epidemiology from the Harvard School of Public Health, is widely published and renowned for his clinical work, teaching, research, and advocacy. Among his numerous professional honors, he is the recipient of the American Academy of Pediatrics' Special Achievement Award. Dr. Dubowitz is one of the principal investigators of the LONGitudinal Studies of Child Abuse and Neglect (LONGSCAN), a 20 year study in its 19th year of data collection.

**John J. Eckenrode, PhD**: Dr. Eckenrode is a Professor of Human Development and Director of the Family Life Development Center at Cornell University. He received his Ph.D. from Tufts in Psychology, and after five years at the Harvard School of Public Health, came to Cornell in 1983. His work has concerned stress processes, child maltreatment, adolescent development, and prevention. In addition to conducting research with David Olds on the Nurse Family Partnership program, he is founder and director of the National Data Archive of Child Abuse and Neglect, a facility funded by the Children's Bureau to promote the secondary analysis of child maltreatment data. He is a fellow of the American Psychological Association, Division 7.

**Mary Ann Forgey, PhD, LCSW**: Dr. Forgey is an Associate Professor at Fordham University Graduate School of Social Service. She teaches a range of social work practice courses and recently developed a new elective in military social work. Her research within the Army has focused on patterns

of intimate partner violence (IPV) and evidence based IPV assessment. She received a Fulbright Scholar Award in 2005 to Ireland, where she taught and conducted research about IPV assessment in collaboration with University College Dublin. Her IPV research has been published in Violence and Victims, Journal of Family Violence and the Journal of Social Work Education. In addition to her teaching and research, Dr. Forgey has developed and conducted training programs in IPV for numerous organizations including the NYPD and NYC Administration for Children (ACS). Prior to her academic career, Dr. Forgey served as the Director of Army Community Services and Family Advocacy Program Manager for the US Army in Wiesbaden, Germany.

**l. Kevin Hamberger, PhD**: Dr. Hamberger is Professor of Family and Community Medicine at the Medical College of Wisconsin and an affiliate of the Injury Research Center at the Medical College of Wisconsin. He received his Ph.D. in Clinical Psychology from the University of Arkansas in 1982. Since that time, he has conducted treatment and research programs with domestically violent men and women and developed and evaluated health care provider training programs to deliver violence prevention services to patients. He has published over 100 articles and chapters and six books and serves on the editorial board of six scientific journals. In addition, Dr. Hamberger has been recognized by Division 43 the Division of Family Psychology of the American Psychological Association, the Wisconsin Coalition Against Domestic Violence, and the Institute on Violence, Abuse and Trauma for leadership, innovation and substantial contributions to the field of family violence.

**Ernest N. Jouriles, PhD**: Dr. Jouriles is Professor and Chair of the Department of Psychology at Southern Methodist University in Dallas, Texas. He received his Ph.D. in psychology from the State University of New York at Stony Brook in 1987. Dr. Jouriles conducts research on children's responses to domestic violence and why some types of marital conflict are more detrimental to children than others. Developing interventions is a primary focus of his research. His research on violence in adolescent romantic relationships focuses on developing new methods of assessing relationship violence, understanding risk factors, and evaluating preventive interventions. Dr. Jouriles, whose publications include over 60 scientific articles and book chapters, presented at the Department of Defense Domestic Violence Intervention/Treatment Protocol Development Working Meeting. His research has been funded by numerous federal and state agencies.

**Kathleen Kendall–Tackett, PhD**: Dr. Kendall–Tackett is a health psychologist and an International Board Certified Lactation Consultant. She received a Bachelor's and Master's degree in psychology from California State University, Chico, and her Ph.D. from Brandeis University in social and developmental psychology. She is a Clinical Associate Professor of Pediatrics at Texas Tech University School of Medicine in Amarillo, Texas, and Acquisitions Editor for Hale Publishing. Dr. Kendall–Tackett is a Fellow of the American Psychological Association in both the Divisions of Health and Trauma Psychology, and is Associate Editor of the journal Psychological Trauma. She is a founding officer of the American Psychological Association's Division of Trauma Psychology. Her awards include the Outstanding Research Study Award from the American Professional Society on the Abuse of Children, and she was named 2003 Distinguished Alumna, College of Behavioral and Social Sciences, California State University, Chico. Dr. Kendall–Tackett is author of more than 230 journal articles, book chapters and other publications, and author or editor of 20 books in the fields of trauma, women's health, depression, and breastfeeding. Her Web sites are *www.UppityScienceChick.com* and *www.BreastfeedingMadeSimple.com.*

**K. Daniel O'Leary, PhD**: Dr. O'Leary is a Distinguished Professor of Psychology and Director of Clinical Training at Stony Brook University. He received the Distinguished Scientist Award from the Clinical Division of the American Psychological Association in 1985, and he was installed in the National Academies of Practice in Psychology in 1986. He has published over 235 articles and twelve books. His current research focuses on the etiology and treatment of partner aggression, and the link between marital discord and depression.

**Christopher M. Murphy, PhD**: Dr Murphy is Professor of Psychology at the University of Maryland, Baltimore County. He also directs the New Behaviors Program at the Domestic Violence Center of Howard County, Maryland. This Center consists of comprehensive clinical training, service, and research programs focusing on perpetrators of intimate partner violence. Dr. Murphy's research focuses on cognitive–behavioral and motivational interventions for abusive behavior in intimate adult relationships, factors that predict successful response to partner violence treatment, emotional abuse in relationships, and the links between intimate partner violence and the use of alcohol and drugs. His work has been supported by grants from the National Institute of Mental Health and the National Institute on Alcohol Abuse and Alcoholism. Dr. Murphy has authored more than 50 articles and book chapters on the topic of intimate partner violence.

**Bruce D. Perry, MD, PhD**: Dr. Perry is the Senior Fellow of The Child Trauma Academy, a nonprofit organization based in Houston, Texas, that promotes innovations in service, research and education in child maltreatment and childhood trauma (www.ChildTrauma.org). Dr. Perry has conducted both basic neuroscience and clinical research. His focus over the last ten years has been integrating concepts of developmental neuroscience and child development into clinical practice. Dr. Perry is the author of over 300 journal articles, book chapters and scientific proceedings, and recipient of numerous professional honors. He attended medical and graduate school at Northwestern University, completed a post–doctoral fellowship in psychiatry at Yale University School of Medicine in 1987, and a fellowship in child and adolescent psychiatry at the University of Chicago in 1989.

**Desmond K. Runyan, MD, DrPH**: Dr. Runyan is Professor and Chair of Social Medicine and Professor of Pediatrics and Epidemiology at the University of North Carolina at Chapel Hill. He is the Director of the LONGSCAN Coordinating Center. The LONGSCAN project is a 20–year study of the impact of child maltreatment, now in its 19th year. The Center coordinates the five different, but overlapping longitudinal studies at Baltimore, Chicago, North Carolina, San Diego and Seattle. Dr. Runyan's work involves the application of clinical epidemiology to the problem of violence against children. His research has focused on the impact of societal intervention on the mental health functioning of the child victims and the impact of the foster care system, court testimony, and the medical examination on the children. He also directs is a 5–year effort to assess the effectiveness of a specific parenting education program, The Period of PURPLE Crying, to reduce or eliminate the problem of shaken baby syndrome for the state of North Carolina. Dr. Runyan is also the National Program Director for the Robert Wood Johnson Foundation Clinical Scholars Program. This program seeks to prepare leaders in health care who can function in academia, in government service, and in private settings to help improve healthcare for all Americans.

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# Editors

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Dr. McCarroll received his PhD in Psychology from the University of Arkansas in 1970 and his MPH from the Harvard School of Public Health in 1978. He completed an internship in clinical/counseling psychology at the US Army Silas B. Hays Hospital, Fort Ord, California, 1978-79. From 1979 to 1982 he was the Chief of Mental Health at the U.S. Army Hospital, Berlin. He was the Assistant Chief of Psychology at the Walter Reed Army Medical Center from 1982 to 1988. In 1988, he joined the staff of the Department of Military Psychiatry, Walter Reed Army Institute of Research where he was Deputy Chief for Administration and also conducted a research program in the psychiatric effects of traumas and disasters with the Center for the Study of Traumatic Stress (CSTS), Department of Psychiatry, Uniformed Services University of the Health Sciences. He retired from the US Army in 1995 and joined the CSTS staff. He has published widely on family maltreatment, military medicine, and the psychological effects of exposure to traumatic events.

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Nancy T. Vineburgh, M.A. is Assistant Professor in the Department of Psychiatry at The Uniformed Services University of the Health Sciences in Bethesda, Maryland, and Associate Director of the Center for the Study of Traumatic Stress (CSTS) where she oversees its Office of Public Education and Preparedness.

Ms. Vineburgh is an expert in health communication, health marketing and public education. She has created numerous, high profile public education campaigns that have generated national and international attention: *Fight the Bite,* the nation's first health campaign for Lyme Disease awareness; *Courage to Care*, an electronic campaign addressing the well-being of deployed soldiers and their families; *Can a Depressed Parent Be a Good Parent, You Bet,* the nation's first campaign on parental depression sponsored by Children's Hospital Boston; *Where to Draw the Line,* a three year campaign for National Alcohol Screening Day sponsored by NIAAA and SAMHSA. She helped develop an educational campaign, *Courage to Care Courage to Talk,* whose educational resources address communication around the injuries of war that was featured in two Pentagon media venues.

Her work has earned numerous awards including *Woman of the Future* by *Hartford Woman Newspaper* in recognition for her broadcasting on women's health; The Combined Health Appeal Media Award and Connecticut's Arthritis Foundation Public Education Award for her work related to Lyme Disease education. Her work in the field of military health communication has received the American Graphic Design Award for three consecutive years, 2007, 2008 and 2009.

Ms. Vineburgh received her B.A. from Connecticut College in New Lon-

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**Robert J. Ursano, MD**

Robert J. Ursano, MD, is Professor of Psychiatry and Neuroscience and Chairman of the Department of Psychiatry at the Uniformed Services University of the Health Sciences (USUHS), Bethesda, Maryland. He is Director of the Center for the Study of Traumatic Stress and the editor of the medical journal Psychiatry, Interpersonal and Biological Processes. He was educated at the University of Notre Dame and Yale University School of. Dr. Ursano served as the Department of Defense representative to the National Advisory Mental Health Council of the National Institute of Mental Health. He is a Fellow in the American Psychiatric Association, the American College of Psychiatrists, and the American College of Psychoanalysts. He was the first Chairman of the American Psychiatric Association's Committee on Psychiatric Dimensions of Disaster. Dr Ursano is a member of the National Academies of Science, Institute of Medicine, Committee on Psychological Responses to Terrorism; and the National Institute of Mental Health Task Force on Mental Health Surveillance after Terrorist Attack. He has received numerous awards including the Department of Defense Humanitarian Service Award, the Lifetime Achievement Award from the International Traumatic Stress Society, and the William C. Porter Award from the Association of Military Surgeons of the United States. Dr. Ursano is widely published in the areas of Post-Traumatic Stress Disorder and the psychological effects of terrorism, bioterrorism, traumatic events and disasters and combat with has over 200 publications including co-author or editor of seven books.

# Child Maltreatment

In this section, we present interviews and summaries of research of six individuals who have published extensively on child abuse and neglect.

Sandra Azar discusses the use of cognitive and behavioral principles in child rearing. While much of her work has been devoted to helping mothers with cognitive difficulties, the principles apply equally to any parent.

Ernest Jouriles has helped women in families in which there is co–occurrence of child and adult maltreatment. Dr. Jouriles' research has been directed toward understanding the complex relationships between domestic violence and physical aggression against children. Particularly interesting has been his work on children's perceptions of violence by parents and the relation of such appraisals to the type of problems exhibited by children.

John Eckenrode has been one of the pioneers of research on home visitation by nurses and the long–term effects on children and families. He addresses such issues as qualifications of service providers and how home visiting can be targeted to mothers at the highest risk for child maltreatment and other family problems.

Bruce Perry has worked and taught extensively about the effects of maltreatment on the developing brains of children. His neurosequential model provides basic understanding of how maltreatment affects children and how the model can be used to help them recover and develop.

Howard Dubowitz is one of the world's experts on child neglect. His work has been directed at teaching health care providers how to prevent, screen for, recognize risk factors, and work with neglectful families. A major emphasis of his work has been on the involvement of fathers in families, particularly in areas where child neglect is likely to occur.

Desmond Runyan is a principal investigator for the longitudinal study of child abuse and neglect (LONGSCAN), a 20–year study of the impact of child maltreatment. His research and clinical work has focused on a wide variety of problems affecting the lives of children. His chapter describes the

LONGSCAN project and some recent results of that study.

Each of these authors has a particular focus, but much of their research includes both prevention of child maltreatment, intervention strategies, and the design of service delivery systems. This section has overlap with domestic violence. Too often, the child maltreatment and domestic violence prevention and treatment communities do not work together due to lack of funding, training, or legal restrictions. Through the course of this book, the reader will note the importance of the need to consider child maltreatment and domestic violence as all part of the same problem of family malfunction.

# The Social-Cognitive Theory of Parenting: A Brief Review of the Work of Sandra T. Azar

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 8, Issue 4, Fall 2005*

Dr. Azar is widely published in the topics of child maltreatment and parenting. She has written extensively on the termination of parental rights by the courts due to child maltreatment. She advises mental health professionals to be extremely cautious in their evaluations and statements because of the lack of data that exists in this arena. Such caution is particularly advised given the diversity of today's families and the fact that existing databases on families are largely based on studies of middle class, two-parent families and lack information on single parents, low socio-economic class families, very young families, or other complex family situations.

Her work advances an assessment approach that focuses on parental behavior and functioning as opposed to a model that emphasizes personality and intelligence. Accordingly, she strongly encourages more research in building a more extensive database of information about families and parenting. She believes that many current models are inadequate to explain the processes involved in parenting and that a newer, broader model is needed.

Her model is cognitive-behavioral and is based on the principle that thoughts influence behavior. Parenting is viewed within a general stress-coping model, which examines what the individual brings and what is required. Expectations about the self tend to be flexible and allow a wide range in which to enact the role of parent. She asks, "Is parenting a doable task? If so, what are its demands?" The social and cognitive tasks to be negotiated are relational and generally involve capacities that are required for many domains of adult development. The emphasis in her model is on improving

the capacity to problem-solve and to remain cognitively flexible in the face of changes in the child and the changing contexts of life. Having realistic expectancies for the parenting role and the capacity to recognize where these expectancies may be ineffective and to re-adjust them are key to parental development. Her cognitive-behavioral model will work across the many varying circumstances of parenthood in today's world in that it does not require a biological basis, just the capacity to learn the parental role and to have gone into it with accurate perceptions of what that role entails.

The following review is taken from a chapter entitled "Adult Development and Parenthood" (Azar, 2002) in which Dr. Azar describes her perspectives on parenting. Additional references are provided.

### How does one learn to be a parent?

Azar reviews two opposing theories of parenthood. The first sees parenthood as a stage in normal adult development. In this view, parenting is seen as essentially instinctive. As a result, criticism of the parent is highly likely in the event of failure. (How could one fail at something that is instinctive?) Azar argues against the parenting-as-normal-development theory. She presents the view that an individual's life course is flexible, random, and driven by context. Parenting, a unique context for the development of psychological maturity, involves stresses that can lead to personal growth or to maladaption. For some, parenting may be overwhelming and result in child maltreatment, depression, and other negative outcomes. For others, the stresses of parenting are within their "developmental reach" and this stage can lead to personal growth, greater maturity, and improved parenting skills.

### What affects parenting?

In Azar's view there are three major areas that impact parenting. The first is the environment (or the context of parenting). Differences in parenting would be expected in a high-crime area compared to parenting in the suburbs in terms of how much control is exercised over a child. The second is the child. Different parenting strategies and challenges would be expected for a special needs child, an adopted child, a foster child, or a child from a spouse's previous marriage. The third area is that of the parents. In today's world, there are many decisions to be made about parenthood and the role requirements imposed on parents by society. The heterogeneity of the parental role defies narrow boundaries typically seen in developmental literature. She addresses the Whether, Who, How, When, Where, and How Long of parenting. Each of these is a question and a choice point to be considered in assessing their impact on the relation between the parents and the child.

**Key Points**

The social and cognitive tasks for a parent are relational and involve capacities that are required for many domains of adult development.

Azar's model focuses on parental behavior as opposed to one that emphasizes personality and intelligence.

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# Social-Cognitive Theory Applied to Maltreating Parents

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 8, Issue 4, Fall 2005*

***Dr. McCarroll: How did you get started in child maltreatment work?***

Dr. Azar: My first studies as an undergraduate were on memory and the role of cognitive mediation. That's where my interest in social cognition came from, but even then I was interested in poverty and at-risk children.

***Dr. McCarroll: You have worked in many different areas of child maltreatment.***

Dr. Azar: Child maltreatment is an interdisciplinary topic and includes pediatricians, social workers, public policy people, and others. The field just does not lend itself to a traditional psychological approach.

***Dr. McCarroll: How would you explain the concept of child maltreatment to a lay audience, to people who say "How could this kind of thing happen?" or "How could somebody do that?"***

Dr. Azar: Parenting is a very complex cognitive task. Often, we just say, "Parenting is instinct." Parenting is a job, but often in our society we do not see it that way. Parents have to juggle: "The kid needs to learn how to keep his shoes tied. I've got to get the other three children to school. I'm tired. They kept me up last night because one of them had a fever." Each of those stresses requires cognitive capacity to solve. But, when you put them all together in individuals who may be limited in some capacities or may have difficulty being flexible, the task becomes impossible.

There are multiple causes for child maltreatment. In some cases I see it as a learning deficit. Some people have grown up in families where the standards for parenting are different from the norms of the rest of society. These parents are isolated and lack resources and social support and have distorted scripts for the parenting process. They may misinterpret a child's behavior, which can lead them to a perception of exceptional malevolence on the child's part. They may think, "This child is doing this on purpose and is trying to get to me." That kind of appraisal will heighten their arousal and lead them to do things they might not otherwise engage in.

*Dr. McCarroll: How do you work with a parent who experiences those distortions?*

Dr. Azar: All my work has been aimed at challenging those distortions, but it's a very tricky task. To them, their distortions are as familiar and as natural as breathing. As a result, you have to produce lots of exemplars before people shift their thinking and are willing to realize that it is their thinking that gets them into trouble.

The process that I use can work in ten or twelve weeks with home visitors and groups. Groups are very important because people are much better at seeing distortions operating in other people than in themselves. If people can engage in the process of exploring why they are in trouble and how they might change their behavior, you can change these distortions in a short span of time. But, you need to be very skilled at tenderly moving them through the challenging process.

The work involves modeling. I show them how thoughts influence behavior. Different thoughts produce very different outcomes. I get them to help me think about generating their ideas. I may present scenarios. For example, "You save up for weeks to buy a new white dress, and you are very happy wearing it. Then little Johnny comes toddling toward you with this glass of red liquid and spills it all over your new white dress." I get them to imagine very slowly that situation and ask them to tell me what they are feeling physically and then what is going on in their head. "What thoughts are you having about Johnny?" Typically, you get things like, "It's not fair. Why me? I never get to have nice things. This kid really doesn't care. He did this on purpose. He's just like his father." I will try to give some links to other people in their lives who do not care about them or who treat them unfairly. Then I will work on discriminating the child from those other people and teaching them self-statements that will cool the fire of their anger and frustration with the child. Examples are, "He's only two. He doesn't know any better. It's my job to stay calm in these moments." Then I help them problem-solve. "What could I do next time to prevent this?" For a while during the therapy the child is invisible. It is the parents' needs, their wishes, their hopes, their thoughts that take prominence. It is my job is to help them see how those thoughts are detrimental.

I always tell my clients, whether they are child abusers or not, that they have to be the central character in their story. When they stop being the central character in their story then they are just reacting to everything around them as opposed to creating the action. A lot of the work involves metaphors. Metaphors help people process and retain information.

***Dr. McCarroll: Can you give us examples of some of your favorites?***

Dr. Azar: In trying to explain the concept of child development and age-appropriate tasks and behaviors, I might approach a mother and place something in front of her. I'll say, "Here's a carburetor. I want you to fix this carburetor." And the mother will laugh and look at me. I then say, "Don't laugh! You cannot leave this room until you get this carburetor fixed." (Occasionally, I run into one who can.) I use that metaphor when a mother brings up a developmentally inappropriate behavior she has demanded in a child. I'll say, "Maybe you are asking him to fix a carburetor. That's what it is like for children."

***Dr. McCarroll: How would you recommend that people measure parenting?***

Dr. Azar: Parenting may not be the core of the evaluation. First and foremost should be a careful functional analytic view of the incident being evaluated. Try to understand its antecedents and look for clues from that. One can ask, "What specifically does this parent have difficulties with? Is it discipline? Is it daily organization of the child's life? Is it providing nutritious meals?" There may be hundreds of parenting education classes, but they do slightly different things and often there is no recognition of the specific needs of the parents. Another problem may be the way in which material is presented. Some parents have learning disabilities. We need to present information in multiple modalities to help them process it. In some cases, you can role-play and be more active in the intervention as opposed to giving a lecture about how children develop. I talk about kids' "paycheck." Parents pay kids for things they do not like to see. If the kid has a choice between playing quietly and hitting his sister and the parent's attention is the paycheck, then they are going to hit their sister because Mom will be over there in a second. I try to illustrate the importance of reward and praise to keep a behavior going. You have to be a bit charismatic and approach parents in ways that they have not been approached before, such as by legal and child protection people. Parents have to believe that you think that inside there is a good person.

Therapeutic practice requires an engagement process with parents. That means hearing their definition of what their difficulties are and how they frame the problem and then trying to link that frame to what we know may be core etiological factors. The parent's cognitive map is so important. What we present is not going to register if their schema about parenting is disparate from the helper's view.

***Dr. McCarroll: What are the most crucial needs in the child maltreatment field?***

Dr. Azar: We need more research. It is hard to get funded as a child abuse

researcher because we don't have a diagnosis like those who study depression or schizophrenia. It's harder to define what our problem is.

There is also a lack of dissemination of research results. We have some very promising approaches for assessment and intervention. In spite of existing empirical data, much of what is being carried out in most localities does not fit those models.

*Dr. McCarroll: Do you see public policy regarding child maltreatment focusing on the right problems?*

Dr. Azar: The recent addition of family violence into the Centers for Disease Control has been a good policy move. Placing family violence in the bailiwick of public health is a good public policy move. This is one of the ways we can help to fortify families to strengthen them against risk.

*Dr. McCarroll: Can you tell us what you are working on now?*

Dr. Azar: I am trying to explore some elements of cognitive incapacities that might produce risk to children. Here, I am focusing on neglect, not on child abuse. However, I do not see child abuse and neglect as disparate. They are both failures in judgment. One involves a little more impulsivity; the other a little more passivity in terms of children's needs. They both involve not being able to identify problems and respond to them appropriately.

*Dr. McCarroll: We certainly appreciate your time. You have been very generous. We look forward to your continued good work.*

Dr. Azar: Thank you.

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**Key Points**

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Parenting is a very complex task. Often, we just say, "Parenting is instinctive."

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I tell my clients that they have to be the central character in their story. When they stop being the central character, then they are just reacting to everything around them as opposed to creating the action.

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REVIEW OF RECENT RESEARCH OF SANDRA T. AZAR, PHD

# The Social Information Processing (SIP) Model Applied to Teaching Parenting Practices

*By James E. McCarroll, PhD*
*February 2010*

Dr. Azar has continued her research on improving parenting practices. She views parenting as a learned skill, not something that comes naturally. Her model for understanding the development of parenting skills is through the use of cognitive and behavioral principles. This model is called social information processing (SIP) (Azar, 1986; Crittenden, 1993; Milner, 1993, 2003). SIP includes knowledge structures, executive functioning, and the cognitive product of the interaction of the other two. This approach can be used for prevention as well as amelioration of parenting deficits and provides a unified cognitive model to guide research as well as parenting interventions (Azar & Weinzierl, 2005). The authors target parental oversights that can lead to unintentional injury as well as child maltreatment. These parental oversights include both errors in parental judgment and contextual variables.

Categories of contextual factors playing a role in both child maltreatment and injuries are the following:

- Socio-cultural variables such as poverty and social isolation;
- Caregiver variables such as mental illness substance abuse, unrealistic and failure of supervision; and
- Child variables such as impulsivity, inattention, and high activity levels (see Peterson & Brown, 1994, for more discussion of these factors).

Azar and colleagues see parental behavior on a continuum from poor caregiving due to their behavior or omission to positive caregiving that facilitates child development. Some of the skills required in parenting include the following five areas:

- Problem solving with a balance of positive and negative strategies and disciplining;
- Social cognitive skills such as appropriate expectations of children's capacities;
- Self-control including impulse control;

- Stress management including relaxation; and
- Social skills such as empathy.

Many more examples are given in Azar and Weinzierl (2005). These abilities and skills are examples of some of the many complex requirements for good parenting and for risks when they are not practiced.

The provision of services to parents with cognitive difficulties (PCD) includes managing risk to children as well as enhancing their ability to function as good parents. Dr. Azar works to build the capacity of such parents, to improve organizational responses to them, and to train and support the needs of persons who work with these parents. This work is called human capacity building. It provides a theory that facilitates the development of sensitive intervention techniques and linkages between agencies, such as child protection agencies and other organizations that serve parents and their children.

The model presented by Azar and Weinzierl (2005) is expanded in a later paper devoted to improving the human capital of service workers and parents with cognitive difficulties (Azar & Reed, 2009). Child protective services (CPS) responses to child welfare cases often are crisis-oriented. Parents with cognitive difficulties (PCD) may not be responsive to such efforts at that time due to the nature of their own difficulties. Much more work by the CPS worker may be required to help the PCD. Azar and Read's description of PCD include deficits in attention, risk assessment, perspective taking, planning, frustration tolerance, and trial and error learning that lead to day-to-day problems in giving care to children. Such daily difficulties can lead to neglect as seen in the failure to monitor children, maintain home cleanliness, children's medical care, hygiene, and school attendance. Recognition of the cognitive difficulties of parents can lead to training that can improve their capacity to make decisions and comprehend what is required of them. Dr. Azar's recent work has been directed at the promotion of cognitive capacities in service providers. SIP theory provides a basis for considering the service provider's cognitive system and their potential to make errors and be less effective in service provision when the PCD case appears, but is unidentified. This can lead to a failure to identify the challenges the parent faces. Azar and Reed discuss cognitive disabilities and why special efforts should be given to address their needs as related to the CPS system. The following is taken from their paper.

Low IQ is typically the chosen measure of cognitive disability. PCD are overrepresented in the CPS population compared to the general population (US Department of Health and Humans Services, 2007). Their CPS involvement is often for child neglect (see for example Ethier, Couture & Lacharité,

2004). Parents with low IQ may exhibit inappropriate expectancies of self-sufficiency from their children, poorer problem-solving capacities, and more negative appraisals of their children's behavior. Low IQ may not be detected by CPS workers or the parent may not want to admit to it. Azar argues, however, that there are certain cognitive difficulties, called selective information processing, that lead to parenting risk (Azar & Weinzierl, 2005).

While there are many programs for children with disabilities, few exist for adults. Also, professional workers may have negative biases toward PCD, which can result in discriminative ideas and practices toward them. Examples are concern over the pregnancy of a PCD and doubts about their ability to take care of children such that their parental rights could be terminated.

Azar and Read argue for building human capacity to take place on multiple levels in social service systems. SIP is the theoretical basis for strengthening human capacity. It is based on three components: (1) schemas of the service worker that include their role, expectations of parents, stereotypes, and other knowledge structures that can bias them against the parent, (2) executive functioning such as attention and memory, and (3) judgments about causes of behavior. Azar and Read discuss the first and third elements assuming that most workers have adequate executive functioning, although this can be degraded when under stress.

The skill building for increasing the human capacity of the service worker are the identification of skills of the PCD, process strategies that will be useful in working with the PCD, breaking down the biases of the service worker and promoting empowerment of the PCD. The first of these, identification of skills, can occur through formal screening or testing, but also through what Azar and Reed call "in-the-moment" identification. An example of this is noticing and working through a communication difficulty. Instruments for identifying and measuring cognitive challenges are limited such that an in-the-moment strategy is likely to be the worker's primary tool. This strategy is directed toward communication with the PCD, determining if the PCD understands the meaning of the communication and that the PCD can ask for assistance when it is needed. This latter point is important as PCD can adopt what Azar and Reed call a "cloak of competence" in which they portray themselves as understanding when they do not.

Worker process strategies include using different means of communicating with the PCD. Often auditory skills are weak or are not enough for the parent to grasp instructions. A multimodal approach that includes visual, sensory, and motor strategies can facilitate understanding along with concrete examples and practice. Development of this strategy by the worker should include learning to accommodate different learning styles of PCD

and the use of other supports to help the parent with the material. This is a long-term need that may require community support such as prompts from a service office for appointments.

The second level of development of worker process strategies includes understanding the function that the behavior of the PCD may serve. For example, not attending appointments may be taken for lack of motivation when the fact is that the PCD could not tell time, manage time, or read a bus schedule. This training can be accomplished by teaching the service worker to look for the antecedents to the behavior. In addition to building skills for working with the PCD, the worker is required to have triage and referral skills and knowledge of helping agencies in the community that can provide supports to the PCD.

Breaking down biases and promoting empowerment of the PCD is the last area suggested by Azar and Read for building the human capacity of the worker and the PCD. Common biases of workers are beliefs in parental incompetence, expectations of failure of the parent, a view that parents cannot act as agents on their own behalf and that they are not amenable to intervention. Training for the worker would include sensitizing them to explicit and implicit biases and how to promote empowerment of the PCD. There are many empowerments that can be considered based on the idea that PCD can have input to decision-making and interventions that may also lead toward self-determination. These efforts challenge the worker's expectations for the PCD. More realistic expectations by the worker can work to decrease their feelings of helplessness and withdrawal from service. Continued training and supervision are also important elements of the work to build the human capacity of the worker.

Azar and Reed have presented a theory and practical plans to increase human capacity of the service worker and the PCD in an effort to improve the CPS case management of PCD. The increased worker skills and knowledge can facilitate development of the PCD by reducing worker burnout and decreasing the concerns of PCD about raising their children or losing custody of them.

Many of the points made by Dr. Azar were illustrated in a People Magazine article, October 5, 2009. This is the story of a PCD raising her gifted sixth grade daughter. They work as a team to manage the household and take care of each other. A service coordinator from a local non-profit organization works to provide support for them and others with intellectual disabilities. This article notes that according to the 2005 U.S. Census, 132,000 people with intellectual disabilities were caring for children in their homes. Experts believe that the number is much higher.

Dr. Azar's work underscores the importance of approaching several fields

simultaneously and creatively to challenge existing systems in order to make the lives of children, parents, and service providers better.

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**Key Points**

Dr. Azar views parenting as a learned skill, not something that comes naturally.

Parents with low IQ may exhibit inappropriate expectancies of self-sufficiency from their children, poorer problem-solving capacities, and more negative appraisals of their children's behavior.

Recognition of cognitive difficulties of parents can lead to training that can improve their capacity to make decisions and comprehend what is required of them.

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SECOND INTERVIEW WITH SANDRA T. AZAR, PHD

# The Social Information Processing (SIP) Model Applied to Neglectful Parenting

*By James E. McCarroll*
*February 2010*

**Dr. McCarroll: You have continued to write and work in the area of cognitive behavioral approaches to parenting.**

Dr. Azar: I have. My work has been directed at understanding the factors that lead to missteps in parenting, the extreme being child abuse and neglect (see Azar & Weinzierl, 2005). Parental missteps can also underlie injuries in children in that preventive measures might have kept some of the incidents from happening. However, some might have been maltreatment or a failure to protect children. There is overlap in the two literatures.

**Dr. McCarroll: The errors in parental judgment, contextual variables, and parental oversight are part of your model. You also talk about knowledge structures, executive functioning, and appraisal processes.**

Dr. Azar: The model can be used for prevention as well as amelioration. The Azar and Reed (2005) article expands this model to improving human capital. I think about cognition in neglectful behavior by parents. We were looking at low IQ mothers. There is an association between neglect and parental intellectual limitations. That pulled me into the neglect area a little more deeply because they are more at risk for child neglect. This work has lately been at the macro level. I worked on developing a coalition across the country on programs that provide support for parents with cognitive challenges. I have also worked with the city of Philadelphia when they wanted to improve their services for child neglect. For example, I am presenting a series of workshops for brand new case workers in Philadelphia to sensitize them to the needs of cognitively challenged parents. Some of these parents might have had head injuries or are low in IQ. The workers see a lot of non-compliance with services and frustration in the parents. It may merely be that the parent does not understand what they are being asked to do and they are getting frustrated with the case worker. Most of this work is directed towards looking at what needs to be done in the child protection system to work better and to communicate better with the parents who are cognitively challenged. That is the group where there is a risk of disconnect between the parents and the professionals involved.

I feel like you can theorize, but then you have to take it into the real world. I have become a consultant to the city of Philadelphia because of the work I have done around cognition in parenting and their deep desire to better meet the needs of cognitively challenged parents. I never intended to be studying low IQ mothers. The people who are working with the cognitively challenged feel like my work has a lot of relevance for what they are dealing with. I have suddenly become the spokesperson for that group. An example of that is a recent article in People Magazine about a cognitively challenged parent successfully raising a gifted daughter when given the right kind of services. Expectations are important in this field. Sometimes it is a little daunting. Some people are inspired by such work and some are overwhelmed by these ideas.

The grant I have now is testing the model that is presented in the Azar and Weinzierl (2005) article, a model of child neglect. I am interviewing mothers of pre-schoolers in Philadelphia testing the validity of the model for neglect. It is the same model that I tested for child abuse, but extending it to neglect. Parallel with that, I have also been thinking about special needs parenting and about how we might assist the child protective system to be more sensitive to special needs parents. Sometimes, they do not understand what workers are asking them to do. The programs that are provided are not adapted for parents with special needs, but are rather generic ones. Azar and Reed (2009) is a description of what needs to be done to train professionals.

The funding for my grant, Maternal Intelligence, Social Information Processing, and Neglect, came from the National Institute of Child Health and Human Development (NICHD). We are going to study 167 mothers of 3-5 year olds. Half of them will have had a substantiated child neglect case and half of them will not. We will oversample mothers in both groups who are more cognitively challenged, mothers whose IQs are in the lower ranges.

We are going to try to get at neglect in two ways. One way is to use substantiated child protection records of neglect cases to decide on neglect versus no neglect for the two groupings and the second is more of a continuum perspective. For example, we will evaluate the home for evidence of the cognitive and physical material stimulation available for a child. For example, how many books are around, how many toys that you learn language with, how barren is the home, how monotonous is the environment around the child in visuals, how much time do they spend with the TV on? It is a collation of what child development thinks of as cognitive stimulation in the home environment. Lack of stimulation is one element of neglect.

We will also look at home safety, home hazards, injury attitudes, home cleanliness and a lot of other variables. Neglect will thus be a latent variable that is measured on a continuum. One of the questions is whether we can

predict from the social-cognitive factors, the social information processing (SIP) factors, the substantiated neglect mothers from the non-neglectful mothers. And then, do social information processing variables predict the level of neglect-like behavior? I think it is going to be a solid test of the model's utility for understanding neglectful parenting.

### Dr. McCarroll: Is it a longitudinal study?

Dr. Azar: It is not at this point, but I could see that that would be the next iteration. Right now, it is just looking at differences. While this is not longitudinal, there will be a sizeable sample in which to look at these factors in a neglectful population. Neglected children are an understudied population.

### Dr. McCarroll: How are you going to check their IQ?

Dr. Azar: We will do an abbreviated WAIS with each of the mothers and we will expand the social information variables with standardized tests. For example, we are going to use the Wisconsin Card Sorting Test (http://www4.parinc.com/ProductSearch.aspx?q=wcst) to look at cognitive flexibility. That adds a measure of executive functioning and will allow us to obtain more data on core cognitive functioning. We are also using the Alternate Uses Test (http://www.indiana.edu/~bobweb/Handout/d1.uses.htm). It looks at divergent thinking as well. It is an old test that was used to look at creativity. It is really simple. You give the person objects and then ask them to generate how many uses the object has other than the typical uses. You give them a newspaper, you give them a shoe and you ask them how many other things could you use this for and it looks at their ability to kind of think outside the box a little. When you are parenting you have to think outside the box. So, these measure the cognitive the flexibility and cognitive complexity pieces of the model.

### Dr. McCarroll: What are the social-cognitive capacities that are required to be effective as a parent?

Dr. Azar: We are using the ones that I typically use in my model. There are many variables: belief systems about children, problem solving capacity, cognitive flexibility, cognitive complexity, and attributional style and attributional biases toward children. But, we are also looking at it more broadly. One of the other things this project is looking at is whether this is a more global problem than just one specific to parenting. We have some pilot data to suggest that that is a reasonable hypothesis. That is, are these parents unrealistic in all relationships? Are they making these misattributions in all their relationships? Are they poor problem solvers around a myriad of things, everything from finances to problems with friends or bosses at work or those

kinds of things? For example, we have created an unrealistic expectation across relationships questionnaire.

So, we are looking at the broadness of these social information processing problems rather just than the specificity of them to parenting. So, when you ask me, "What are the variables for parenting?" I would say these are the ones, but now we are saying that this is a more general social information problem.

We are talking about rigidity across the kinds of judgments this parent is making. Is it a broader spectrum of deficits or disturbances, I would rather say disturbances, in these adults that are going to be problematic? That would argue that we need to target across them to improve life. For example, suppose I am a poor problem solver and my landlord tells me I am going to be evicted. I have a higher probability of being homeless if I cannot problem solve in the situation (i.e., if I cannot organize my environment in such a way to protect my children and give them a roof over their heads). Parents who are inflexible in their cognitive capacities are not going to have the safety net that other parents have. They cannot get themselves out of a corner once they are backed into it. If they cannot access the resources, they are more in danger of becoming neglectful of the basic needs of their kids.

Similarly, if I am not good in my expectations about relationships, I am probably going to get into more fights with the people around me and that is going to also create less social support, which, again, detracts from the resources I might need for my family and would again heighten the probability that neglect might take place.

Part of supervising is being able to monitor on a moment-by-moment basis your child's behavior. So, if you have poor monitoring capacities, you are going to have more difficulty monitoring your kids and this leads to neglect.

***Dr. McCarroll: How will the grant proceed beyond the assessment? How do you see it unfolding?***

Dr. Azar: The first goal is to document that you can differentiate neglectful families. We have selected instruments that are not hard to learn. I am training bachelor's level people to collect the data. This could provide a battery for case workers. I think the child welfare system has been lacking some simple ways of training case workers to assess families. I purposely tried to select things in the work that I do and the way I create them that they could be used by case workers or by psychologists who are doing evaluations of the parents. These tests would help us both identify at-risk parents for prevention purposes or for the child welfare system itself to identify and target where the parents might need some assistance. I do not argue that the ones

I am looking at are all the ones we need for a battery, but right now there are very few that child case workers are using. So, if all goes well and these factors do in fact differentiate parents then we will be able to train case workers to use these kinds of batteries as they assess parents and then target particular interventions, depending on their incapacities.

### Dr. McCarroll: How are you going to recruit the controls?

Dr. Azar: We will go to Head Start and to day care programs. The other innovative thing about this project is that we are going to get some geographic data about the environment around the parents. We are going to get our usual measures of social support, life stress, and how many resources the parent has, but we are also going to get neighborhood data. Philadelphia is a well mapped city. Penn State has data bases that will be used to construct variables of risk for the parent like how many grocery stores are available in their neighborhood, how much crime is in their neighborhood, and how many resources like parks are there in their neighborhood. We will have an aggregate score for the risks and resources in the mother's immediate neighborhood.

For me, being an intercity mother is like being in a video game and you need to know at what level they have to play the game. So, for a mother who is low on cognitive ability and poor in problem solving, if she runs out of food and the only things that are close by her are 7-Eleven type stores, she's going to run out of food faster. This part of the project is going to look at the social and resource context the parents live in and look at the risk within contexts. Using Geographic Information Systems we can get maps of each mother's neighborhood. With someone's address, we can get such things as the average income of people on the street, how many murders were there within a six-block radius, how many parks you have available within five blocks.

When you talk about neglect, context may be important. If there is no food pantry or doctor's office or bus routes nearby or if the mother does not know where the bus routes are, then you have a context where even the best functioning mother might not do well. We are going to try to sample across the city so we get information on various neighborhoods. We are going to collect data about her knowledge as well.

We hope to learn whether within child protection if IQ matters or if more selected cognitive problems interact with high risk contexts. If we can validate the model's utility, we will also have a battery that we can then use to evaluate parents. Based on our findings, the model will also have validity for developing interventions.

*Dr. McCarroll: The Army has a big program for people with disabilities called the Exceptional Family Member Program. It is for any soldier or family member who has mental health, medical, or physical problems. Your model might be applicable to a military context.*

Dr. Azar: It really might. When a military spouse is deployed. It may be that the husband and wife are a very well functioning dyad when he is home, but when he is sent overseas and she is left alone to try to fend for herself, she could have problems coping with a system she does not understand. That would make sense.

*Dr. McCarroll: But, regardless of disabilities, these principles apply generally to parenting.*

Dr. Azar: I agree. I am looking at parents with IQs in the 65 to 79 range. The higher number, 79, is not in the mentally retarded range, but you still might see high densities of poor cognitive flexibility and poor problem solving. I have gotten some pretty scary answers from PhDs on my unrealistic expectations questionnaire.

*Dr. McCarroll: I was thinking, too, that when people are under stress some aspects of cognitive functioning are subject to degradation or to breakdown.*

Dr. Azar: Yes. I was also thinking of persons with head injuries. This is not my area of expertise, but there is some literature on executive functioning problems in homeless men and a lot of them were vets. I have had cases of head injuries where the family got no explanation of what the injured person might be like, no explanation of what his brain injury was going to mean for his interpersonal functioning.

In problem solving, people need to be able to think two steps ahead. I remember I had a young mom who was not eating well. When she was pregnant with twins the doctor kept asking her to eat better and she would be having macaroni with butter. When the babies were born they were very lethargic and did not look great, but she looked at me and said, "Look, they have all their toes and fingers. You were wrong. I didn't need to eat really well." There is not a complexity to the way they think.

*Dr. McCarroll: I wondered if one of the goals of your project is to identify risk levels.*

Dr. Azar: I am hoping that it would help us to identify risk, but like violence prediction it is hard to identify low frequency behaviors. Also, we are talking about behaviors of omission, which are more difficult to predict. We have to keep that in mind that our predictive models will always have limitations.

***Dr. McCarroll: What are the limitations of training case workers to do the kind of work your model calls for?***

Dr. Azar: Most importantly, we need to pick people who can work gently with clients and who are very observant. Cognitive work requires a deep respectfulness for the person that you are talking to because you are challenging their thinking. You have to do it in a kind of Colombo way. He got his point across, but he did it in a gentle and back-off-at-any-moment kind of way. If you have people who can be patient and do that, I think you could train them. You probably would need masters' level supervisors who can do the behavioral programming and pull the person out of the mire ever so often. Sometimes a professional gets frustrated when they are being unsuccessful. They need someone who checks their cognitions. We are just as susceptible to cognitive distortions as are other people. I mean, when we go to houses that smell, where kids are poorly clothed, people are not clean, and there are rat droppings around, that has an impact on the person who goes there.

Trainees and workers need somebody who can help them sort through what is going on and can stand back from it and help them keep moving with the case. The problems are usually a lot more chronic when it comes to neglect. They are typically not acute, which means you are not going to see massive success immediately. This work really requires a certain kind of mentality in that you look for the success in small increments.

***Dr. McCarroll: Would you give your case workers in training a mini course in cognitive-behavioral psychology? I liked your concept of "in-the-moment" reactions..***

Dr. Azar: Yes. They need to learn more behavior modification techniques. They need to be able to do functional analysis, to take every skill and break it into smaller steps and then break it down again if they need to. Then, they need good cognitive behavioral skills to use when they hit bumps in the road with a mother. They always need to ask why she thinks something happened in order to see if there is some cognitive obstacle to proceeding with the behavioral techniques you want her to use.

The training issue also bears on the fidelity of the program. It is so much easier to work with some one in supervision when you have a video of them working. I can point out that they look disgusted by what the client said and the clients feel that. It is not surprising that the client does not respond like you would like her to. I remember a supervision case in which the mother had her head on her hands leaning on the chair. Her chin was on the desk. The two supervisees were busy doing their behavior mod chart and were totally oblivious to this mother's being disgruntled and unable to engage. They ignored it.

*Dr. McCarroll: Thank you, Dr. Azar. I wish you good luck on your grant. Well, your work is inspiring.*

Dr. Azar: OK. Thank you so much.

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**Key Points**

There is an association between neglect and parental intellectual limitations.

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Lack of stimulation is one element in neglect. In a household, how many books are around, how many toys that you can learn language with, how barren and monotonous is the home, how much time do they spend with the TV on?

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The social-cognitive capacities that are required to be effective as a parent include:
— Belief systems about children,
— Problem solving capacity,
— Cognitive flexibility,
— Cognitive complexity, and
— Attributional style and attributional biases toward children.

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Parents who are inflexible in their cognitive capacities are not going to have the safety net that other parents have. They cannot get themselves out of a corner once they are backed into it.

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# Child Maltreatment in the Context of Domestic Violence

*By James E. McCarroll*
*Joining Forces Joining Families Volume 9, Issue 3, July 2006*

Scientific literature on family violence has documented the co-occurrence of domestic violence and child maltreatment. However, the occurrence of one does not mean that the other is automatically present (see, for example, Jouriles & LeCompte, 1991). Dr. Jouriles' research has been directed toward understanding the complex relationships between domestic violence (e.g. violence directed at or between spouses or adult partners) and physical aggression toward children.

In an early study of families in which battered mothers had requested sheltering for themselves and their children, boys were more often the victims of parental aggression than girls (Jouriles & Norwood, 1995). This aggression toward boys seemed to occur due to their tendency to exhibit more externalizing behavior (e.g., oppositional, aggressive, non-compliant, rule-breaking) than girls, but this was not the whole story. Both fathers and mothers were more aggressive toward boys than toward girls. Mothers' aggression toward boys tended to be more in response to externalizing behaviors whereas fathers were more aggressive toward sons even when differences between boys' and girls' externalizing behavior was taken into account.

Further research by Jouriles and colleagues explored differences in mothers', fathers', and children's reports of parental aggression toward children (Jouriles, Mehta, McDonald, et al., 1997). They studied families in which the parents sought clinical services for their children's behavior problems. Children reported lower levels of parental aggression than that reported by either parent. Investigators noted that in the absence of a "gold standard", it is impossible to determine which family member reports are the most accu-

rate. [*Editor's note*: The term gold standard denotes the highest possible level of value. A gold standard test is not infallible, just the best that is known. Unfortunately, applicable gold standards in medical practice or behavioral science are rare.]

There are many complex issues to be addressed when obtaining data from both children and parents. Family members may describe the same act of aggression differently. Children may fear punishment or removal from the family if they disclose parental abuse. There may be downward biases in parents' reports of aggression related to its severity. For example, they may be more likely to report spankings than beatings. The authors concluded that it was not possible to unambiguously determine the prevalence of aggression from a single family member's report (either parent or child). They suggested that assessment of aggression should include, at a minimum, independent reports from multiple family members and an assessment of factors that might bias their reports.

An intervention study to reduce conduct problems among children of battered women residing in shelters tested the effects of providing support to the mothers and teaching them child management skills (Jouriles, McDonald, Spiller, et al., 2001). Assessments of child behavior were conducted at five different points over a 16-month period following the mothers' departure from the shelter. Compared to children who received usual shelter services, children in the intervention condition improved at a faster rate, the proportion of children showing clinical levels of conduct problems decreased, and mothers showed greater improvements in child management skills.

A study of the effect of witnessing interpersonal violence on 8 to 14 year old children residing in battered women's shelters found five different patterns (clusters) of child maladjustment that could reach clinical levels (Grych, Jouriles, McDonald, et al., 2000). These clusters were made up of combinations of high levels of externalizing (aggression and disruptive behavior) and internalizing (anxiety and depression) behaviors, mild distress, and no problems reported. Patterns of the clusters were similar for girls and boys. High levels of externalizing problems were much more common than internalizing problems. Children who reported clinically significant levels of depression and anxiety (internalizing problems) were also more likely to demonstrate elevated externalizing problems, but the reverse was not true. The amount and type of aggression experienced by children and their perception of parental conflict distinguished among the groups of children. Their reports of interparental violence and parent-child aggression appeared to fit a dose-effect model, at least for fathers' behavior (father aggression toward mother and toward child).

Another finding was that mothers were less violent toward their partners than were fathers. Possible explanations for this were: 1) mothers' violence toward their spouse may be in self-defense, 2) fathers who are abusive may tend to draw away from their children and thus be viewed in a more negative light by the children, and, 3) fathers may not be biologically related to the child and may therefore be perceived differently.

Perceptions and appraisals of conflict differ both methodologically and statistically. Some reports seem to be more valid when collected from the child (e.g., internalizing feelings) whereas parents may be better raters of the child's externalizing behaviors. Finally, Jouriles' studies showed that a significant percentage of children living in shelters do not exhibit distress or signs of behavioral maladjustment. Understanding why such children continue to function well despite the stress is an important question and one on which there is little research.

Children's perceptions of violence by parents may differ depending on the context and their appraisals of interparental conflict, which affects the existence and type of problems exhibited by children (Jouriles, Spiller, Stephens, et al., 2000). In this research, children were asked to report their own appraisals of interparental conflict using three measures: self-blame, threat, and fear of abandonment. Self-blaming correlated with mothers' reports of externalizing child problems. All three measures correlated with child self-reports of anxiety and depression. Importantly, child age moderated relations between the report of the children and mother's reports of child adjustment problems.

The authors stressed the importance of considering children's appraisals in a developmental framework and that age should be considered when attempting to understand relations between children's appraisals of interparental conflict and child adjustment problems. For example, younger children are more likely to blame themselves and feel more threatened and more fearful of abandonment in response to conflict than are older children.

If domestic violence and child maltreatment exist in the family, there is no research that shows that one treatment approach is better than another (Jouriles, McDonald, Slep, et al., 2005). An approach has not been demonstrated that is successful in simultaneously treating both domestic violence and child maltreatment.

Jouriles and colleagues raise a number of clinical, legal, and ethical issues in assessing child abuse in a domestically violent family (Jouriles, McDonald, Slep, et al., 2005). If there are children in the family, assessment of domestic violence may uncover child maltreatment, which (by law) necessitates a report to Child Protective Services. In addition, such findings can prompt feelings of intrusiveness and coercion on the part of the parents as well as

fear of having a child or children removed from the home and the possibility of legal sanctions against the abuser. Parents may also worry about financial losses due to the removal of a parent or possible loss of income from having to attend treatment or court. Children may worry about whether they had a role in the abuse, fear having a parent taken away or being removed themselves, and the threat of further violence toward them or toward a parent. Clinicians worry about how to work with a family given the requirements of the law as well as their own physical safety should the parental abuse hold the clinician responsible for disruption or breakup of the family.

In a recent publication, Jouriles and colleagues (Jouriles, McDonald, Slep, et al., 2005) conclude that:

- Children in domestically violent families are at increased risk for physical child abuse compared to children in homes without domestic violence.
- The most typical pattern of co-occurrence of child and spouse abuse appears to be one in which the adult partners are mutually aggressive and one or both of the adults maltreats the children.
- Assessment for child abuse in physically violent families is prudent for both treatment planning and prevention of further violence.
- Assessment is best conducted when there are well-developed policies to assist both clinicians and clients in avoiding pitfalls of such assessment in the process of domestic violence services.

[*Editor's note:* The research presented here by Jouriles and colleagues was conducted on women and children in domestic violence shelters and involved severe interparental and parent-to-child maltreatment. The investigators point out that it is not clear whether or in what circumstances the results of this research can be applied to other populations of parents and children. Nevertheless, their work has been thoughtful, and deals with a problem (co-occurrence of domestic violence and child maltreatment) that affects the military services as well as the larger US society. The reader must be careful about generalizing these results to non-shelter populations. However, we believe that their work deserves consideration for its results and recommendations, particularly for assessment, prevention, and intervention in situations in which both child and spouse maltreatment occur.]

### Assessment of Domestically Violent Families: Practical Considerations Based on Research by Jouriles and Colleagues

Dr. Jouriles' research has practical implications for assessment that can be incorporated into the Army Family Advocacy Program. We offer the following points for your consideration.

- Child maltreatment should be carefully defined and assessed. It can include acts of commission (e.g., hitting, slapping, shaking) and omission

(neglect). Neglect has many subcategories (medical, educational, emotional). Child maltreatment is also characterized by its context (e.g., with or without domestic violence) and its frequency and severity.

■ Problems that children experience in domestically violent families do not arise solely from witnessing domestic violence. These children are also often child abuse victims. Children exposed to domestic violence should be assessed to determine (1) whether the children were victims or participants in the incident, and (2) their appraisal (understanding) of the events.

■ What does a child's witnessing of domestic violence imply for assessment and treatment? Often, children intervene in domestic violence in an attempt to stop the violence. Distinguishing between parental conflicts that are irresponsible or inappropriate versus incidents that are harmful for children can be difficult, but is important to the assessment. One must also consider the behavior of the parent to the child in making a judgment about whether the family conflict is harmful to a child.

■ Reports of spouse and child maltreatment vary greatly by the reporter. Therefore, multiple sources of information are needed for the assessment. In addition, it is important to consider the child's age and developmental level.

■ Is maltreatment a within-individual phenomenon (father abuses adult and child) or a between individuals phenomenon (father abuses adult partner, adult partner abuses child)?

**Research suggestions**

■ What are the factors that predict physical aggression toward girls versus boys in distressed households (Jouriles and LeCompte, 1991)?

■ Why is the battering of women associated with an increased amount of parental aggression toward sons but not daughters (Jouriles & Norwood, 1995)?

**Key Points**

Dr. Jouriles' research has been directed toward understanding the complex relationships between domestic violence and physical aggression toward children.

Children's perceptions of violence by parents may differ depending on the context and their appraisals of interparental conflict, which affects the existence and type of problems exhibited by children

Assessment is best conducted when there are well-developed policies to assist both clinicians and clients in avoiding pitfalls of such assessment in the process of domestic violence services.

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INTERVIEW WITH ERNEST N. JOURILES, PHD

# The Co-Occurrence of Child and Spouse Abuse in Families

*By John H. Newby, PhD*
*Joining Forces Joining Families Volume 9, Issue 3, July 2006*

***Dr. Newby: How did you get involved in research on the co-occurrence of child and spouse abuse in families?***

Dr. Jouriles: My interest in this topic began in graduate school. A lot of my research involves children living in families characterized by spouse abuse or domestic violence. These children appear to be at a higher risk for problems than other children. Some of the problems are related to domestic violence. But, it became clear to many people working in this area that child maltreatment was also occurring in many of these families and was likely contributing to the children's problems.

***Dr. Newby: When you use the term child abuse or child maltreatment in your work do you mean all categories of child maltreatment?***

Dr. Jouriles: Typically, I do not. The type of child maltreatment focused upon in most of this research is child physical abuse. There are a few studies that look at other forms of maltreatment, but the vast majority address physical abuse.

***Dr. Newby: How common is child maltreatment in domestically violent families?***

Dr. Jouriles: There is a lot of variability in the frequency reported in the literature due to how child maltreatment is defined. However, most studies suggest that the rate is greater than 40%.

***Dr. Newby: Does that 40% include families in which the violence ranges from very mild to very severe?***

Dr. Jouriles: There is an association between the frequency and severity of domestic violence and the likelihood of parental aggression toward children. The more frequent and severe the domestic violence between the parents, the more likely there is to be parental aggression toward children. Most of the research on the co-occurrence of child abuse and domestic violence focuses on families that have sought help from a shelter because of the domestic violence. When such help is sought the domestic violence is often very frequent and severe.

*Dr. Newby: What are some of the reasons for the co-occurrence of child abuse in families that experience spouse abuse?*

Dr. Jouriles: Some of the risk factors for spouse abuse and child abuse are similar. Family variables that correlate with spouse abuse also seem to correlate with child abuse. Examples include substance abuse within the family or a history of violence in the parents' family of origin. Certain personality traits such as hostility or poor impulse control are observed in families where both spouse abuse and child abuse occur.

*Dr. Newby: Are there specific issues that you consider in the assessment and treatment of families seeking help for co-occurring child and spouse abuse?*

Dr. Jouriles: Yes. The assessment should include the possibility of more than one type of violence occurring in the family. More people are becoming aware of the link between domestic violence and the maltreatment of children. I am still surprised by the number of people who primarily deal with domestic violence and are reluctant to assess the situation for child maltreatment. Part of this has to do with the reporting requirements for child maltreatment. The same requirements do not apply for domestic violence. Clinicians also need to be concerned about the safety of family members. It is important to assess whether any family member is in immediate danger.

*Dr. Newby: What is the priority in the treatment regimen in these families?*

Dr. Jouriles: It depends on what is going on in a particular family. I am not aware of research indicating that when both child and spouse abuse are occurring, one set of problems is dealt with before others. You have to handle each individual family on a case-by-case basis.

*Dr. Newby: Are you aware of any research comparing differences between incidents of child abuse in domestically violent versus non-domestically violent families?*

Dr. Jouriles: I am aware of research indicating that child abuse is much more prevalent in domestically violent families compared to non-domestically violent families. Anecdotally, I can tell you that within domestically violent families, there are ways that children get abused that are directly connected to incidents of spouse abuse and domestic violence. For example, children may be abused when they attempt to intervene in episodes of domestic violence.

*Dr. Newby: Are there specific patterns of spouse or child abuse that occur in domestically violent families?*

Dr. Jouriles: You can find examples of almost any configuration of par-

ents hitting each other and one or both parents hitting the children. It is an area that a lot of people have talked about, but there has not been much research on the subject.

***Dr. Newby: Have there been any successful interventions relative to curtailing the co-occurrence of child and spouse abuse in families?***

Dr. Jouriles: I am not actually aware of any interventions that have been directly tailored for dealing with co-occurring child and spouse abuse. The Project Support intervention that Renee McDonald and I developed and have been evaluating does work with women and children exiting domestic violence shelters. We work on child management skills and have found that there is a reduction in parental aggression towards children as a result of the intervention. Also, women who take part in the intervention are less likely to return to the batterer who was responsible for them seeking shelter. Clearly, there is a need for more research focusing on families with co-occurring child and spouse abuse.

***Dr. Newby: Could you comment on the belief that witnessing domestic violence by children should be considered emotional maltreatment?***

Dr. Jouriles: From my own research as well as the research of others there is a lot of evidence suggesting that witnessing domestic violence is harmful, and the more violence that is witnessed, the more harmful it is going to be. However, you can also make the argument that parents do a lot of things that are potentially harmful to children and generally should not be not considered child maltreatment. For example, smoking in front of a child could be harmful. In defining child maltreatment where do you draw the line? Witnessing domestic violence is certainly not good for children, but is it really a form of child maltreatment in the same way we think of physical abuse or neglectful parenting? I'm not sure.

***Dr. Newby: You seem to be saying that there should be some caution regarding the diagnosis of emotional maltreatment relative to children who witness domestic violence.***

Dr. Jouriles: We are starting to do some research on this in our lab. Sometimes I wonder whether a child witnessing a push, grab or shove would be more harmed than the child witnessing yelling and screaming. If we start routinely defining the witnessing of domestic violence as a form of child abuse, I suspect that we would end up getting a lot more child abuse cases and the system would have to be ready to handle the increase.

***Dr. Newby: What are your future research plans on the co-occurrence of child and spouse abuse in families?***

Dr. Jouriles: We are continuing to work on some of our intervention re-

search that involves families identified because of domestic violence and who have co-occurring child abuse. We are trying to reduce parental aggression and the violence that these children are exposed to including aggression that may be occurring between their parents even though the parents are temporarily separated. Since most of my past intervention research has been done with women and children, I am also interested in working more directly with the men in these families.

Dr. Newby: How would you do that?

*Dr. Jouriles: Fathering has received much less research attention than it warrants, particularly fathering by men who engage in violent behaviors. There are some complex issues occurring in some of these families. For example, you may have a man in the family who is abusive towards his partner, but has a warm caring relationship with his children.*

*Dr. Newby: What has been your experience in trying to reach the husbands and fathers of women and children residing in shelters?*

Dr. Jouriles: Given that safety is always a huge concern for women and children in domestically violent families, it is a delicate situation. There are some agencies that primarily work with men in violent relationships. They have encouraged us to start working with them. Doors are being opened to possibly conduct research and develop interventions with abusive husbands and fathers.

*Dr. Newby: Thank you for this interview.*

Dr. Jouriles: You are welcome.

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**Key Points**

The more frequent and severe the domestic violence between the parents, the more likely there is to be parental aggression toward children.

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There is a lot of evidence suggesting that witnessing domestic violence is harmful, and the more violence that is witnessed, the more harmful it is going to be.

REVIEW OF RECENT RESEARCH OF ERNEST N. JOURILES, PHD

# Effects of Domestic Violence on Children: Behavior and Memory

*By James E. McCarroll, PhD*
*July 2009*

Our first interview and summary of Dr. Jouriles' research focused on the co-occurrence of child maltreatment and domestic violence. Complex relationships are involved in this work: children witnessing domestic violence, aggression of the father toward the mother, and aggression toward the children. Specific topics discussed in those articles indicated the importance of assessing for different types of maltreatment, particularly of children and how to consider treatment issues for both children and adults. Particularly interesting was his description of Project Support, a program for working with mothers during their stay and after leaving a domestic violence shelter. This work is directed at improving parenting skills and lowering parental aggression toward children.

An important part of this work was also directed toward understanding children's perceptions and appraisals of conflict. Children's concepts of the conflict depend on its context and those appraisals can affect children's subsequent behavior. In this research, children were asked to report on three concepts: self-blame, threat, and fear of abandonment. These measures correlated with depression and anxiety, but were moderated by the child's age. The authors urged the importance of considering children's appraisals in understanding their adjustment problems.

Dr. Jouriles' and colleagues have published several new studies. McDonald and colleagues examined the effects of different kinds of family violence on children's internalizing and externalizing behaviors (McDonald, Jouriles, Tart, et al., 2009). Children and their mothers (n=258) recruited from domestic violence shelters completed measures of men's intimate partner violence (IPV), women's IPV, partner-child aggression, and mother-child aggression. Mothers reported their children's internalizing and externalizing behaviors and children reported their appraisals of threat in relation to IPV. Since the women were all severely abused by their male partner, one of the purposes of this study was to examine whether additional forms of family violence contributed to children's adjustment problems. After controlling for men's IPV, each of the additional forms of violence was associated with children's externalizing problems. Mother-child aggression was more strongly

associated with externalizing problems for boys than for girls. Partner-child aggression was associated with internalizing problems and with children's threat appraisals. The authors noted that IPV seldom occurs without other forms of violence and that all of them contributed to children's adjustment problems.

Treatment programs for children should assess and treat all forms of violence, especially mother-child aggression. Large numbers of children are brought to domestic violence shelters each year. In the sample reported here, in the 6 months prior to the study, almost half of the children had been subjected to severe violence by their mother's partner and about one third by the mother. There are many barriers to providing services for children of mothers who come to domestic violence shelters. For example, women's shelters have limited resources for assessing and helping abused children (McDonald, Jouriles, Tart, et al., 2009). It is also possible that such action could have negative consequences for the mother if the child were to be identified through a report to child welfare agencies, including the mother losing custody of the children. Such outcomes could deter the women from seeking help. Also, it is very difficult to offer services to children in the midst of what is often a chaotic situation for the mother. These are not simple issues. Intimate partner violence and child maltreatment often co-occur; the solutions and the consequences for both adults and children are serious. Many other complex results and suggestions for both services and research were suggested by McDonald et al.

McDonald and Grych (2006) continued to explore children's appraisals of interparental conflict: are the appraisals of 7-9 year olds reliable and do they mediate the association between exposure to interparental conflict and their adjustment problems? The authors found that children's appraisals of interparental conflict could be reliably measured and that perceptions of threat and self-blame function similarly in 7-9 year old children as they do in adults. This study has important implications for understanding children's appraisals of conflict: perceptions of threat and self-blame occur early in life and can affect children's development and behavior.

Jouriles and colleagues continued their research on cognitive functioning in young children and their explicit memory (Jouriles, Brown, Silver, et al., 2008). Explicit memory is the ability to capture, process, and store new information (Schacter, 1987). In this study, the authors explored the relationship between explicit memory and intimate partner violence (IPV). Children's explicit memory was negatively affected by IPV even when controlling for aggression towards the children themselves and demographic variables. Parent-child aggression was not related to any measure of explicit memory functioning above the effects of IPV and mother's partner living in

the household. The frequency of IPV was positively related to children's explicit memory. When the mother's positive parenting was low, as measured by the Positive Parenting scale of the Parent Perception Inventory (Hazzard, Christensen & Margolin, 1983), IPV was related to poorer memory function. When positive parenting was high, there was a weaker relation between IPV and explicit memory function. Thus, mothers can decrease some of the negative effects of IPV on children through positive parenting such as playing with the child, spending time with the child, listening, and talking, and doing things together that the child likes. However, the potential negative effects of IPV on children's developing brains cannot be discounted.

The understanding of the beginning and continuation of psychological and physical aggression in couples is an important area of research and practice. It has been well established that pre-marital psychological aggression predicts later aggression in marriage (see for example, Murphy & O'Leary, 1989; O'Leary & Slep, 2003). Links were explored between psychological and physical relationship aggression and later psychological distress among 125 high school students over an 8-week period (Jouriles, Garrido, Rosenfield, et al., 2009). Psychological aggression was much more frequent than physical aggression. On one measure, 91% of participants reported experiencing at least one act of psychological aggression (mean-10.1) and 27% reported physical aggression (mean=1.1) during the study period. There were no difference in males and females in their appraisals of the unpleasantness of psychological and physical aggression. Among those who experienced both types of aggression, psychological aggression was rated as more unpleasant than physical aggression, and psychological aggression was less likely to be rated as the partner "playing around." Both psychological and physical aggression were correlated with psychological distress. (It has been frequently found that adult women find psychological aggression more damaging to their mental health than physical aggression (see for example Arias and Pape, 1999). Possible reasons for the harmfulness of psychological aggression suggested are that it occurs more frequently than physical aggression and was perceived as more intentionally hurtful (Jouriles, Garrido, Rosenfield, et al., 2009). Psychological aggression was also associated with relationship anxiety: worry about being alone with their partner, worries about their partner doing something bad to them, and wanting to avoid their partner. Relationship anxiety is a relatively new concept. It is correlated with depression and trauma. The authors suggest that it may be a useful concept to help identify adolescents in abusive relationships.

Physical aggression was inconsistently associated with psychological distress. This may have been due to the short period of reporting (8 weeks) or the adolescents in this study were not at high risk for physical aggression.

The finding of physical aggression being attributed to "playing around" was intriguing to the investigators and thought worthy of further study.

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**Key Points**

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Intimate partner violence and child maltreatment often co-occur; the solutions and the consequences for both adults and children are serious.

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The dynamics of the co-occurrence of child maltreatment and domestic violence are complex including children witnessing domestic violence, aggression of the father toward the mother, and aggression toward the children.

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Large numbers of children are brought to domestic violence shelters each year. Treatment programs for children should assess and treat all forms of violence, especially mother-child aggression.

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Children's appraisals of interparental conflict can be reliably measured and their perceptions of threat and self-blame function similarly in 7-9 year old children as they do in adults.

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Mothers can decrease some of the negative effects of IPV on children through positive parenting such as playing with the child, spending time with the child, listening, and talking, and doing things together that the child likes. However, the potential negative effects of IPV on children's developing brains cannot be discounted.

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# Helping Children in Domestically Violent Families

*By James E. McCarroll, PhD*
*July 2009*

**Dr. McCarroll: Much of your research has been on the effects of domestic violence on children. Children living in a home with severe domestic violence are also at risk for maltreatment.**

Dr. Jouriles: When intimate partner violence (IPV) and child maltreatment co-occur, both contribute independently to child problems. Intimate partner violence is harmful for kids, maltreatment is harmful for kids, and both in combination are more harmful than either of them alone. I think that is important.

**Dr. McCarroll: Can we make the assumption that children exposed to interpersonal adult violence are traumatized?**

Dr. Jouriles: I would not go that far. There are different types of violence exposure. You could make the argument that a child is exposed to violence if they are living in a home where the parents are violent even if the children are not directly seeing the violence. The children can be aware of the violence because of what their siblings say or because they notice bruises on a parent. Also consider that some define violence as an act of physical aggression that has occurred in a given time frame. Others use very different definitions that might include more frequent and severe violence. I am not sure that exposure to a push, shove, or grab between parents would traumatize kids.

**Dr. McCarroll: Your papers use the terms externalizing and internalizing in referring to the behavior of children. Would you describe what you mean by these terms?**

Dr. Jouriles: Externalizing often involves behaviors associated with diagnoses of Conduct Disorder, Attention Deficit Hyperactivity Disorder, or Oppositional Defiant Disorder. It involves aggressive behaviors such as stealing, noncompliance, not following rules, and other antisocial activities. Those behaviors are often considered more prevalent among boys than girls in the general population, but we find that in violent families often both boys and girls are engaging in those types of behaviors.

Internalizing consists of depression, anxiety, and a lot of what we think about in terms of trauma symptoms.

**Dr. McCarroll: Do you see children with both externalizing and internalizing behaviors?**

Dr. Jouriles: You definitely see children with both. A lot of studies on the classification of child psychopathology have identified these two broad dimensions — externalizing and internalizing — but, it is often the case that they go together. That is, when a child has externalizing problems, they are sometimes exhibiting internalizing problems as well. There is also a developing literature on relational aggression, a type of aggressive behavior that has to do with turning one's friends against someone else such as by spreading rumors. That type of aggression is often associated more with girls than boys, although both genders tend to engage in it.

**Dr. McCarroll: How do you approach treatment with children and parents with these problems? In one of your articles, you suggested staffing domestic violence shelters with people who can help the children.**

Dr. Jouriles: That would be an ideal situation, but work done at a shelter or during a short stay is only the tip of the iceberg. We need to keep working with the families after they leave the shelter. Violent families are often multi-problem families. That is, violence is one of many problems in these families. It can be overwhelming figuring out where to start. But, in working with the women, we found a very powerful effect if we stuck with them, after they left the shelter, and tried our best to help them over time.

**Dr. McCarroll: The military has a huge investment in new parent support programs including home visitation. How did you teach parenting skills to the mothers in the limited time available to you? What was important and how did you do it?**

Dr. Jouriles: While they are at the shelter the mothers often are dealing with many other urgent concerns. We try to develop a rapport with them so they trust that we have the family's best interest in mind. We also try to help in getting the families resources. Once they leave the shelter we start home visits with them. During the initial home visits, we just try to help them get settled and back on their feet. We eventually start working on child management skills with the idea that these women can play an important role in helping children recover the effects of living in a severely violent family. Our intervention is very hands-on in that we describe child management skills, model the skills for the mothers, and role play with them. Then we bring in the kids and practice with them. There is a lot of repetition; it's not a parenting class.

*Dr. McCarroll: Can you detail some of those skills that you consider the most important?*

Dr. Jouriles: We spend a lot of time just trying to enhance the parent-child relationship. Some of the skills have to do with just being able to spend time with the kids that is rewarding to both the mothers and the children. We also teach how and when to praise, to comfort their kids, to develop listening and communication skills, and to play with their kids. We also teach strategies to discourage antisocial child behavior that do not involve physical aggression. Examples are time out and removing privileges effectively to decrease the likelihood of antisocial child behaviors. This strategy can be very effective when you have a child that is already acting out in a significant way. You need both.

*Dr. McCarroll: Is there a hierarchy of teaching to the mothers? Do you focus first on to controlling the antisocial behavior or on the positive parenting?*

Dr. Jouriles: We usually start with the positive parenting, but if there is an emergency situation we would do what is necessary to handle it.

*Dr. McCarroll: Have these women moved to a new home out of the violence or do you find them going back into the same home?*

Dr. Jouriles: Most of our work has started with women who are trying to set up a residence independent of their violent partner. But, most of them have one foot in and one foot out of the relationship. When there are kids involved it gets complicated.

*Dr. McCarroll: You noted in your papers the need to work with the severely violent men.*

Dr. Jouriles: If there is a man involved in the family or if the woman does reunite with the man, we talk with the woman about involving the man in the sessions that we offer. A lot of these men are already in domestic violence treatment programs. The parenting part is in addition to it. We are not trying to keep anything secret and the woman's safety is always of primary importance.

Does our intervention stop the violence? I would not say that it does in all cases, but I do think that it reduces it. We make the women aware of just how the exposure to violent adults can have a negative influence on their kids no matter who is committing the violence.

*Dr. McCarroll: You wrote about the need to learn about the experiences of children in families. What kinds of experiences are you interested in learning about?*

Dr. Jouriles: When we talk with children about what is going on with their

parents. The siblings often have very different views. Some are very frightened by their parents' violence whereas to others it is more of an annoyance. We have also found that, even in families where there is severe intimate partner violence, the violence is often not the most important issue going on in the kids' lives. There is a lot we can learn from talking with the kids to get a better understanding how they are fairing within these families.

***Dr. McCarroll: One of your recent articles was on the effects of exposure to violence on children's explicit memory. What is explicit memory?***

Dr. Jouriles: Explicit memory is used interchangeably with working memory. Explicit memory is very important in a lot of developmental tasks, including doing well in school and following instructions. When a parent gives multiple commands, a child needs to keep everything straight in their mind.

I believe that the effects of a parenting intervention are perhaps more broad than most of the studies indicate. For example, in our research, to date, we have looked at the effects of IPV specifically on externalizing problems and internalizing problems. We have also found that living in these violent families seems to be linked to memory processes. I think that is very intriguing. An important question is if a psychosocial intervention, such as parenting, will have effects that go beyond the externalizing or internalizing problems into, for example, memory processes. We need to broaden our approach and our measurement, especially for kids in these multi-problem situations.

***Dr. McCarroll: The literature on the effects of war on children seems to show that disturbances of children typically follow the disturbances of the parent. In other words, if the mother is distressed the child will be distressed. In your studies you are working with the mother to ameliorate the effects of stress on the kids, and yet one would suspect that the mothers are having problems, too. Do you think that positive parenting training is therapeutic and a form of intervention for the mothers themselves?***

Dr. Jouriles: I do think so, at least with some of the families with which we have worked. The mothers are very happy with the fact that they can do things to help their kids. It is important to keep in mind that with our parenting interventions we spend a lot of time working specifically with the mother on issues that she is experiencing. About half of our sessions are devoted to the parenting intervention, but the other half are devoted to helping the mom. A lot of the moms are basically starting their lives over in a new residence, in a new neighborhood. We help the mother to get settled and to make good decisions about what is going on in her life and in her family's life. From my perspective what we want to do is to find out what works and to do our best to offer programs that work for these families.

*Dr. McCarroll: Deficits in explicit memory were shown in your studies by careful measurement. How would a parent or a teacher recognize that a child is having memory problems that require some kind of intervention versus kind of dealing with the normal ebb and flow of what happens in the classroom or day-to-day in a family's life? How would they notice them? Are these effects subtle or are they more easily seen?*

Dr. Jouriles: If a parent or teacher notices that the child is having difficulties keeping things straight or following commands or forgetting easily, I think that that would be a clue that there may be an issue. In the classroom there is a lot more opportunity to see if there are difficulties with memory just because of the tasks that kids are asked to do. There are different tasks in which we can help children with attention and with memory processes. We can get the children back on the right track.

*Dr. McCarroll: How would you recommend that they do that? By getting an appointment with a primary care doctor or with a psychologist?*

Dr. Jouriles: The family could ask the pediatrician if this is unusual. "Is this something I should be concerned about?" The pediatrician is a good gatekeeper. Also, school personnel often can be very helpful not only pointing a parent in the right direction, but in getting converging evidence as far as whether this is a problem both at home and at school. The school counselor can help because their services are not going to cost the parent anything. Schools have staff trained to test for such problems. But, with regard to parenting and parent-child interaction, especially with pre-schoolers and young school age kids, a lot can be done to promote positive child behavior just by the positive parenting and being very aware of how you are parenting. Parents can teach children many different things. Most of us want our kids to do well and not just to behave well. We can help our kids make better decisions and take care of themselves such as by cleaning up after themselves and exercising and eating well. All of these can be influenced by parenting.

*Dr. McCarroll: Child maltreatment and IPV are usually handled in different social and legal systems. When there is co-occurrence, how can agencies work together to protect children?*

Dr. Jouriles: I believe that individuals who work with intimate partner violence need to assess for the possibility of child maltreatment and people who work primarily with child maltreatment also need to consider intimate partner violence in the families. A good starting point is to assess for its co-occurrence. However, I think that very little of that is going on in agencies around our country.

*Dr. McCarroll: Thank you.*

Dr. Jouriles: You are welcome.

**Key Points**

When intimate partner violence (IPV) and child maltreatment co-occur, both contribute independently to child problems.

Explicit memory is very important in a lot of developmental tasks including doing well in school and following instructions. When a parent gives multiple commands, a child needs to keep everything straight in their mind. Living in these violent families seems to be linked to problems in children's memory processes.

**BACKGROUND TO RECENT RESEARCH ON HOME VISITING TO PREVENT CHILD MALTREATMENT**

# Home Visiting: Research Review and Implications for Family Advocacy Programs

*By James E. McCarroll, PhD, and Robert J. Ursano, MD*
*Joining Forces Joining Families, Volume 8, No. 1, Fall/Winter 2004*

In this review of a series of articles we summarize recent research reports on home visiting and its relation to preventing child abuse and neglect including some of the research of John J. Eckenrode. Dr. Eckenrode is interviewed in separate articles in this volume.

A series of articles on Hawaii's Healthy Start Program (HSP) was recently featured in *Child Abuse & Neglect* (Duggan, McFarlane, Fuddy, et al., 2004; Duggan, Fuddy, Burrell, et al., 2004; Windham, Rosenberg, Fuddy, et al., 2004; Chaffin, 2004). The Healthy Start Program (HSP) is a national prevention program for families at risk for child maltreatment. These articles raise important research questions for Army home visiting programs and Army professionals charged with their oversight.

The articles in *Child Abuse & Neglect* were based on a three-year follow-up of home visiting of at-risk families on the island of Oahu, HI. The research methodology was a randomized trial. The first study (Duggan, McFarlane, Fuddy, et al., 2004) addressed whether home visiting prevented child maltreatment. The second study (Duggan, Fuddy, Burrell, et al., 2004) examined the impact of home visiting on parental risk factors (e.g., maternal mental health, substance abuse, partner violence) and whether the intervention affected a mother's interest in and utilization of community services to address risk factors. The third study (Windham, Rosenberg, Fuddy, et al., 2004) investigated the relationship between parent and child characteristics and mothers' reports of child maltreatment in the first three years of the child's life. An invited commentary summarized the three studies and provided suggestions for further research (Chaffin, 2004).

The three studies examined the same sample, 643 at-risk families en-

rolled in HSP from November 1994 to December 1995 in six home visiting programs. Families were identified as at-risk by a variety of sources: information from prenatal care providers, review of the mother's medical record, and assessment at the hospital when the child was born. A semi-structured assessment instrument, the Kempe Family Stress Checklist (Kempe, 1976), also determined risk. Family enrollment was voluntary. The study randomly assigned families to either the HSP (n=373) or to a control group (n=270). Home visits were conducted in the HSP group by paraprofessionals working under professional supervision. All home visitors had a high school diploma. Supervisors had a master's degree in a public health, health, or a human service field and three years experience in client service and administration or a bachelor's degree and five years of relevant experience.

Home visitors were given five weeks of initial core training and additional training including explicit examples of how parental risks might be linked to home visiting goals and intervention activities. The home visitors were trained in a range of services to help parents address existing crises, to model problem-solving skills, and how to access services (e.g., income, nutrition, domestic violence, parental substance abuse and poor mental health). They also provided parenting education, modeled effective parent-child interaction, and ensured that the child had medical care. Services were directed to the mother and the father, if possible. The HSP model called for 3–5 years of home visiting in which families who were enrolled at the initial level were visited weekly. There were explicit criteria for promoting the family to a higher level based on increased family stability and identification of a positive support system. With promotion to higher levels, the frequency of home visiting was decreased to biweekly, monthly and quarterly.

Control families did not receive the home visiting intervention, but were evaluated using the same methods as HSP families. Outcome data were collected in annual maternal interviews using self-reports of abuse and standardized measures, observations of the home environment, and records indicative of child abuse and neglect (Duggan, McFarlane, Fuddy, et al., 2004).

Child maltreatment was defined primarily by the mother's report of her own psychologically and physically abusive behavior toward the child on the Parent-Child Conflict Tactics Scale (CTS-PC) (Straus, 1995; Straus, Hamby, Finkelhor, et al., 1998). The authors were mainly interested in identifying severe physical assault and assault on the child's self-esteem. Factor analysis (a method for grouping variables) of the CTS-PC showed that severe physical abuse (burned or scalded the child on purpose, grabbed child by the neck or choked, threw or knocked down the child, and hit child with fist or kicked hard). Assaults on the child's self-esteem included items normally

considered psychologically abusive (called child dumb or lazy, mother said she would leave child, and swore or cursed at the child) plus one physical abuse item (slapping the child on the face, head, or ears). Because of the inclusion of one physical abuse item with psychologically abusive items, the authors called this cluster assaults on the child's self-esteem. These items reflected maternal behavior that was demeaning and potentially damaging to the child's developing sense of self-worth. Official records of child maltreatment were also used, but the number of reports was very low and hence may have underestimated child maltreatment incidents.

**Strong risk factors for Severe Child Physical Maltreatment (Chaffin, 2004)**

- Parental depression
- Mother having no partner
- Mother involved in violent relationship
- Child small for gestational age

**Strong Risk Factors for Assaults on Child's Self-Esteem (Chaffin, 2004)**

- Maternal depression
- Mother having no partner
- Mother involved in violent relationship
- Mother's illicit drug use
- Mother's perception of child's demands
- Child's age

At the end of the three-year evaluation, the home-visited and control groups did not differ significantly on either maternally reported child abuse or substantiated reports of child maltreatment. There was a modest impact in preventing child neglect (Duggan, McFarlane, Fuddy, et al., 2004). The program had no significant effect on the mothers' desire for and use of community services. Also, home visiting had little impact on parental risks for child maltreatment in the first three years of a child's life (Duggan, Fuddy, Burrell, et al., 2004). The study showed the same risk factors are associated with child maltreatment regardless of home visiting. Severe child physical assaults were significantly associated with maternal depression, with the mother having no partner, and the mother's involvement in partner vio-

lence as a perpetrator, not solely as a victim (Windham, Rosenberg, Fuddy, et al., 2004).

In addition, both the child's age (highest for 2-year olds) and the child being small for gestational age were related to severe child physical assaults. Interestingly, severe physical abuse was not associated with the mother's age, education, race, parity, or household income level.

Assaults on the child's self-esteem were associated with maternal depression, the mother having no partner, the mother's involvement in partner violence, illicit drug use, the child's age (increased over time from year 1 to year 3), and the mother's perception of the child's demands (Windham, Rosenberg, Fuddy, et al., 2004). The child's demand level was measured by mother's assessment of the child's temperament and behavior.

There were numerous findings related to the role and performance of the home visitor. It appeared from HSP records that home visitors might have lacked skills, training, and supervision. Home visitors seldom noted concern about possible child maltreatment (Duggan, McFarlane, Fuddy, Burrell, et al., 2004) or parental risk factors for child maltreatment (Duggan, Fuddy, Burrell, et al., 2004). Despite the fact that home visiting services were to have been developed based on a case plan that addressed the risks identified in an assessment interview, the authors found that many programs drifted from their original intent. Most families had only one or two goals and these were sometimes broadly stated (e.g., "To be happy!"). These were seldom translated into measurable objectives. For this reason, home visiting activities could not be linked to the achievement of family goals and objectives. Overall, there was also no significant program effect on any of the major parental risk factors for child maltreatment. One of the responsibilities of the home visitor was to recognize the need for professional interventions and to make appropriate referrals. There was little evidence that home visitors were alert to the mothers with the highest levels of abusive behavior. Often, home visitors neither developed a plan to address important factors in the life of the family, nor linked home visiting activities to family goals and objectives (Duggan, Fuddy, Burrell, et al., 2004).

Chaffin's commentary (Chaffin, 2004) asks whether it is time to re-think home visiting as a mechanism to reduce child maltreatment and emphasized the following points. There is a need for randomized clinical trials in psychosocial research. While there are government requirements for data from randomized clinical trials to demonstrate the safety and effectiveness of food, drugs, and medical (and veterinary) treatment, no such requirements exist for psychosocial interventions and there is no approving agency to certify their effectiveness. Practitioners are accredited, but interventions are not. Child abuse prevention programs are often based upon and justi-

fied by advocacy, theory, fashion, guesswork, weak program evaluations and hope. Chaffin addresses how science values skepticism and facts, whereas advocates often have a predetermined agenda and seek facts that buttress their agenda. The price paid for this is often a high level of funding, a sense of mission among the practitioners, and a willingness to accept evaluation data only if the results are positive. The following are among Chaffin's interpretations (Chaffin, 2004) of these studies.

- Partner violence, substance abuse, and parental depression are strong risk factors for future child maltreatment. However, these are the areas that home visitors most often feel least equipped to address.

- Focusing the efforts of home visitors on the known risk factors of the clients may be a better strategy for reducing child maltreatment than the empowerment philosophy. Empowerment models may serve clients poorly by requiring them to self-assess their own risks and intervention needs accurately in order to receive help.

- Empowerment models have strengths that should not be lost. Among these strengths are: establishing collaborative relationships, securing client motivation and buy-in, and avoiding authoritarian service styles that drive clients away.

- Universal programs (targeting all families rather than selecting high-risk families) may be an inefficient use of resources, as many of these families may never mistreat their children.

- The effectiveness of home visiting has not yet been demonstrated. Further study is needed to document which elements of home visiting programs work for which families and for which problems.

- Home visiting programs should not be considered proven models that can be taken off the shelf and be reliably expected to reduce maltreatment. They might better be considered interventions still requiring testing and development.

- Further research should be directed to (Duggan, McFarlane, Fuddy, et al., 2004):

- Study home visiting in a more sophisticated way. The elements for more direct study include home visitor communication skills, visit content, and service quality.

- Include a range of child abuse and neglect indicators in studies rather than relying on substantiated reports or hospitalizations to infer program success. The use of protocols and formal referral arrangements for families with multiple and complex problems would help the home visitors focus on the most important problems rather than trying to solve all the needs of the families.

- Have clear goals and tested models for research that can provide essential

information that will improve the effectiveness of the programs.

- Implement and study a variety of home visiting models and programs as well as a variety of home visiting research efforts.
- Have control groups since studies purportedly showing program effectiveness in uncontrolled studies can be highly misleading. Historically, many home visiting programs show improvement in parental risk factors in families, but so did control families. Without the control comparisons, program success is assumed rather than demonstrated and is ultimately harmful to the program and the families.
- Integrate home visiting into a larger array of community services. In the Army this could be an easy task, but its effect on child maltreatment must be documented. Such a project is potentially more feasible in the Army than in the civilian community due to the concentration of on-post services. However, integrating service delivery with the outside community is more difficult. Nevertheless, in order to determine where families go for help and whether such help is effective in reducing child maltreatment and parents' risk levels remains to be demonstrated.
- Study the effects of participant attrition. In the research reported here, about half the study families dropped out by the end of the first year (Duggan, McFarlane, Fuddy, Burrell, et al., 2004). There was no difference in attrition between study and control groups. Understanding the reasons for program dropout has potentially important implications for program success. An important project that could be undertaken by the Army is to relate program attendance and participation to dropout rates and other measures of the success of home visiting programs.
- Study father involvement. Father involvement was found to be low in these studies even though about two thirds of fathers had been assessed as being at-risk of perpetrating child abuse. The Army has a much greater opportunity to involve fathers in home visiting programs than does the civilian community. Research opportunities abound in this area, as there is essentially no literature at this time on the effects of such programs on fathers.
- Focus the efforts of home visitors on the risk factors that can be modified. This requires the home visitor to learn the proximate causes of child maltreatment, relate them to parent and child risk factors, and develop a plan to address them.

Supervision, training, and ongoing monitoring of the home visitor appear to be critical elements of any home visiting program. While getting from plan to goal may be difficult to demonstrate, it is entirely possible for home visitors to document observations and their attempts to address the

risk factors within the families. Home visiting offers promise, but requires further study. The point of this review is to stimulate research and management interest in improving home visiting programs and making them cost-effective. Home visiting has shown positive benefits (Eckenrode, Ganzel, Henderson, et al., 2000) and remains a promising opportunity for decreasing child maltreatment. It also has the potential for increasing the involvement of fathers in family and community programs and for reaching young mothers who might be socially isolated in remote military communities. With the increasing frequency and length of overseas deployments such efforts will be important in serving military families. We hope that home visiting will receive increased research emphasis in the Army and continue to serve as a keystone of the Army's child maltreatment prevention efforts.

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**Key Points**

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The effectiveness of home visiting in preventing child maltreatment is yet to be determined.

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Home visiting had little impact on parental risks for child maltreatment in the first three years of a child's life. The same risk factors are associated with child maltreatment regardless of home visiting.

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At the end of the three-year evaluation, the home-visited and control groups did not differ significantly on either maternally reported child abuse or substantiated reports of child maltreatment. There was a modest impact in preventing child neglect.

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BACKGROUND OF RESEARCH AND INTERVIEW WITH
JOHN J. ECKENRODE, PHD

# Home Visiting Revisited: One Spoke in the Wheel, Not the Silver Bullet

*By James E. McCarroll, Ph.D.*
*Joining Forces Joining Families Volume 8, Number 2, Spring 2005*

The following interview with distinguished scholar and researcher, John Eckenrode, PhD, of Cornell University, presents a provocative discussion of home visiting expanding upon the previous review of home visiting programs, Home Visiting: Research Review and Implications for Family Advocacy Programs.

Dr. Eckenrode raises important questions about home visiting.

- Should the program goal be prevention of child abuse or prevention of child neglect?
- Would it be more effective and engaging to reframe child abuse prevention as promotion of maternal and child health and development?
- What are the pros and cons of approaches that target parental risk factors versus an empowerment strategy?
- What are the differences in programs that use nurses versus paraprofessional home visitors?
- How can we better utilize fathers and other family members to increase the benefits of home visiting?
- What do we know about the cost-effectiveness of home visiting?

*Dr. McCarroll: The journal* Child Abuse & Neglect *recently published a series of research studies on the effects of the Hawaii Healthy Start Program (HSP) on home visiting. We reviewed those articles (Duggan, McFarlane, Fuddy, et al., 2004; Duggan, Fuddy, Burrell, et al., 2004; Windham, Rosenberg, Fuddy, et al., 2004) and Mark Chaffin's commentary on them (Chaffin, 2004) to initiate dialogue and research ideas around the Army's experiences with its home visiting model. Please share your thoughts on those articles as well as your views on home visiting as a means of preventing child maltreatment.*

Dr. Eckenrode: The Duggan articles are consistent with what some other research is showing, especially with regard to the particular home visiting model that was tested in Hawaii. The evidence coming out of the parapro-

fessional home visiting models is mixed, at best, and negative at worst. But, I thought the message was not entirely as discouraging as Dr. Chaffin's commentary suggested. In the Duggan articles there were at least some modest benefits of the program in terms of mothers' self-reported neglect behavior.

There was little or no evidence that the program was preventing physical abuse, severe or minor. This is an important point because when we think of these programs we tend to think of the prevention of abuse, physical or sexual abuse, rather than neglect. In fact, most of the issues that the home visitors are dealing with have to do with neglect given the population young mothers and fathers with whom they typically work. Even in our Elmira trial (Olds, Eckenrode, Henderson, et al., 1997; Eckenrode, Ganzel, Henderson, et al., 2000) when there was some evidence for long-term effects, we were careful to say that what we were preventing was primarily neglect rather than abuse. Chaffin touched on a number of important issues with regard to the quality of the evidence and the need for better research and the state of the art in terms of what the data show. In general, it was a timely and a well-written piece.

**Dr. McCarroll: Is the primary prevention of child maltreatment still a reasonable goal of a home visiting program?**

Dr. Eckenrode: It is. However most of the successful early intervention and family support programs would be labeled as comprehensive programs and do not focus exclusively on child abuse and neglect. They tend to be a bit broader – family support, parental support, and early education programs that deal with a range of issues. The program begun by David Olds in Elmira was not proposed to the community or to the parents initially as a child abuse and neglect prevention program. It focused more generally on maternal and child health; child abuse and neglect were among the issues or outcomes of that program. That is important. Some of these programs have become known as child abuse and neglect prevention programs because of who has picked up on what issues and what advocacy efforts have taken place. But, it is important to put it in the larger context, not only for the field, but also in terms of running these programs and in identifying families who will be in them. It is more effective when it is cast in terms of a program to promote maternal and child health and well-being and development of children, with child abuse and neglect being one of several program goals.

**Dr. McCarroll: Duggan and colleagues point out that the vast majority of parents will not maltreat their children. Hence, having them participate in home visiting programs is essentially a waste of resources, whereas targeting**

*already maltreating parents puts a different cast on it. Would you go for a targeted approach or a universal approach?*

Dr. Eckenrode: The data are pretty clear at this point that these services are probably not having a very big impact on families where the need is not very high: the well-functioning, two parent, middle income families with no identifiable risk factors such as substance abuse or mental health problems or domestic violence or those kinds of issues. While such families may have some minor benefits from participation, it is unlikely that those families would benefit greatly or that they would remain in the programs very long. Most of these programs have high attrition rates, and the attrition rate will be higher among families that do not feel they have the need. Given how difficult it is to fund these programs at the level of communities, even for the high-risk parents, it is unlikely that we would be able to justify a universal approach. The situation may be different in the military where there are different structures and different funding options and so forth, but at least in the civilian community, I do not think we will see a push at the policy level for universal approaches because the data do not support it at the moment.

**Dr. McCarroll: Do you see benefits of targeted services toward such groups as first time mothers and already maltreating parents?**

Dr. Eckenrode: I am most familiar with the program that selected primarily first time mothers. The data are less strong in terms of the effectiveness of these programs with parents that have already had one or two children. Some fair consideration should be given as to whether first-time parents are an important sub-population who would be open to health messages, open to change, and may have questions about the health of their children, and therefore may be more amenable to those kinds of interventions. Plus, they tend to be higher risk, as teen parents are, for example. There is room for more research on whether other populations of parents can benefit as much. Regarding maltreating parents, I have not seen strong data indicating the effectiveness of these programs for preventing recidivism of maltreatment among already identified maltreating parents. I am not sure that I would target a home visiting program on already maltreating parents, especially if one were interested in prevention rather than remediation.

**Dr. McCarroll: What has been your experience on the use of screening tools? I know that the Duggan articles used the Kempe family checklist (Kempe, 1976). The military has its own risk assessment instrument.**

Dr. Eckenrode: I am not an expert on what particular measures can be used as screening tools. We targeted low income, single parent status, and

age as risk factors. Other programs such as ours have taken a broader demographic approach and recruited mothers who have met certain demographic criteria. There are other risk factors for maltreatment, as cited in some of the literature such as in the Duggan papers and the Chaffin article and work by Neil Guterman (2001) that point to the need to target and customize our approaches to parents who have risk factors that are known to be associated with child abuse and neglect, such as substance use, psychological problems or the presence of domestic violence. It is precisely these kinds of risks that home visitors, particularly paraprofessional home visitors, are not very well trained to tackle. They are difficult problems to deal with and may require some combination of approaches, home visiting and other kinds of therapeutic approaches for some of the more serious issues such as substance abuse and mental health problems. You cannot really expect home visitors in a modest intervention such as this to deal with very significant family problems such as those.

*Dr. McCarroll: Would you give us your thoughts on differences between programs that attempt to correct the risk factors that brought the family into the program in the first place, as Duggan et al. and Chaffin advocated, versus those that use an empowerment model emphasizing parental strengths?*

Dr. Eckenrode: It is not an either-or situation. I have a lot of respect for the empowerment model and the work of my colleagues at Cornell, Urie Bronfenbrenner (1979) and Mon Cochran (Cochrane, 1995; Forest, 2003) who use and promote it. We have developed programs at Cornell that try to build on those insights in working with families and family support workers. But, there are certain, straightforward risk factors that are present in families. For example, if you start working with mothers pre-natally there are some obvious risk factors impacting child development such as maternal smoking or alcohol use. I do not think anyone would argue that focusing on those risk factors in the young pregnant woman would be a mistake. Completely letting a mother engage in such behaviors that define her own goals in a home visiting program would be a misguided effort. On the other hand, there is a lot that can be learned from empowerment approaches in terms of how we work with families, how they are approached, the collaborative efforts that are used in these programs with parents, respect for parents, respect for diversity and training cultural competence of our visitors. These are all very positive things and they speak more to the approach that is used by the visitors than the content of what is being attempted. There needs to be some balance between this approach of targeting risk factors including what we know from epidemiological literature about certain risks that are present for mothers and children in the population. Some families have more of

those risk factors, whether it is poverty or substance use or domestic violence, and we certainly cannot ignore those when it comes to these types of prevention programs. But, it does raise some questions. How do you do that while preserving the dignity of the enrolled family? How do you recruit them as partners in the process? How do you build upon the supportive element of the home visitor-family relationship? The key to the success of any of these programs is the quality of that relationship between the home visitor and the mothers.

**Dr. McCarroll: *How would you assess the quality of the relationship between the mother and the home visitor?***

Dr. Eckenrode: There have been attempts to do that. Some of the more recent work that David Olds and his group have been doing in Denver has explicitly tried to measure the quality of that relationship between nurses and mothers (Forest, 2003). Typically this is done through self-report measures of the mother as a part of the evaluation design. It asks them not only about what happened, but also the qualitative aspects of that relationship. Jon Korfmacher (Korfmacher, Kitzman, & Olds, 1998) looked at some of that when he worked in Denver with David Olds. But, there are other approaches. You can also probably get good, reliable data from looking at that relationship from the mother's point of view. But, you can also get assessments from the visitor's point of view as well in terms of how well that relationship is going.

**Dr. McCarroll: *What have been the differences in outcomes using nurse home visitors compared to paraprofessionals?***

Dr. Eckenrode: There have probably been more evaluations of paraprofessional models than nurse models at this point. The Duggan studies examined a paraprofessional model. The only trial that I know of that has explicitly tried to compare randomly assigned families to a nurse or paraprofessional home visitor is David Olds' Denver trial (Olds, Robinson, Pettitt, et al., 2004), which is now completed, and those kids are now in elementary school. Most of the paraprofessionals were from the community and did not have a college degree. The data clearly show the superiority of the nurse home visiting condition across several child and maternal outcomes. Typically, the pattern of results shows small gains for the paraprofessional-visited families, which were not statistically different from the control group families, and larger gains for the nurse-visited families that were statistically different from the control group. The paraprofessional approach seems to have very limited, modest effects. With large scale dissemination of the paraprofessional model, I would presume that there are some benefits for some families, but across the board and across these studies we are just not

seeing very big effects at this point.

**Dr. McCarroll: I wonder if that is due to the educational background of the nurses or whether the paraprofessionals are not getting adequate training and supervision.**

Dr. Eckenrode: It is kind of a mix. In David Olds' trial in Denver they basically got the same level of training and supervision (Olds, Robinson, Pettitt, et al., 2004). So, it was not program implementation differences that could explain that. When I hear David talk about it, it is a combination of things including their level of education and ability to respond to issues in a family. There are also legitimacy issues and the sense of respect that people accord nurses in the community. First time pregnant women may be more open to the kind of relationship with a nurse and the kind of information that a nurse can provide because of questions around health issues. Nurses may be in a better position to provide this kind of information. It is harder for a paraprofessional to come into a family and achieve that same comfort level around these kinds of issues. There are also programmatic issues. We know there is more turnover among paraprofessional home visitors than with the nurses due to the inability, understandably, of many community agencies to pay their paraprofessionals very well. We know that the continuity of that relationship over the time with the home visited parents is an important program component that could be linked to success. So, there are other structural reasons that might work against the effectiveness of the paraprofessional model.

**Dr. McCarroll: Due to the wide dispersal of forces, the military is often only able to use volunteers or paraprofessionals, and not nurses. Can you envision a mixed model for the military in which a nurse or an experienced person acts as a supervisor of volunteers or paraprofessionals and alternates visits with them?**

Dr. Eckenrode: Yes. It is possible these kinds of hybrid models might be successful in some cases and contexts with some families. I do not think we have the data, at least in the randomized trials, to know the answer to that. Those are probably forthcoming as people experiment with different combinations such as the level of education and level of supervision. We may reach a day where there are data to support something like what you describe. Whoever the visitors are, there are some program elements that need to be in place in terms of adequate training, supervision, caseloads, and length of follow-up to ensure success. I certainly do not think you can go in with a paraprofessional model even if they are supervised by higher level people, do it for six weeks with a narrow focus on one or two issues, and

expect to see much by way of long-term effects. I would rather see a more comprehensive, long-term approach with a smaller number of families than a watered-down approach that tried to reach all the families and is unlikely to be successful.

***Dr. McCarroll: At what stage in a woman's pregnancy would you start such a program?***

Dr. Eckenrode: That is a good question. As the pregnancy progresses, mothers become more and more focused on it. But, you do not want to wait too long into the third trimester to recruit women because if there are risky health behaviors or nutrition problems, then you really need to get to them earlier. It is certainly better to recruit in the second trimester than the third. Realistically, you just might not be able to pick up families much earlier than that. I do not know what the standards are for pre-natal visits, but that is probably a guideline that can be used as to when these programs should start. Often these families are recruited through the pre-natal programs.

***Dr. McCarroll: Also, in terms of developing models, the military may have an advantage over civilian communities in the opportunity to recruit fathers into home visiting programs.***

Dr. Eckenrode: I think there is a lot of interesting work that could be done in terms of father involvement and how that might help keep mothers in the program longer. Such an approach might help to deal with some of these attrition issues. Father involvement could act as a multiplier reinforcing what the nurses are doing. We also know that family members can have a negative effect. If the young mother is living with family members that are not on the same page as the nurses or other home visitors their effects can be detrimental to the program's effectiveness. But, the opposite is also true. One of the original goals of the program was having the involvement of a husband, a grandmother or a partner present during the pregnancy, at the birth of the child, and around the house enough to help with child care activities. There is a lot of room for work and improvement there.

***Dr. McCarroll: What information is available on program costs?***

Dr. Eckenrode: There is a new study that has come out of Washington State that examines the costs and benefits of several early intervention and family support programs. In terms of the nurse visiting program, the data show that it is cost-effective over the long term, and that a Healthy Families approach actually does not recover the costs of the program. The information is available on the web. The summary report is at *www.wsipp.wa.gov/ rptfiles/04-07-3901.pdf*. The technical appendix is at *www.wsipp.wa.gov/*

*rptfiles/04-07-3901a.pdf* and references at *www.wsipp.wa.gov/rptfiles/ 04-07-3901b.pdf*. The Washington State project provides a more comprehensive view of outcomes than earlier cost-benefit studies allowed. A monetary value was put on education outcomes, substance abuse outcomes, teen pregnancy outcomes, and child abuse and neglect outcomes, in addition to criminal outcomes. We hope this effort produces a more complete accounting of policy options that can increase the efficiency with which taxpayer dollars are spent.

*Dr. McCarroll: Any final thoughts that I have not asked you about?*

Dr. Eckenrode: An important point to make is that home visiting programs by themselves are kind of modest interventions requiring us to have modest expectations and goals. They need to be seen in the context of the whole web of services available to families and to children. I think the most effective long-term approaches will be those in which home visiting is a part of a network of services such as combining home visiting with other high quality programs like center-based child care. The other challenge is how to bridge between these programs once families leave the home visiting programs. How do you continue working with these families through the pre-school years until the children reach school age and beyond? As stand alone programs, they are not likely to have great impact on families. They really need to be thought of as one component of a more comprehensive approach to something like preventing child abuse and neglect, which would include other kinds of approaches to already maltreating families, community-based prevention efforts, and school-based prevention efforts. Home visiting is one spoke in the wheel and it might be an important one and an interesting one, but it is not the silver bullet that has come along that is going to solve all these problems.

*Dr. McCarroll: Thank you for this information. I am sure our readers will appreciate your thoughts on home visiting. We look forward to your input in the future.*

Dr. Eckenrode: You are welcome. My pleasure.

**Key Points**

Most of the issues that the home visitors are dealing with have to do with neglect given the population young mothers and fathers with whom they typically work.

These [home visiting] services are probably not having a very big impact on families where the need is not very high: the well-functioning, two parent, middle income families with no identifiable risk factors such as substance abuse or mental health problems or domestic violence or those kinds of issues.

Home visiting programs by themselves are modest interventions requiring us to have modest expectations and goals. They need to be seen in the context of the whole web of services available to families and to children.

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REVIEW OF RECENT RESEARCH OF JOHN J. ECKENRODE, PHD

# Primary Prevention of Child Maltreatment

*By James E. McCarroll*
*January 2010*

Dr. Eckenrode's latest publications (at the time of this writing) include an overview of current knowledge of the primary prevention of child maltreatment (Eckenrode, In press). The following is a summary of the important points of that chapter.

Primary prevention can occur at the level of the individual child, parent, or family, or it can be directed toward a community or a society at large. All effects of prevention are difficult to evaluate, particularly those that are directed toward communities or societies. Eckenrode discussed two major models of primary prevention: the developmental-ecological (Belsky, 1993) and the public health model (Kellam & Langevin, 2003). The developmental-ecological model views multiple risk and protective factors operating at the levels of individuals, families, and communities. This model suggests that focus on single risk factors is unlikely to be successful unless combined with other interventions. The public health model is more familiar to the medical and epidemiological community as it organizes prevention in three levels: primary, secondary and tertiary. Eckenrode notes that recently the language of primary, secondary, and tertiary prevention has been replaced by the more understandable terms universal, selective, and indicated (Mrazek & Haggerty, 1994; Kellam & Langevin, 2003). Universal replaces primary and denotes interventions directed at whole populations; selective interventions replaces secondary prevention and denotes targeting interventions at the population at increased risk; indicated interventions replaces tertiary prevention and denotes the population at greatest risk for recurrence of a condition. An example of an indicated intervention is a program aimed at preventing recurrence of maltreatment among parents with prior child protective services involvement.

Eckenrode summarizes the current state of knowledge of programs that have shown efficacy in preventing abuse and neglect. A wide variety of programs currently exists, but the manner and results of evaluations vary. Studies using a design involving randomized assignment to intervention and to comparison groups are given the highest priority. However, such a design is rarely possible so evaluations are conducted that still provide information, but have limitations (McCall & Green, 2004). The most consistent evidence of effectiveness comes from the Nurse Family Partnership (Olds, Hill,

Robinson, et al., 2000) home visitation programs. Research shows that home visitation is more likely to prevent dysfunctional parenting and child maltreatment by focusing on high risk groups rather than attempting to serve a universal need. Other examples of home visitation programs are presented and the complex elements of conducting and evaluating home visiting programs for parents are discussed. Other areas in which primary prevention programs have been instituted are localized in pre-schools and in schools while others are broadly based public education and information programs.

Eckenrode devotes considerable effort to explain the need for research on child maltreatment prevention as well as methodologies of how programs are evaluated. The reader is pointed to many sources of information based on evaluation. These sources take the form of lists or registries that identify effective programs. This discussion is valuable to the practitioner and to the policy maker in describing the evidence on which rankings of programs are based.

Additional discussion is given to the phases of prevention research (efficacy, effectiveness, and dissemination) and the standards of evidence for each. The increased rigor of methodology shows the development of the field of prevention research and the need for increased scrutiny of evidence at the level of practice and policy.

Finally, Eckenrode presents his views on the next steps in child maltreatment prevention research. Important among these is the need to link risk and protective factors to maltreatment. He stresses that there is no substitute for the measurement of maltreatment and that there are often multiple measures of maltreatment: official reports, self-reports of victims and parents of abusive or neglectful behavior, observations of parent-child interaction and medical records. The importance of measuring maltreatment is stressed because often only the purported risk factors for maltreatment are measured. He calls for increased collaboration among the fields of research, practice, and policy. An example of this need is for knowledge about how mental health, substance abuse, and partner violence affect child maltreatment. While there has been much development of knowledge in the field of child maltreatment prevention research, he advises caution on moving too quickly from the design of interventions to the wide-scale application of programs without the supporting technical assistance such as training, infrastructure, and continued monitoring and evaluation to support them in the field.

This chapter is a valuable resource for both practitioners and policy makers in that it summarizes the field of prevention research in general as well as its application to child maltreatment prevention. It makes increasingly clear the need for those who practice and who evaluate to have an understanding of research methods. Without understanding the need for multiple sources

and measures one is likely to expend enthusiasm and resources on programs that have not met standards for implementation.

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**Key Points**

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Primary prevention of child maltreatment can occur at the level of the individual child, parent or family, or it can be directed toward a community or a society at large.

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Two major models of primary prevention are the developmental-ecological and the public health model. The developmental-ecological model views multiple risk and protective factors operating at the levels of individuals, families, and communities. The public health model organizes prevention in three levels: universal, selective, and indicated.

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There is a need for increased collaboration among the fields of research, practice, and policy. An example is the need for knowledge about how mental health, substance abuse, and partner violence affect child maltreatment.

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visiting for pregnant women and parents of young children. *Current Problems in Pediatrics; 30*:109–141.

# Developments in Evidence-Based Home Visiting Program to Prevent Child Maltreatment

*By James E. McCarroll*
*July 2009*

*Dr. McCarroll: Your previous interview was largely devoted to home visiting. Have there been new developments in that arena?*

Dr. Eckenrode: I think the biggest development in the last six or eight months has been the interest by Congress in home visitation as a part of the proposed health care reform. Nurse home visitation programs have provided the best evidence. The debates now are around "What is the evidence and who is to decide what is effective?"

*Dr. McCarroll: A recent paper (MacMillan, Wathen, Barlow, et al., 2009) describes many of those state programs. Can you summarize the current state of the Nurse Parent Partnership program that you are evaluating?*

Dr. Eckenrode: I am mostly connected with the Elmira study. We just completed data collection this year of the Elmira families. This was a 27 year follow-up. We just finished data collection so we have not begun analyses with that data yet. We have a paper that recently appeared in the *Archives of Pediatrics and Adolescent Medicine* (Eckenrode, Campa, Luckey, et al., 2010) on the 19 year follow-up study. It shows that there is some continuing effect of home visiting on criminal justice involvement, in this case, particularly for the girls. Data analysis on the 27-year follow-up will look at how these 27-year olds are doing developmentally as young adults.

*Dr. McCarroll: MacMillan stressed the need for proceeding in logical steps from research to the way people actually conduct their programs. Fidelity is important in moving from the laboratory to the field. How do you see home visiting programs that are evidence-based moving through the implementation stages, from design to evaluation to the community where they are available to people?*

Dr. Eckenrode: There are clearly challenges, especially when programs are already ongoing. Some are very well-established and have a long track record so it is hard to come in in midstream and advocate the step-by-step approach needed to develop, evaluate, and disseminate them. But, on the

other hand, I think there is going to be a continuing push for accountability and for increasingly rigorous evidence, which is usually obtained through randomized trials. One of the problems is that there is not enough funding available to conduct rigorous trials for the variety of programs serving families and children. It is going to become harder and harder to advocate for large scale expenditures of public dollars on programs that do not have that kind of evidentiary base.

*Dr. McCarroll: When you implement a rigorous program, what are the issues with regard to recruitment, training, and retention, particularly in rural areas or isolated areas?*

Dr. Eckenrode: There are clearly resource issues including personnel such as the availability of trained staff. Transportation in getting people out to families or families into centers is another important issue. Those are very real problems that require some creative solutions. You may have to regionalize and combine resources from a variety of places and obtain funding streams in order to have the resources available to mount efforts in rural or sparsely populated areas. But, you can run into some of the same problems in urban areas where there is a high concentration of poverty. An interesting development is the use of multidimensional programs such as child abuse prevention programs using a variety of modalities. Some, like public service announcements, are fairly low cost. A more intensive approach is to focus specifically on higher risk families. This puts the imperative on targeting the families that are most in need so that you use your resources most wisely. For example, MacMillan talks about the Triple P program (Positive Parenting Program) (Sanders, Pidgeon, Gravestock, et al., 2004; Prinz, Sanders, Shapiro, et al, in press). It is a multi-dimensional prevention program that uses a variety of strategies. It is being tested in counties in the Carolinas that do not have big urban centers, but there are a lot of rural and semi-rural communities. There are examples of more comprehensive, multi-dimensional programs that do reach into those kinds of communities and look like they are having some success. These emerging models might be more transferable than some of the ones that have been developed in more urban settings requiring a larger work force.

There are also a number of nurse home visitation programs that serve rural populations as well. In the end, the idea is to maintain fidelity to the original program models. The Elmira home visiting program was the first nurse home visiting model. It was developed in a semi-rural, relatively small town of about 30,000 people, but with a lot of rural areas around it.

*Dr. McCarroll: They were also probably not high mobility though, which is*

*one of the problems of the military.*

Dr. Eckenrode: Absolutely. I think that is a unique challenge to the military where you may only be able to hold on to families for a relatively brief period of time. On the other hand, you have monitoring and surveillance systems that are probably better than on the civilian side of things. You know where your people are going. In the civilian sector you often lose track of people who move from state to state. But, there is still another challenge. Some of the positive effect of these programs is due in part to the continuity of the relationship the families have with the home visitor rather than simply the content of what is being delivered. I do not know if there is an easy answer to that one.

**Dr. McCarroll: Have you evaluated the relationship-building aspect of the Nurse Family Practitioner program?**

Dr. Eckenrode: More attention is being paid to measuring what actually goes on in the relationship between the home visitor and the parents. There are explicit attempts to get feedback from the parents about the quality of that relationship and get feedback from the nurses. There is also a clear attempt to select home visitors that have good relationship-building qualities. Some of these qualities are hard to quantify, but there is clear recognition that you want people who have both the credentials and the people skills to empathize and relate to these young mothers in an open and non-stigmatizing way. But, the data suggest that those are not a sufficient to make those programs effective. You also need the training and the content knowledge.

**Dr. McCarroll: One of the issues brought up by Duggan and colleagues in the evaluations of the Hawaii Healthy Start home visiting program was the tension between the home visitors wanting to maintain a good relationship, yet maintaining fidelity to the program (Duggan, McFarlane, Fuddy, et al., 2004; Duggan, Fuddy, Burrell, et al., 2004; Windham, Rosenberg, Fuddy, et al., 2004). Apparently, some home visitors felt that they had to make a choice between one or the other and most often they tended to fall in the direction of keeping a good relationship rather than doing what they were supposed to be doing with regard to corrections and surveillance.**

Dr. Eckenrode: The nurses are given some latitude in terms of individual visit-by-visit protocols depending on what they encounter with the family. There is certainly some decision-making required on the part of the nurses. Again, that is why you want some trained individuals who are used to doing what is essentially clinical decision-making and not just following a standard manual or protocol word for word and feeling like they can not deviate from it.

*Dr. McCarroll: My reading of your work puts heavy emphasis on the qualifications of the nurses. Do you think people from other disciplines could be selected and trained to be adequately functional?*

Dr. Eckenrode: That is probably likely. We do not have the data to back it up right now, but a number of different models are being tested. It would be great if that would happen because it would expand the potential work force of people who could be used as home visitors. But, we think there is something special about the nurses given the population being served and the issues that are salient to that population of young people. These are new parents and young pregnant mothers-to-be. A lot of the issues they are concerned with are health-related. I do not think such a program would be easily replicable with say a social worker or an early childhood educator. But, I think we should encourage that kind of experimentation.

*Dr. McCarroll: There are many more levels of nursing training now than there used to be. They are going to play a larger and larger role in health care. That is probably the good side. The down side is that the level of training may be lower. But, the lower level degree nurses may have some credibility by the fact that they have a nurse title and could be trained up to another level.*

Dr. Eckenrode: That is right. Any kind of large scale dissemination of nurse home visiting will require a multi-pronged approach to addressing the infrastructure at the local level to support such programs. Hopefully, there will be some incentives to increase the nursing work force and to retrain people who are working in other settings or are only working part time or are out of nursing for one reason or another to do this kind of work.

*Dr. McCarroll: Are there differences in home visiting programs regionally? For example, if you find that people do things differently in South Carolina than they do in Oregon? How much latitude do you think a program can have given that you still have a requirement for fidelity?*

Dr. Eckenrode: I am not the expert on the dissemination side and do not have a real close up view of how the programs are running in terms of those local or regional adaptations. Clearly, when you have ethnic and racial and language differences, you need to adapt the program to be sensitive to those differences in parenting practices or social customs. But, it is a fine line between adaptation and maintaining fidelity. If you stray too far from the model, you risk the danger of watering it down and changing it to such an extent that it is no longer effective. That is why I think that any significant adaptations to a model should also be done within the culture of experimentation and testing and not just left up to a local providers to decide how to and when to adapt a program.

Health Families America right from the beginning did not want to have a single manualized program that everybody had to follow, but wanted to leave it up to local communities to adapt a certain set of broad principles to meet their local needs. The Nurse Family Partnership is a much more manualized program where specific elements need to be in place before they will support the program. So, time will tell the extent to which you can change and adapt these programs to meet local conditions.

I do not think that children's or parents' needs change all that much from one region to another. For example, the need for strong attachment bonds is not different in Alaska or South Carolina. What changes are the regional service structures that have been put in place to support the programs. The need to work within those structures might be different from region to region, but I do not think a protocol around encouraging mothers to be more securely attached to their infants is going to change from region to region or really much from culture to culture or even when you go internationally. There are some relatively basic, universal issues and the same is true with reducing risks during pregnancy. Getting mothers to stop smoking is the same issue in the south as in the north as in the east as in the west. What changes are the service delivery systems in those regions.

*Dr. McCarroll: In the programs that you see coming forth, do you think home visitors will still be based on high risk or be required to perform a larger set of functions?*

Dr. Eckenrode: I think that some of the organizations that are looking at this are coming down on the side of more targeted interventions for high risk families. There are still people out there advocating for universal approaches, but it is a tough sell. The evidence from many programs seems to indicate fairly clearly that you get the most benefit from the higher risk families who are most in need. The lower risk families that are more intact are less stressed and those families just do not have as much need for these kinds of services. They tend not to be as engaged if the family does not perceive the need. It is hard to retain them in such programs.

*Dr. McCarroll: How do you select those families if they do not want the program, do not feel they need it, or do not want it involved in their life? What would be your list of high risk people in addition to young unmarried mothers?*

Dr. Eckenrode: Young parents are particularly at risk. Certainly the unmarried, single mothers, socio-economically stressed families, families where there is instability in terms of caretakers or in terms of residential mobility, which would obviously be relevant to the military. If you put these things

together it is usually a combination of age and marital status and stability and income. Those together carry a lot of the weight. Then you could look at other family stressors such as illnesses and things of that kind that could also compromise a parent's ability to provide sensitive care to their children. Examples of these are maternal depression, substance use, and the presence of domestic violence. I think these are all red flags in a sense in terms of the potential need for some support to those young parents. The Nurse Family Partnership has tended to look at these demographic risks: age, marital status, and socioeconomic status. Other programs have broadened that list some to include stresses within the family, but I think from a policy perspective, it is hard to have a broad and comprehensive assessment. It is a little easier from a policy perspective to plan services at the community level around the broader demographic groups. Those carry a lot of weight and I think the more specific family stresses often flow from low income and young age.

*Dr. McCarroll: The military also faces the problem of an increasing number of families that have children with disabilities. Another developing problem that is hitting the country is families of injured service members. We do not really know the effects these have on child rearing practices.*

Dr. Eckenrode: In terms of disabilities, some of the programs have been developed out of the concerns of parents of children with behavioral problems or disabilities. The Triple P program really started in Australia not as a child abuse and neglect prevention program, but as a program to promote effective parenting of children who were difficult to parent and children with learning disabilities, behavioral problems, and other kinds of handicapping conditions. That program really sprang out of those concerns, trying to assist parents in providing sensitive and supportive parenting in those contexts and not rely on more coercive forms of parenting to get kids to behave or to do certain things and not do other things. Some of those models might be particularly good ones to look at because they came out of that tradition.

*Dr. McCarroll: The people who read our newsletter want to know, "What can I do today? What can I do to change my work tomorrow?" How do you answer that kind of question without sending them a paper to read?*

Dr. Eckenrode: It depends on their level. A number of things have to happen from a policy level to make these things work. There has to be some commitment from the top to invest in proven programs or, even more difficult, to shift money away from programs that already exist to proven programs. That is a difficult shift in the policy arena.

There is also a need to create specialized knowledge within organizations to keep them abreast of what is happening. New information comes on

board so fast that it is worth spending at least some money to create the kind of specialized staff or knowledge to keep abreast of it. But, it is not just about funding programs, but is also about the quality control and fidelity issues. The first thing I would do is find out what is going on and what is happening on the ground and see if what is going on is based in evidence. We need to create the knowledge base needed to keep on top of what is happening in the outside world. Once you decide to implement a program, then build in quality controls to make sure that it is being done with fidelity and with continuous quality improvement.

*Dr. McCarroll: Thank you for your insights on the state of home visitation and on the important policy issues of implementing such programs.*
Dr. Eckenrode: You are welcome.

**Key Points**

We targeted low income, single parent status, and age as risk factors. Other risk factors for child maltreatment are family stressors that could compromise a parent's ability to provide sensitive care to their children such as illnesses, maternal depression, substance use, and the presence of domestic violence. I think these are all red flags in a sense in terms of the potential need for some support to those young parents.

High risk families include young unmarried mothers, socio-economically stressed families, families where there is instability in terms of caretakers or in terms of residential mobility, which could be relevant to the military.

There are still people advocating for universal approaches for home visiting, but it is a tough sell. The evidence from many programs indicates clearly that you get the most benefit from visiting the higher risk families who are most in need.

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# The Effects of Violence on the Brain of the Developing Child

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 10, Issue 3, January 2008*

Dr. Perry presented the inaugural lecture in the McCain Lecture Series (*www.lfcc.on.ca*) in London, Ontario, Canada, on his work on the effects of family violence on children. The lecture describes optimal as well as disrupted child brain development, and provides practical advice on strategies to shape optimal development for children.

Dr. Perry explains that early life experience determines how a child's genetic potential is expressed. The development of the brain is "use-dependent" meaning that brains develop according to the stimuli they encounter. Because each child's experience is different, each brain adapts uniquely. Optimal development is achieved when the child experiences consistent, predictable, enriched, and stimulating interaction in attentive and nurturing relationships. Brain development is also susceptible to negative influences. Children who do not have a stable and nurturing environment are subject to damage to their developing brain. Prolonged, chronic stress leads to maladaptive neural systems, which may be adaptive for the child's survival in the short term, but problematic for later intellectual, emotional, and social development.

Dr. Perry's lecture addresses points for parents, service providers, and community leaders to foster improved child and family development and functioning. He emphasizes key scientific principles paired with practical suggestions that can be implemented widely in public education programs:

- *Promote education about brain development*. While FAP personnel are not neuroscientists, they can help educate the public about key principles of brain development to help parents understand the long-term impor-

tance and implications of their actions.

■ *Respect the gifts of early childhood.* High quality early childhood care settings should provide enriching, safe, predictable, and nurturing environments. During early childhood, the brain is developing most rapidly. This phase presents the best opportunity to foster optimal brain development.

■ *Address relational poverty in our modern world.* In today's world of smaller families and frequent deployments for military families, there are fewer opportunities for the development of connections between people. Dr. Perry's message is to increase the opportunities for children to interact with others: have family meals, play games, increase contact with extended families and neighbors, and limit watching television.

■ *Foster health developmental strengths.* Certain skills and attitudes help children meet the challenges of life and may inoculate them against the adverse effects of violence. Dr. Perry presents six core strengths for children, which he calls "a vaccine against violence". The child who develops these core strengths will be resourceful, successful in social situations, resilient, and may recover more quickly from stressors and traumatic incidents. [See box, Six Core Strengths for Children]

**Six Core Strengths for Children: Helpful for parents, caregivers, and healthcare providers**

■ Attachment: ability to form and maintain healthy emotional relationships
■ Self-regulation: capacity to contain impulses, notice and control urges as well as feelings such as frustration
■ Affiliation: being able to join and contribute to a group
■ Attunement: being aware of others, recognizing their needs, interests, strengths, and values
■ Tolerance: understanding and accepting differences in others
■ Respect: valuing differences and appreciating worth in yourself and others

**Key Points**

The development of the brain is "use-dependent" meaning that brains develop according to the stimuli they encounter. Because each child's experience is different, each brain adapts uniquely.

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# The Role of Genetics in Children's Brain Development

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 10, Issue 3, January 2008*

Promoting greater understanding of the brain and its critical relationship to child development will help the Army Family Advocacy Program (FAP) develop innovative prevention and treatment processes. In his interview, Dr. Perry discusses the basic needs of children and the consequences for the child's developing brain if these needs are not met. Generally, the environment of childhood interacts with the child's genetic endowment to produce healthy development. When there is chronic abuse or neglect, lasting damage may result. Dr. Perry's experience in the clinic and the laboratory around chronically neglected children reinforces the need for children's stable emotional attachments, touch from primary adult caregivers, and spontaneous interaction with peers. He describes how developments in modern technology can undermine the strength of the family and the development of peer relationships that promote the growth of cognitive and caring potentials in the developing brains of children.

Prior to birth and during childhood, important processes of brain development necessary for adult cognition occur. The development of the brain proceeds in steps:

- The development of nerve cells,
- Movement of the cells to their proper place in the brain,
- The expression of the function of each type of cell,
- Loss of cells that are redundant or are not used,
- Development of nerve cells so they can connect with different parts of the brain,
- Development of cell-to-cell communication,
- Development of structural supports for nerve cells, and
- Improvement of efficiency of neural transmission.

These steps are dependent upon genetic and environmental interaction for their proper development. Understanding the neuroscientific implications of early childhood brain development lends a greater appreciation of children's needs. During early childhood, when the greatest changes occur, the caregiver has the opportunity to create an environment for the child to maximize the expression of genetic potential.

**Key points**

Promoting greater understanding of the brain and its critical relationship to child development will help the Army Family Advocacy Program (FAP) develop innovative prevention and treatment processes.

Generally, the environment of childhood interacts with the child's genetic endowment to produce healthy development.

Understanding the neuroscientific implications of early childhood brain development lends a greater appreciation of children's needs.

During early childhood, when the greatest changes occur, the caregiver has the opportunity to create an environment for the child to maximize the expression of genetic potential.

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INTERVIEW WITH BRUCE D. PERRY, MD

# Healthy Families, Healthy Communities

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 10, Issue 3, January 2008*

*Dr. McCarroll: in addition to your clinical and research work, you have been involved with the Army's Family Advocacy Program (FAP) for many years teaching in the Family Advocacy staff Training program.*

Dr. Perry: Most of my FAP teaching is focused on understanding the normal stress response, its implications for people exposed to traumatic events like combat, and how chronic and prolonged stress can impact families that have a deployed parent. I cannot think of any system where understanding stress and the consequences of stress are more important than the military. We think about military stress in terms of exposure to combat and traumatic stress, but there are other stressful components for the military family. In the last three or four years the rate of deployment and the stressors on children, spouses, and other family members of the military have been high. Increasingly, our focus has been on intervention strategies and activities that increase resilience of the military and on those things that make the military community more vulnerable, especially during deployments.

*Dr. McCarroll: Where does one draw the line between psychological stress and psychological trauma?*

Dr. Perry: That is an important question for the field of mental health. Two people can have the same experience, but for one person the level of stress is so high that it is traumatic and for the other person it is not. From a neurobiological perspective, events become traumatic when stress response systems are activated in such an extreme way that they go from being adaptive to being maladaptive.

*Dr. McCarroll: How would one recognize the change?*

Dr Perry: You look for physiological changes such as changes in sleep patterns, irritability, mood and energy levels. When those things happen, you need to step back and say, "My life is too complicated. There is too much stress going on. I am wearing out my body." The stress response system affects the brain, the immune system, the heart, the lungs, the skin, and the gut. People who are under chronic duress end up getting physically run down and are much more likely to get colds, have a hard time recovering from an infection or have cardiac problems. Their underlying genetic tendencies or

vulnerabilities will be unmasked by this chronic stress.

One of the challenges is to create systems in education, health care and human services that are responsive to these issues. For example, children may attend a school where there are only a few military children. These children may have difficulty concentrating, and be tired from lack of sleep because of worries about their Dad or Mom. They may look like they have academic problems or an Attention Deficit Disorder. These children are often misunderstood by the public education system. Their problems go unnoticed because adults who play significant roles in their lives are not trauma-informed or military-sensitive.

**Dr. McCarroll: Can some of these problems be prevented? if so, what general principles of prevention do you recommend?**

Dr. Perry: One of the most important factors in prevention is group cohesion. If you feel you are part of a supportive community you can sustain a tremendous amount of duress. If all the families left behind when soldiers deploy support and assist each other, that support can be a tremendous help. The people who are most isolated and the most vulnerable are the military families living in the wider community. There may not be another military family living on their block that is experiencing deployment or goes to their church or whose child goes to their child's school.

One lesson we have learned about prevention and dealing with traumatic stress is that relationships matter. Your social network is tremendously important. The more you are isolated and physically or emotionally separated from the rest of the military community, the more vulnerable you become.

**Dr. McCarroll: So, your advice to isolated families would be to increase their social support?**

Dr. Perry: Yes. Tap into your extended family, into your community, your neighbors, or whatever social network you have. That will help sustain you, and is probably the most important principle. Other important factors are information and education. The more you know about an expected set of events, the more you will be able to deal with them. Information is power. You can tell people what to expect and the anticipated time course. You can tell them, "You are not crazy. Most people experience these things. If it gets worse or it is so prolonged that you cannot manage it, here are some resources. These are the people you can talk to and this is the person who may be able to help you." We find that the combination of information and access to resources can be very helpful.

**Dr. McCarroll: If you have a child or adolescent with behavior problems that**

*emerged during a deployment, where do you start?*

Dr. Perry: Most people know that a child's main support system is his or her parents. You can have a child overwhelmed by a trauma that also impacts the parent, e.g., the father was killed or wounded in combat. The mother would also be overwhelmed and her ability to help the child would be compromised. Consequently, we need to pay attention to the emotional needs of the parent. That is an important place to start. If the mother's needs can be met, she can become stronger and better able to meet the needs of her child(ren). The child's needs must be met also. If you meet the needs of the parent and the needs of the child, you will be more effective than just targeting your interventions to the child. The act of intervening and giving support to the parent and the child can prevent a negative cycle from feeding on itself.

One should also question the health of the community. "Is this a community where there is a support group? Is this a community where there is an isolated National Guard family? Has a family been in this community long enough to make friends?" Your intervention would be to provide a combination of social work, conventional psychiatric or psychological interventions, and the sharing of information about resources. If the family is connected to a healthy community, minor interventions can be extremely helpful.

**Dr. McCarroll: How do you work with parents to make them trauma-informed? To what extent can you bring together neurobiological structures and functions with behaviors, needs, and treatments, and do you think it enhances understanding these issues?**

Dr. Perry: We do quite a bit of that, and we use materials that we have written for families including slides and mini-lectures. We also have lay teachers. If a parent or a child is killed in a car accident, we will have a client we worked with five years ago who also lost a child help us with that parent. This approach is very helpful because sometimes our typical jargon does not translate well. The information is communicated better by someone who shares the same perspective as the person with whom we are working.

**Dr. McCarroll: Our Army statistics reveal that the rates of child neglect have increased since the war started. This has been attributed to lack of (parental) supervision, unkempt homes, and mothers with depression. Have you encountered this?**

Dr. Perry: Our colleagues report this. If you look at the waxing and waning of child abuse and neglect complaints, it is very much tied to community cohesion, economics, and mobility. Whenever there is a downturn in factors that would stabilize a community, there is an increase in neglect and abuse.

*Dr. McCarroll: Treatments and prevention might extend beyond the issues of community cohesion. How do you help people who enter a system and do not share the same priorities (i.e., cleanliness in one's home and attentive parenting)?*

Dr Perry: Teaching people about parenting is a huge challenge. We used to live as big extended families in which you experienced child-rearing practices. You learned a lot about children because you were around them. Today's families are much more mobile and smaller. It is not unusual for someone to be an only child or have one sibling and grow up in a system in which there is no mechanism for effectively transferring child-rearing practices. People are talking about the need to get some of these practices into public education because we are not teaching them in families any more.

*Dr. McCarroll: How does one remediate those families?*

Dr. Perry: You can identify high-risk family situations and provide non-punitive education and support services for these families. They would benefit from home visitation models. However, these programs are often inefficient because they are poorly targeted.

*Dr. McCarroll: Thank you for your contributions to the military community and for this interview.*

Dr. Perry: Thank you for the opportunity.

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**Key Points**

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Events become traumatic when stress response systems are activated in such an extreme way that they go from being adaptive to being maladaptive.

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One of the most important factors in the prevention of stress is to maintain group cohesion. If you feel you are part of a supportive community, then you can sustain greater adversity.

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If you meet the needs of the parent as well as the needs of the child, you are much more effective than if you just target interventions to the child.

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When there is a downturn in factors that would stabilize a community, there is often an increase in neglect and abuse.

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**REVIEW OF RECENT RESEARCH OF BRUCE D. PERRY, MD**

# The Neurosequential Model of Therapy

*By James E. McCarroll, PhD*
*May 2009*

Dr. Perry has continued his research on the relationship of neuroscience to child maltreatment. A recent textbook chapter expands this exploration to the development of psychopathology (Perry, 2008). Child maltreatment increases the risk for many disorders. The subject of Dr. Perry's chapter is "Why." The following is taken from that chapter.

Maltreatment can be comprised of a combination of neglectful and traumatizing experiences. Maltreatment and trauma affect the developing brain through multiple, often overlapping mechanisms. Trauma impacts the stress response systems and neglect, through an absence of experiences required to express genetic components in developing neural systems, has other complex effects on the developing brain. Trauma may cause post-traumatic stress disorder and neglect may cause an attachment disorder. In addition, trauma or neglect may cause an alteration in neural systems based on an underlying genetic vulnerability. Finally, symptoms or other disturbances caused by maltreatment may disrupt ongoing developmental pathways through degrading cognitive and emotional functioning.

Dr. Perry spells out the principles of neurodevelopment as a basis for understanding the developing brain. His review is very helpful to the non-neuroscientist for increasing knowledge of how development is impacted by maltreatment, but also for explaining these effects to parents or other interested parties. The following is a brief summary of topic areas. Please see Dr. Perry's publication (2008) for details.

Basic brain neurodevelopment — Development proceeds in a sequence beginning in utero. The earlier a trauma or neglect occurs, the more chance there is for disturbance of development. The following is the sequence of development:

- *Neurogenesis* — Cell birth occurs largely in utero. This can be severely affected by mother's drinking as well as other insults.
- *Migration* — Neurons move to settle in the places where they will establish a permanent function such as to the brainstem or the cortex. Cell migration can be affected by genetic or environmental factors.
- *Differentiation* — Neurons mature into unique structures producing neurotransmitters such as serotonin. Neurochemical, hormonal, or stress response changes can affect the way cells transmit information.

- *Apoptosis* — Cell death. More neurons are present in the developing brain than are needed. Some neurons will connect with others and some will not. Neurons with little environmental stimulation may not survive. This loss will affect brain development.
- *Arborization* — Neurons continue to differentiate. They will send out fiber-like receptive processes that connect with other cells. This increases the complexity of brain function by creating networks of cells to receive and process information.
- *Synaptogenesis* — This occurs through chains of neurons connecting (called synapses) with other neurons. This development permits flexibility of brain organization and function, which underlies all brain activity.
- *Synaptic sculpting* — The connections between neurons (the synapses) continue to evolve through the brain processes already developed. This process is driven by neurotransmission, which occurs in response to stimulation, a "use it or lose it" phenomenon. This process continues throughout life and is the basis of complex brain activity such as learning and memory, emotion, and higher level cognitive functioning.
- *Myelination* — This is the development of a covering of cells on the neurons that permits faster functioning. As myelination continues throughout adolescence and young adulthood, complex brain processes become more efficient.

As can be imagined, trauma and neglect can affect any or all of the above processes making for less efficient and functional brain development. As clearly noted above, brain development is sequential and the product of both genetics (nature) and the environment (nurture).

Dr. Perry's chapter includes detailed descriptions of the developmental impact of trauma and neglect on the brain with examples at various child ages and stages of neurodevelopment. There is also detailed description of brain structures and how they are affected by maltreatment. Some familiarity with these structures and their functions will give the practitioner a good idea of how the brain functions and how disturbances of neurodevelopment hinder it.

One purpose of Dr. Perry's exposition of the processes of neurodevelopment is to acquaint the reader with the complexity of the effects of maltreatment. He calls maltreatment "the Great Imposter." By this he means that maltreatment can mimic many psychiatric conditions. There is a practical implication of this viewpoint. Current descriptions of psychopathology in the psychiatric diagnostic system, the DSM-IV (American Psychiatric Association, 1994) do not consider the effects of maltreatment as a mechanism that underlies psychopathology. Abuse of children and adults and child ne-

glect are V codes, a focus of clinical attention rather than diagnostic categories. Because of this lack of consideration of maltreatment as a cause of a disorder, treatment plans may pursue only symptoms while ignoring the cause, maltreatment.

Dr. Perry also presented his neurodevelopmental model of brain development in the publication Reclaiming Youth (*www.reclaimingyouth.com*) (Perry & Hambrick, 2008). Reclaiming Youth International (RYI) is an organization dedicated to helping adults better serve children and youth who are in emotional pain from conflict in the family, school, community, or with self. In this article, Dr. Perry outlines developmental challenges that contribute to risk and resiliency. Developmental challenges are not only maltreatment-related, but consist also of threat, humiliation, deprivation, chaos, and violence. These problems continue and beg for changes to address these challenges. For example, it is unlikely that weekly therapy for one hour can reverse or even seriously impact the alterations in brain function or behavior caused by developmental trauma or neglect.

The neurosequential model of therapy (NMT) is not a specific technique, but rather an approach to clinical work. It matches the timing of specific therapeutic techniques to the stages of brain development and neural networks mediating the neuropsychiatric problem. It consists of child assessment, identification and articulation of the primary problems to be addressed, identification of key strengths, and the application of interventions, which could be educational, enrichment, or therapeutic, to help families and professionals meet the needs of the child. A brief description of these steps follows.

- *Assessment* — Given the knowledge of brain development and effects of insults at specific times, the assessment consists of a detailed child history from conception through the present. The nature, timing, and severity of challenges is reviewed and an estimates of developmental effects are created. A second component of this assessment is a review of relational history of the child. This assessment targets attachments and related vulnerabilities and strengths based on the child's history of relationships.

- *Functional review* — An interdisciplinary team conducts an assessment of current functioning including speech and language, social skills, self-regulation, and other functions. This assessment forms a baseline from which the staff and parents can chart the child's progress.

- *Recommendations* — The NMT process yields a map of where to go with a sequence of interventions based on the problems identified. This process will attempt to replicate the normal sequential process of neurodevelopment. Treatment starts with the most basic brain area involved and moves up to higher levels of functioning. For example, a therapeutic pro-

gram for brainstem development (the lowest level of brain organization) could include breathing, yoga, music, and therapeutic massage. This can lead to self-regulation skills. Once this stage has been addressed and improvement has been shown, work can move on to higher functions such as play therapy and relational skills. Finally, verbal and insight-oriented therapy and cognitive-behavioral strategies can be given to improve cortical functioning.

Because brains function in a "use it or lose it" mode, patterned repetitive activity is therapeutic. The brain is organized hierarchically and so is therapy, which consists of positive nurturing interactions with trustworthy peers, teachers, and caregivers.

Dr. Perry's final article included in this review is devoted to the application of neurodevelopmental principles and procedures to maltreated children (Perry, 2009). His goal is to provide knowledge that will allow clinicians to incorporate these principles into practice and policy. Perry reminds us that there are millions of maltreated children in the protective services, mental health, juvenile justice, and educational systems in need of services. As previously noted, treating the trauma is often not enough. The NMT model of sequential brain development is a guide to timing positive therapeutic experiences to restore functioning and build the capability for growth. Because of the sensitivity of the developing brain, he emphasizes early and aggressive intervention that can be implemented for young mothers and fathers to promote infant mental health and development.

Throughout his work and his publications, Dr. Perry has emphasized practice based on neurodevelopmental principles applied in an age and development-appropriate fashion. Finally, he observes that parents often have experienced the same traumas as their children. It is possible to generate a "map" for adults in the child's relational network. This plan can identify the strengths and vulnerabilities of the adults and allow both the child and parents to engage in mutually beneficial activities that can help both improve their lives.

**Key Points**

Maltreatment can be comprised of a combination of neglectful and traumatizing experiences. Both affect the developing brain through multiple, often overlapping mechanisms.

Trauma or neglect may cause an alteration in neural systems based on an underlying genetic vulnerability.

Maltreatment is "the Great Imposter." It can mimic many psychiatric conditions.

The neurosequential model matches the timing of specific therapeutic techniques to the stages of brain development.

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SECOND INTERVIEW WITH BRUCE D. PERRY, MD

# Effects of Military Deployment on Children

*By James E. McCarroll, PhD*
*May 2009*

*Dr. McCarroll: I appreciate the opportunity to talk to you again. Much of our last interview was on the stress of continued military deployment on families. Let me just continue with that theme. Since we published that interview in January 2008, have you had any more people coming to your Child Trauma Academy (CTA) who are military and whose stories would help to shed some light on these issues?*

Dr. Perry: We have had a number of families where the stress of continued deployment has impacted them, particularly how the children are functioning. We have provided some guidance and input to schools about how to be sensitive to these children and not label them. If you are not imbedded in a military community, the rest of the world does not appreciate these issues very well because we are all swept up in our own lives. If you are the only child in the classroom whose parent has been deployed multiple times and you are worried about how they are doing, that influences the way you are behaving, sleeping, and acting in class. The probability that the teacher is going to be aware of this is pretty low. In a few of these kids who are struggling the teacher uses the normal formulation: "This is a child with learning problems, this is a child with attention deficit; this is a child who is just a bad kid." We have tried to spend as much time as possible reminding the educators and the other people who live and work with these children that their changes in behavior and functioning are not at all unexpected considering the ongoing duress that these kids are under and that the parent who is still at home is also overwhelmed and distressed. So their ability to be comforting and organizing for these children is some times compromised. The group that we have seen the biggest problem with has been the children who are living outside the military community, where there is not an awareness of the challenges that they are undergoing.

*Dr. McCarroll: Can you categorize the kids in terms of what you see the most?*

Dr. Perry: Most of what we see is an adjustment response. In some cases, you could give them a diagnosis of attention deficit hyperactivity disorder (ADHD) since that diagnostic category really does not have any necessary exclusionary criteria. If you strictly apply the criteria, a lot of these kids will

have attention problems that would meet that threshold. But, I think that giving them that label and then assuming that they are like other attention-disordered kids is a mistake. We can try to help people be aware of the fact that these are more anxiety-related issues. When you can be reassuring and give these children opportunities to talk about their concerns and fears, their behavior will improve.

*Dr. McCarroll: Do you think that the community of teachers and others who have contact with children who are not on a military post are any more aware of these kinds stresses than they were earlier in the war?*

Dr. Perry: No. If anything it is less because it was more in the minds of people when it was more prominent in the news. To some degree the decrease in violence in Iraq and the shift in focus to Afghanistan has caused them to be less focused on it. It may be that when a child's parent is deployed now they may be at less risk because there is less violence, but the reality for the child is the same.

*Dr. McCarroll: At the CTA you see children who are referred by a variety of sources as well as walk-ins. What kinds of symptoms are they showing?*

Dr. Perry: Our organization has partnerships with a number of clinical programs across the world. We have direct contacts with clients who are referred to us because they are having some sort of emotional or behavioral problems, and we also have this big network in which we are taking advantage of the eyes and ears of many, many, many clinicians in other settings. Some are in school settings, some of our partners are juvenile justice settings, some are in conventional mental health, and some are in child protective settings. Through direct referral and hearing these things from our partners we learn a little bit about what is going on with some of these families.

*Dr. McCarroll: In addition to ADHD and anxiety what else are you seeing in military kids?*

Dr. Perry: In some of the older children we see things that would be more along the lines of what you could consider oppositional defiance that is more an externalizing behavioral problem.

*Dr. McCarroll: Of what age group are you speaking?*

Dr. Perry: Thirteen, fourteen, fifteen years old. These children sometimes have been moved multiple times and are trying to fit into a peer group. This is a particularly challenging time for any child and for any family that has a child that age. We see teenagers who have really been struggling with the lack of having a father around and are using unhealthy ways to act out there

issues. That leads to things like defiance in the classroom and, at some times, vandalism. We have heard about these kids from some of the schools we work with. Very often they will talk about these children in the context of their problems and it is only when we take a history that we find out that this is a family where there is a parent who has been deployed three times. "Well, do you think that may have something to do with it?" And they go, "Oh yeah, well, maybe."

*Dr. McCarroll: Your neurodevelopmental model moves the intervention though stages of brain development. Does that model tend to apply to this kind of child or do you take another strategy with them?*

Dr. Perry: Most of these children were pretty well regulated before all this happened. They were on-task in school and did not have any major developmental changes. When they developed adjustment symptoms or anxiety symptoms or even what we might call vicarious posttraumatic stress disorder (PTSD) symptoms, they responded pretty well to cognitive interventions. These kids respond to talking. But, a lot of them are so dysregulated and so anxious that we couple the cognitive work with somatosensory activities that can help them be quieter internally. Some respond really well to motor activities, like the physical activity of sports, while some others respond very well to things like music. Some of them like to use their hands and are very creative. A combination of somatosensory activity and conventional cognitive approaches are used to help these kids.

*Dr. McCarroll: At about what age would you use the cognitive approach?*

Dr. Perry: If we have a child who is five or six, who is relatively well organized and does not have any previous developmental insults that would make them overly sensitive, then we can talk with them pretty easily. You obviously would have to use an age-appropriate activity and to approach it slightly differently than you would someone who is older, but these kids do respond well to certain kinds of cognitive engagement.

*Dr. McCarroll: Over what time frame does that take place?*

Dr. Perry: We will usually work with them for six months or more. However, we have heard that there are children who have had relatively limited periods of time like two weeks to two months. The feedback that we get is that even a few weeks of some adult engaging them, giving them information, trying to be supportive and reassuring, helps these children. At least they are functioning in the classroom or they are functioning in the home in regards to sleep or behavior.

**Dr. McCarroll: Is that an inpatient program with therapy every day?**

Dr. Perry: No. Most of the kids with whom we work are in a typical community setting. Once or twice a week we will have some sort of therapeutic activity. We try to include the parent and other adults that live and work with the child in the process. They see us and they hear the language we use and the tone of voice. We try to provide the cognitive anchors for these kids and then we ask the parents to essentially mimic what they have seen us do. Part of our work is to create essentially a co-therapist in the parent, or the teacher, or another therapist who may be also working with the child.

**Dr. McCarroll: Can you comment on what you see as resilience factors that are internal to the child? What do you see as their major building blocks?**

Dr. Perry: There are a of couple areas. One that is very underestimated is that the children who have a set of values or a belief system that has been incorporated into their child rearing end up being much more resilient. If they are able to draw upon their world view, their faith, their sense that what mom's doing or what dad's doing is right, they have better outcomes. The belief system is really important. There is also a very powerful positive social element to being part of a community of faith. Those children have relational anchors such as an extended family, a grandparent, or a teacher who takes special interest in them and gives them a little extra time. Those social anchors appear to play a big role in resilience in the present, in children who may not have a strong social network currently. If they have had that in the past, they are relatively more resilient than children who did not.

**Dr. McCarroll: What resources do you find that people use in the community when they go for help?**

Dr. Perry: A lot of people tend to underestimate the available resources in the community. We find that people who go out into the community and try to connect in healthy ways to neighbors, to a community of faith, to after school programs, or to resources that are not conventionally thought of as "mental health" that those people do much better. If they get the child involved in sports, if they get the child into an after school program, if the child has a mentor, those children do better then those children who do not take advantage of those resource. We think that as part of the staffing process. What we do during consultation is explicitly try to catalog what we call the therapeutic web. We try to help this family get connected to the YMCA, to their neighbors. We are actually very aggressive about that. Since the last time you and I talked, we have developed a couple of metrics to look at relational connections. What we find is that in spite of all of the other things that we might recommend, if you have a high social engagement score, you

only need to act on a couple of the things that we suggest to have a good outcome. If you have a low relational connection score, even if you act on everything we recommend, your outcomes are not as good. This therapeutic web appears to be really important actually to get them though some of these challenging times.

**Dr. McCarroll: *The therapeutic web is really a catchy phrase. Has the concept of therapeutic web and its metrics been published?***

Dr. Perry: We actually just finished a book about this topic which will be published in April of 2010 and have several journal articles that are introducing some of these concepts. The therapeutic web is essentially a term used when trying to help people understand the importance of being safe and connected. The idea is that all these lines, like the web of a spider web, are lines of healthy interaction that come from the people around you. They have an impact on the way you are externally regulated, which influences the basic neurophysiology of your stress response. If you are in the presence of familiar people you will receive non-verbal cues of acceptance, of reward, of comfort, and that changes the stress response physiology of your brain. It puts you in an internal state where you are more open to acquisition of new cognitive content so it is easier to learn new cognitive material. It also puts you in a position where you are more receptive, more accurately perceive social cues, and more able to learn social information. If you are surrounded by people who are safe and familiar, you will feel safer and your physiology will be better regulated. The concept of having a very scant therapeutic web means that you essentially have to depend upon your own internal resources to regulate yourself. If you are not great at self-regulation, you are going to have a higher probability of being poorly regulated. This means that if you are threatened you will stay in that higher arousal state for a longer period of time. Also, if you have trauma-related changes in your brain and you are exposed to an evocative cue, you will spend a longer time in the high arousal state. It will take you longer to come back down to normal. There is a lot of the research about physical and mental health and vulnerability to substance abuse and other behaviors. It turns out that people who have lots of stable, healthy relationships are physiologically healthier. They have better mental health outcomes and better academic outcomes. We think that these things are all interrelated. Over the next ten or fifteen years this is going to turn out to be a very important area of investigation and ultimately will form the way we do education and mental health work.

We have had preliminary presentation of some of these metrics, but the full elaboration of this model has not been published completely. The application of this approach in different settings is somewhat different. For

example, in the therapeutic preschool it looks different than the way you would do it in a residential treatment center. We have several sites that are now looking at outcomes after having used this approach. Hopefully, over the next couple years more and more things will be published.

*Dr. McCarroll: Can you comment briefly on how you conceived of the metrics?*

Dr. Perry: One of the hardest things that we have tried to figure out is the metrics. We are not very good at measuring these relational elements. We have come up with some very simple questions about the perception of the quality of relational interaction and its frequency. What we have come up with is a very simple descriptive anchor. We will look at the presence, quality, and frequency of a maternal interaction, of male role models, and the interaction with father, friends, extended family, school, and so forth. We came up with a kind of a crude number, but I am sure there are more sophisticated ways to look at that.

*Dr. McCarroll: Do you use a number of informants such as the child, the parent, the teacher?*

Dr. Perry: That is exactly right. We did a couple of very interesting and very simple things that turned out to be pretty powerful. We would have people who came in for an appointment write down the number of people they had had a conversation with in a week and in the last day. People who wrote down one name had very scant relational connections, people who wrote down four of five people were pretty moderate, and there were some people who wrote eight, nine, ten, twelve people. Simple things like that turn out to be pretty interesting although there are all kinds of methodological flaws when depending on that alone. We have actually been trying to figure out how to look at this in a way that gives us a some what accurate sense of these relational characteristics.

*Dr. McCarroll: Are there advantages and disadvantages to saying that a child has a diagnosable disorder such as an adjustment disorder, ADHD, or an anxiety disorder?*

Dr. Perry: There are people who think ADHD is kind of like getting pneumonia, that you have it, and it is a singular thing. ADHD is essentially a description. We think that educators, foster parents, and other people tend to categorize children based on these labels. We avoid giving a label that has some kind of pejorative connotation. That is a broader issue in all of mental health. The public does not have a very sophisticated appreciation of neuropsychiatric problems. There is still lot of stigma. We do not want people to

do a short cut into a simple linear problem-solving approach where they say that you have this diagnosis, called ADHD, and this is the treatment, called Ritalin. When that happens, people will just avoid really understanding why this child is struggling.

**Dr. McCarroll: Labels tend to stick don't they?**
Dr. Perry: Yes.

**Dr. McCarroll: I liked your phrase in one of your articles, the great imposter, does that apply to this situation too?**
Dr. Perry: Very much so. Say the child goes though a challenging time, like deployment of the parent. If the child copes with it by withdrawing it can look like major depression. There may be depressive elements, but it is probably not the same as a major depression. If you are a child who handles it in a different way, you may look like a child who has ADHD. For example, we had a child who looked like he had an obsessive-compulsive disorder (OCD). He was just at that age of development where he was already a little obsessive. When his father went away he became superstitious and had all these little rituals. It is like calling a baseball player OCD. They have these weird little rituals around batting, but that does not meant that they have OCD. That is how this boy presented. He had to do certain things before he went to bed. He wanted to do certain things because he had a magical thinking that it would protect his father. But it was not OCD; it was just a form of primitive thinking.

**Dr. McCarroll: So neuro-developmental missteps are "the great imposter?" The great imposter mimics psychiatric disorders.**
Dr. Perry: Yep, yep.

**Dr. McCarroll: Your approaches are very sophisticated. You talked about modeling for parents and other providers. Is there a need, in your view, to ramp up training for providers? Your CTA offers a lot of courses, either online or in person. What is your position on how to get these concepts to the field and to what depth?**
Dr. Perry: That is actually a really good question. It is a big challenge for our group and a challenge for our field in general. When we try to introduce any innovation, there is a process of translating emerging findings into common practices. That takes a long time. In some cases, there are some colleagues of mine who looked at this process in the field of neurology. They established with a whole series of scientific studies, a certain set of practices that would lead to better out comes following stroke. It was well established

and well published, and they looked at how long it was before these established and well-researched, finds turned into common practice in clinical neurology. It was thirty years.

Part of the challenge in our field is educating our peers when we find out something new, a new effective therapeutic technique for example, or more sophisticated ways of looking at children and trying to solve some of these problems. The process of getting these approaches into our education process, takes a long time. One of the other challenges for our field is that, is that it is a lot easer to disseminate simple approaches than more complex ones. We all like simple things and systems have an easier time making simple, incremental, change that has a protocol than they do making a more complex, all-encompassing change. So, part of our challenge with the approach that we are using is that it is really not a specific technique. It is a much more a conceptual approach. Operationally, it can be somewhat different depending on the field in which it is applied: in education, in a residential treatment setting, in a conventional mental health clinic, or in a foster home. The way it is functionally put into action is different in different settings, but the core concepts are similar.

Our challenge is that we are trying to teach this and disseminate this information. We are battling the tendency in some groups to look for the simple answer. We want to have one-size-fits-all. That has been a problem in mental health for a long time. For example, if we find one group has had trauma and we find that a trauma-focused cognitive behavioral group really works, then we run out the door and say "All right. Let's teach this to everyone with trauma." You just can not do this. That approach might be great for half the people, but there are probably groups that are not going to respond as well as others, certain ages probably will also not respond, and there are probably certain types of trauma probably will not respond as well as others. Part of our challenge in mental health is that we are dealing with incredibly complex, multidimensional issues. We tend to still take pretty simple, liner problem-solving approaches that work great maybe sometimes, but a lot of times they are not effective for everyone.

*Dr. McCarroll: I would like to ask you about the gaps you see between your field and the fields that interest you, perhaps fields that have not traditionally worked together. It seems a very important aspect of your work and training is how you try to reach different groups to tie them together.*

Dr. Perry: Exactly.

*Dr. McCarroll: Where do you think are the biggest gaps? Who are the people that you would like to get your information to?*

Dr. Perry: Educators have a tremendous opportunity to understand and help children who are impacted by these issues. They tend to spend more time with children than any of us. In any given classroom you are going to have a child whose in whose household there has been some domestic violence. There is a probability that if you have twenty kids you are going to have three or four of them who have been victims of some kind of maltreatment. If you have a classroom of twenty-five kids over a year you are going to have a high probability that a family member is going to die during that time. There is traumatic loss, death, child maltreatment, a parent who has been deployed, and others. It is really hard to be an educator and not run into children who are affected by trauma.

**Dr. McCarroll: *A lot of life is telescoped into the classroom.***
Dr. Perry: Exactly. We, as a mental health community, owe educators a lot of time, understanding, patience, and attention.

**Dr. McCarroll: *How do you reach that community?***
Dr. Perry: It is hard. Educators are under a tremendous amount of pressure to accomplish these cognitive landmarks, bench marks that they are pushed to achieve. They feel tremendous pressure already and their time is limited. When you come in and say, "Listen. There is more that you need to learn." The last thing they want to do is go to another in-service about something they think is not relevant. Rather than telling them what we think they need to learn, we try to form a relationship with the school and provide whatever service they seek. They will say "I have a kid that needs help with such and such" and we will say "Ok. We will start working with the child." Once you get to know the teacher or the people in the school and you help them a little bit then you have the opportunity to educate them about why you think a child acted this way and what may be helpful in the classroom. Little by little you are able to help them learn by working with them.

**Dr. McCarroll: *In the same way you model for parents in the clinic.***
Dr. Perry: Exactly, exactly. It is a very hard thing when you come in as an expert and tell people something they should know. There are always people in a group who will be receptive, but if you do not meet somebody where they are and walk side by side with them for a little while, you are not going to be able to communicate as effectively. We always try to do our teaching in the context of actual clinical work. A major teaching method we have is a case-based staffing process. We will take a child and a clinician, a school, or the system with which they are struggling. In the context of staffing the child in a structured way, we help the adults think in a way that is developmentally

sensitive. We explain exactly why we would make a certain recommendation. At the same time we are helping them solve a problem we are teaching them about the concepts that help us solve the problem.

***Dr. McCarroll: Is that based largely on the neurosequential model of therapeutics?***

Dr. Perry: It is. We tend to take the neurodevelopmental perspective and then pull in lots of other research. In any given staffing we may end up with therapeutic recommendations that range all the way from music and movement, to cognitive behavioral therapy, to an inside-oriented analytic perspective. It really depends on where they are developmentally.

***Dr. McCarroll: What is the difference between age-appropriate and developmentally-appropriate work with kids. How do you distinguish between those?***

Dr. Perry: That is a really good question and is one of the big challenges. For example, if you have a two-year old and they have some sort of fundamental deregulation that originates from abnormalities in the lower parts of the brain, we know that fundamental somatosensory activities are going to help that: things like holding them, rocking them, and even some forms of therapeutic massage. When you take a two-year old in your lap and you rock them, that is age-acceptable. They think that is ok. But, if you have a sixteen year old who has the same type of deregulation you could not put them in your lap and rock them. They would find it odd and it would be awkward and uncomfortable. What we try to do is find an age-acceptable way to provide patterned repetitive somatosensory activity. You might take this sixteen year old child, put hip hop on, give them their ear phones and have them dance. You might have to do some thing like go running with them, or you might have them swim or do yoga where there is repetitive rhythmic breathing that they can focus on. We try to find and age-acceptable and developmentally appropriate activity.

***Dr. McCarroll: Some of the behaviors that you are describing are arousing and others are calming. How do you decide which ones to use and which ones would be helpful and which ones might not be helpful?***

Dr. Perry: One of the keys is taking the histories about these children. We ask the caregiver or the teacher about the things that the child gravitates toward. You almost always find that kids do an activity that they have found to be self-regulating. They may rock or when they are doing their homework they may hum. They may really love sports or they may really love music. You take something that they already like and you structure and modify it

so it is more effectively patterned and used in ways that are more structured and regulated. When you get a good history you can make plausible estimates about what would be regulating and what is likely to be escalating.

***Dr. McCarroll: What do you say when someonr says they had a bad childhood and they turned out all right?***

Dr. Perry: Well, it is a funny thing because whenever you meet those people or talk to with them they will tell you how much pain they had. Just because they can have a job, just because they can do some things that are well within the norm does not mean that they were not impacted by those developmental insults. One area where they very often have unknown consequences of developmental trauma is in their physical health. The work by Rob Anda and Vince Fellitti on the adverse childhood experiences and physical health outcomes documents that the greater the allosteric load during development the greater your risk is for early morbidity and mortality (see for example, Felitti, Anda, Nordenberg, et al., 1998). Also, it is not always the mental health issues that are the outcomes of developmental trauma. It may be that in one person it is more manifest in social areas, in another person in cognitive areas, another person in physiological health. It really has to do with your own genetic makeup and other factors within your development that may have either buffered or made you more vulnerable in some domain.

***Dr. McCarroll: You can think of examples where people might receive help as an adult such as joining the military and having a good career or finding a good spouse or a good mentor, minister or anything like that. Is that usually the way these people are helped?***

Dr. Perry: Exactly. In fact, this is much of what is in the new book that we have written. What we find is that there are many examples of incredibly wonderful productive people who had really rough starts. There are individuals and or organizations who can help some of these folks overcome these developmental traumas and, in some cases. Sometimes, they can get to a place of strength and wisdom that you can not get to unless you have been through traumatic experience. That does not mean that there was not a cost. I think that what people need to appreciate is that trauma need not destroy somebody. But, anybody who has been through trauma will tell you, "Listen. It changed me it had an impact on me. There was a tremendous amount of pain. I may be fine now, but I got fine because of this person or this opportunity." It is an interesting thing that you almost always find that healing happens when there is offsetting kindness to the earlier unkindness.

Dr. McCarroll: That is a beautiful thought. I like that.

***Dr. McCarroll: Speaking of children with a rough start, what do you believe is occurring neurologically with autistic children?***

Dr. Perry: That is a really good question. There is some new evidence about the inability or inefficiency of the creation of synapses in certain parts of the brain in children who have autism. That makes sense considering the number of repetitions required for these kids to sort of make a change developmentally. I am not sure. It may be from some genetic vulnerability due to the inefficiency or lack of a certain protein involved in efficient synaptogenesis, but it appears that they require two to three times as many repetitions to create a synaptic connection in some parts of the brain as a child who does not have autism. That mechanism would account for some of the sensory integration problems that these kids have. In order to make an association between sight and sound, between smell and touch, between all of these incoming sensory inputs, if that takes more repetitions you can see where they develop a kind of a social blindness and also an exquisite sensitivity to changes in the environment. When you change the environment for you and me, our brains can rapidly shift, but if you already have inefficiencies in the synaptic association between primary and sensory input, shifts would be more overwhelming and in some cases very dramatic for kids that have autism. You can do something just as simple as move a book on their book case and they will literally unravel. I think there is something unusual about the way their brain is organizing at key times both in utero and in the extra-utero period.

***Dr. McCarroll: Do you think that there is any similarity between kids with some form of autism and any other disorders?***

Dr. Perry: There are people who study this who consider autism as a spectrum disorder. It goes all the way from high functioning autism to low functioning autism. I think there is probably some physiological relatedness across that spectrum. There is also a whole different group of kids who can present like autism, but who have been severely neglected. Their developmental insults are more obvious. That is what you would expect from somebody who did not hear very much, was not held very much, and was not interacted with socially. But, with kids who have no developmental trauma or neglect to speak of there still is this continuum that appears to exist. I think that it is a combination of genetic vulnerability and some developmental insult. I think that over time we are going to find more about environmental toxins that are potentially related to the increases in autism that has taken place over the last twenty years.

*Dr. McCarroll: This has been fascinating. I have enjoyed it and thank you for the time.*

Dr. Perry: It was my pleasure and I appreciate the opportunity to talk and share our work.

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**Key Points**

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If you are the only child in the classroom whose parent has been deployed multiple times and you are worried about how they are doing, that influences the way you are behaving, sleeping, and acting in class.

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Some resilience factors of children are having a set of values or a belief system, and relational anchors such as an extended family, a grandparent, or a teacher who takes special interest in them and gives them a little extra time.

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The therapeutic web is a term that helps people understand the importance of being safe and connected. Like a spider web, there are lines of healthy interaction that come from the people around you. Having a very scant therapeutic web means that you essentially have to depend upon your own internal resources to regulate yourself.

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# Meeting Children's Basic Needs: A Conceptual Model of Child Neglect

*By James E. McCarroll, PhD, and Robert J. Ursano, MD*
*Joining Forces Joining Families Volume 10, Issue 1, March 2007*

Much of Dr. Dubowitz's work has focused on child neglect, a complex social problem. Child neglect accounts for the largest number of cases and highest rates of any kind of maltreatment in the U.S. civilian society and in the Army. Recent data also indicate that child neglect in the U.S. Army has risen during recent deployments.

Child neglect has been difficult to define, both in research and in practice. Some communities have more concern for physical aspects of child care while others may focus more on psychological issues. However, there is overall general agreement on the circumstances that are harmful to children (Dubowitz, Klockner Starr, & Black, 1998). Part of the discussion of child neglect is whether to categorize subtypes and, if so, how. In a study of the relationships of three major subtypes of neglect (physical, psychological, and environmental), Dubowitz, Pitts, and Black (2004) found modest correlations among the neglect subtypes indicating some degree of overlap, while still suggesting somewhat unique factors in each.

A recent conceptual model of child neglect at ages 4–6 (Dubowitz et al., 2005) identified 12 children's needs, and conceptualized neglect as occurring when these basic needs are not adequately met. This study related child needs to longitudinal measures of child maltreatment. Three basic needs were derived: emotional support/affection, protection from family conflict, and protection from community violence. The model then assessed whether these three constructs were related to children's adjustment at age 8. Low perceived support from the mother was associated with child behavior problems. Exposure to family conflict and children's sense of experiencing little

early affection were associated with both child behavior problems and with social problems. The investigators concluded that conceptualizing neglect as the failure to meet children's needs could help build our understanding of child neglect.

An important part of Dr. Dubowitz's work is educating health care professionals on family maltreatment. Two articles on child neglect provide very clear and useful language and approaches for providers of health care. The first (Dubowitz, Giardino & Gustavson, 2000) describes manifestations of child neglect, provides principles for assessment and management of neglect and suggests that caregivers focus on children's basic needs rather than on the omissions of parenting. The second article (Dubowitz, 2002) describes the importance of preventing child abuse and neglect, identifies risk and protective factors for child maltreatment, and provides guidance on screening, brief assessment, and initial management of child maltreatment.

One of the important issues that Dr. Dubowitz has emphasized in his research and teaching is the association between father involvement and child neglect. In a 2000 study, Dubowitz and colleagues found that the mere presence of a father did not significantly influence the degree of neglect of the child, but the nature of his involvement did. Fathers who felt more effective as parents were less likely to neglect their children. Less neglect was associated with fathers' longer duration of involvement, more involvement with household tasks, and less involvement in child care (Dubowitz, Black, Kerr, Starr, & Harrington, 2000). The investigators thought that the sense of parenting efficacy might represent parenting skills and suggested that caregivers could play a valuable role in enhancing the involvement and parenting skills of fathers.

In a very recent article, Dr. Dubowitz (Dubowitz, 2006) commented on two studies on child neglect (Coohey, 2006; Pittman & Buckley, 2006), reviewed the significant research on fathers and child maltreatment, and described the current need to understand the roles of fathers in child rearing and child maltreatment. Coohey found several predictors of recidivism among fathers who abused their children: (1) father unemployed, (2) not the biological father of all the children in the family, (3) denying responsibility for his behavior, (4) having previously maltreated a younger child, and (5) seriously injured a child. Dubowitz noted that an important clinical implication of Coohey's work was getting fathers to acknowledge their own responsibility, which has implications for both prevention and intervention.

Dr. Dubowitz noted that Pittman and Buckley's study of 2,841 offenders treated in the U.S. Air Force Family Advocacy Program found many similarities and few differences between mothers and fathers of neglected children. The mothers reported more distress and more problems outside the family,

while fathers reported more rigid expectations of children and less family cohesion. Taking into account such differences may help tailor treatment interventions to address specific problems that differ for mothers and fathers.

Finally, Dr. Dubowitz has performed community research on the effectiveness of strategies to prevent child neglect. The program, Family Connections, was a demonstration project of a prevention strategy assessed in 154 families who received the intervention for 3 months or 9 months (DePanfilis & Dubowitz, 2005). The outcomes of the program were protective factors (parenting attitudes, parenting sense of competence, family functioning, and social support), key risk factors for neglect (caregiver depressive symptoms, parenting stress, and everyday stress), child safety (physical and psychological care of the child), and child behavior (caregiver reports of child internalizing and externalizing behavior). Internalizing behavior included somatic complaints and withdrawn, anxious, or depressive behavior. Externalizing behavior was measured as delinquency or aggressiveness. The intervention aimed to improve protective factors, diminish risk factors, and thereby improve child safety and behavior. Interestingly, the 9 month program had few advantages over the 3 month program. This finding reinforces the need for research on the optimal length of intervention for community-based programs.

There are many implications of Dr. Dubowitz's work for the Army Family Advocacy Program as well as suggestions for further research. Among the research and program development opportunities within the Army community are to: (1) determine the types and prevalence of subtypes of neglect; (2) clarify the degree of overlap of neglect subtypes with other types of neglect and with other types of child maltreatment, and domestic violence; (3) develop neglect prevention programs targeting the subtypes of neglect and the highest risk families; and (4) understand the meaning and implications of children's experiences of neglect and risk for harm.

Dr. Dubowitz's work in the field of child neglect can help educate and inform the Army community. In the current context of rapid, long, and repeated military deployments, it is often hard for parents to balance all the needs of the active duty member(s) and the children. Further understanding of child neglect in our own community can protect our nation's children and strengthen the Army family.

**Key Points**

Three basic needs of children are for emotional support and affection, protection from family conflict, and from community violence.

Programs emphasizing parenting efficacy could play a valuable role in enhancing the involvement and parenting skills of fathers.

Dr. Dubowitz suggests that caregivers focus on children's basic needs rather than omissions of parenting.

Research Possibilities Involving Neglect
- Prevalence of subtypes.
- Targeting neglect prevention programs to the most prevalent subtypes.
- Degree of overlap of subtypes and other forms of child maltreatment.
- Child neglect and domestic violence.
- The meaning of children's experiences of neglect and the risk of harm.

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INTERVIEW WITH HOWARD DUBOWITZ, MD

# Conceptualization and Measurement of Child Neglect

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 10, Issue 1, March 2007*

*Dr. McCarroll: Based on your international experiences, training, and practice, what do we know about child maltreatment across cultures?*

Dr. Dubowitz: To the best of my knowledge all cultures have a taboo against child sexual abuse, although cross-cultural differences do exist. For example, a majority of countries do not have prohibitions against child pornography. Physical abuse issues are a little trickier. Even within the state of Maryland there are differences. For example, some people may equate any hitting of a young child as abuse while others accept spanking as appropriate in some circumstances.

*Dr. McCarroll: Tell us a little about your Center.*

Dr. Dubowitz: Our Center is within the Department of Pediatrics at the University of Maryland Medical School. We have four main activities: clinical programs, clinical research, teaching, and advocacy. Our goal is to encourage the development of policies that will help children and families within the city, the state, and nationally.

*Dr. McCarroll: In your teaching and research do you address the intersection of child and adult maltreatment?*

Dr. Dubowitz: I generally do raise it as an issue. I think this is an important intersection. One of the projects that we are completing is focused on routine screening for domestic violence by pediatricians.. There are studies showing that parents, usually mothers, will report domestic violence to pediatric and other medical staff when asked. Dr.

*Dr. McCarroll: What is the best way to screen for child or adult maltreatment?*

Dr. Dubowitz: I recommend using a screening instrument. Screening cannot and must not be limited to visual examination. So much gets missed when you depend only on gross examination, such as the woman with the black eye. Abuse is a problem that is often well masked.

*Dr. McCarroll: Would you say the same thing about child abuse? Would you*

*rely on a screening instrument as opposed to a visual examination or verbal report?*

Dr. Dubowitz: I think the difficult question is what instrument to use. If there were something practical it would be quite attractive. However, this has been elusive. As part of a project called SEEC — a safe environment for every child — we included two questions that seem to be important. They were part of a one-page questionnaire that parents completed while waiting for the child's appointment. (1) "Have you been concerned that your child may have been sexually abused?" and (2) "Have you felt the need to hit your child?" These questions have shown some predictive value. The big problem is that of response bias in the direction of social desirability and how does one circumvent it. [Editor's note: Social desirability is presenting oneself in an overly favorable light.] In a current study that we are conducting with about 85–90 pediatricians in private practice, we are targeting risk factors such as depression, substance abuse, domestic violence and parental stress as the four big contributors to child abuse and neglect.

*Dr. McCarroll: Your earlier papers emphasize the ecological model as developed by Brofenbrenner (1979) and Belsky (1980). Do you still teach this as a way of conceptualizing how children are affected by their world? [Editor's note: The ecological model is a theory emphasizing the multiple interacting factors that contribute to child abuse and neglect.]*

Dr. Dubowitz: Yes, it is a major focus. It is important for professionals, when these cases evoke feelings of pain, anger, and dismay, to recognize that neglectful parents are not simply evil people. Where these models can be helpful is to caution us not to excuse the behavior, but to understand that there are underpinnings to some of these problems. I often will suggest that pediatricians think of abuse and neglect as symptoms. That seems to help take some of the edge off of angry feelings and helps us realize the importance of the family, cultural, and community issues that contribute to the situation.

*Dr. McCarroll: It sounds like this approach could be helpful to parents as well as to physicians.*

Dr. Dubowitz: I am always careful when presenting the model to not let parents off the hook. It is walking a bit of a tightrope. I do say that parents have the primary responsibility to protect and nurture their children. The cliché that it takes a village is, however, actually kind of true.

*Dr. McCarroll: The high rates of neglect in the U.S. civilian community and the Army are of concern. In many publications one reads about subtypes of neglect, but most jurisdictions do not publish data on subtypes. What is the*

*value of categorizing neglect into subtypes? Would this help to target interventions?*

Dr. Dubowitz: Again, there is quite a bit of variation across states. Very often, states have two, three or four subtypes. One of them is often called failure to provide. This includes the physical aspects of childcare such as food and housing, clothing, and, sometimes, health care. The second main subtype that is often used is lapses in supervision. Some also have educational neglect, but generally it is the physical aspects of children exposed to hazards and concerns about supervision that states are most concerned about.

**Dr. McCarroll: Do you think the subtypes are primarily for researchers? Are clinicians interested in using such categorization?**

Dr. Dubowitz: I think that this is not a question just for researchers. These different subtypes are, in fact, different. To lump together, for example, the child who has inadequate nutrition with a child who is abandoned does not make much sense. The circumstances are quite different. One could argue that for the individual clinician, even having subtypes is too crude. I say this as a clinician. For example, the criminal law on abandonment in one state requires that about 15 or 20 different contextual variables need to be taken into account. In the instance of a child left alone, contextual variables might be the age of the child, the time of day, how long is the child left alone, are the utilities functioning in the house, is there food in the house, does the child know how to reach a parent? In cases of failure to thrive, contextual variables also make a huge difference. Clinicians, even sometimes without even using the terminology, recognize this variability and try to probe the specific circumstances. By doing so they are paying attention to the differences across and even within subtypes.

From an administrative standpoint, I can see how, for example, child protective services might lump these different categories into failure to provide. For researchers as well there is a need to clarify the meaning of these different experiences for children. Also, there is substantial overlap between the subtypes. In the LONGSCAN, for example, with 1,300–1,400 children, in a subsample of children who have experienced lapses in supervision, it gets pretty tricky because many of these children have experienced other types of neglect or other forms of maltreatment as well. [*Editor's note*: See Dr. Dubowitz's biography for a reference to the LONGSCAN.] But I should also give another perspective. There are differences and subtypes of neglect, but ultimately these are symptoms of parents having difficulty meeting their children's basic needs. From a conceptual standpoint does it really matter? If one looks at the underlying parental, family, and community dynamics that are underpinning these manifestations, are they likely to be so differ-

ent? Therein lies a conceptual argument for lumping rather than dividing. So, I think the answer is that it depends specifically on the question. If it is a matter of broader public policy then some of these differences might seem unnecessarily nuanced. On the other hand, if it's trying to understand the specifics around the feeding of young children then the issue of that specific subtype might be quite important.

*Dr. McCarroll: You mentioned in one of your articles that various risk factors such as substance abuse, depression, non-biological parents, and others, have low predictive value for neglect.*

Dr. Dubowitz: I hope I have not been dismissive of risk factors because we need a variety of strategies. Even if a particular risk factor has a low predictive value, I think when you start combining them the predictive power gets better. This gets back to definitional issues. Both domestic violence and maternal depression are strong risk factors for child abuse. If one is looking at only parental age, then the connection is weaker.

*Dr. McCarroll: What are the underpinnings of risk factors? Is this the question of what lies behind the parents' failure to adequately take into account their children's needs?*

Dr. Dubowitz: For a long time it has been convenient to point and wag a finger at a guilty parent, but I think one might take a broader epidemiological view, a public health perspective saying, "Wait a moment." You know, if we are in a society that says on the one hand says we love children and at the same time one in four girls and maybe one in ten boys are sexually abused, I think it behooves us to take this broader perspective of what are the contributors that are underpinning these facts.

I have stubbornly held on to the view that most parents most of the time would like for things to be good for their children. So the big question as we try and put a dent in this problem is to better understand what gets in the way of, hopefully, good intentions.

*Dr. McCarroll: Thank you for your thoughts.*

Dr. Dubowitz: You are welcome.

**Key Points**

Four major risk factors for child abuse and neglect are depression, substance abuse, domestic violence, and parental stress.

Parents, most of the time, would like for life to be good for their children. The big question is to understand what gets in the way of good intentions.

REVIEW OF RECENT RESEARCH OF HOWARD DUBOWITZ, MD

# Project SEEK — A Safe Environment for Every Kid

*By James E. McCarroll*
*January 2010*

Dr. Dubowitz and colleagues have undertaken studies in their clinics to improve child safety and health (Dubowitz, Feigelman, Lane, & Kim, 2008). The Safe Environment for Every Kid (SEEK) project aims to prevent child maltreatment through the development of screening procedures in pediatric primary care clinics for major risk factors associated with abuse and neglect. In this research, they have used screening questionnaires to identify parents with psychosocial problems and compared those screening questions to standard instruments used to detect risk factors for child maltreatment. The Parent Screening Questionnaire (PSQ), a 20-item questionnaire to be completed by the parent waiting for a checkup of their child (under 6 years of age), was developed to briefly screen parents for the targeted risk factors: maternal depression, corporal punishment, family substance abuse, and intimate partner violence and major stress (Fiegelman, Dubowitz, Lane et al., (2007).

A subset of parents participating in the study evaluation were asked to complete questionnaire measures that served as "gold" standards against which to compare the screening questions. [*Editor's note*: The term gold standard denotes the highest possible level of value. A gold standard test is not infallible, just the best that is known. Unfortunately, applicable gold standards in medical practice are rare.] Four papers based on the first SEEK study reported testing the PSQ against standard measures related to the risk factors. The first sample was largely urban, low-income, and black. Most were single mothers with an average age of 25 years. Two-thirds were high school graduates or less and the children had an average age of 5 months. The average household composition was two children and two adults. Medicaid was the insurance for 90% of the families.

In the first paper, the investigators estimated the prevalence of depression of mothers (Dubowitz, Feigelman, Lane, et al., 2007) seeking care for their children in a primary care pediatric clinic. Parents' scores on two depression screening questions from the PSQ were compared to the Beck Depression Inventory II (BDI II, the gold standard for identifying depression in this study (Beck, Steer, Ball, et al., 1996). The two PSQ questions were:

"Lately, do you feel down, depressed, or hopeless?" and "During the past month, have you felt very little interest or pleasure in the things you used to enjoy?" Twelve percent of the mothers met the criteria for at least moderate depression on the BDI II. Twenty-two percent met the BDI II criteria for mild depression. The two PSQ questions individually yielded similar rates, 19% and 17%, respectively. The sensitivity of the two questions was 74% and was considered satisfactory, although not as high as the investigators had hoped. [*Editor's note*: Sensitivity is a measure of the ability of a screening test to accurately identify persons with the problem in question, in this case, depression as measured by the BDI II.]

The authors discussed some implications of screening for depression in a primary pediatric care clinic. One issue was that depression is often masked and that people may not be aware of it or willing to seek treatment for it. Their discussion could be of value to primary care doctors, nurses, and others who may screen for depression outside a mental health clinic. The authors concluded that the prevalence of depression in this population of mothers of young children was quite high, as found in other studies. They also concluded that the two item depression screening questions of the PSQ had adequate statistical properties (stability and reliability) for accurate identification of parents who may be at least moderately depressed and who might benefit from further evaluation.

In screening for harsh punishment by parents, the PSQ was compared to the Conflict Tactics Scale, Parent-Child (CTSPC), a standard measure of parent-child conflict (Feigelman, Dubowitz, Lane, et al., 2009). Two items from the PSQ were associated with discipline: "Do you often feel your child is difficult to take care of?" and "Do you sometimes find you need to hit/spank your child?" The frequencies of "Yes" responses to the two screening items were low. Five percent of parents with infants and 11% of those with older children responded positively to the question of whether the child was difficult to care for. Three percent of parents with infants and 26% of parents of older children responded positively to the second question, the need to hit the child. The CTSPC included both physical assault and psychological aggression items. Minor physical assault on the CTSPC ranged between 1-10%. Six caregivers endorsed items that were considered severe physical assault. Twenty-one percent of parents reported psychological aggression (e.g., yelled, screamed, swore or cursed at the child). The authors concluded that the prevalence of corporal punishment in this sample was high, but similar to that reported in several national studies. The ability of the PSQ to detect harsh punishment was moderate (57%), but it performed better for older children. However, there are many reasons why the results of this study were not more favorable in being able to detect corporal punishment

of children. The frequencies of corporal punishment are very likely underestimates and questions asked of parents on the PSQ and the CTSPC were not exactly the same. However, the authors concluded that primary providers could use the PSQ in several ways. Any family endorsing either of the two items could benefit from counseling in the pediatric office. Physical assault against infants is especially serious. Such harsh disciplinary practices call for helping parents find better alternatives.

Parental substance abuse was screened by the use of two questions on the PSQ: "In the past year have you or your partner had a problem with drugs or alcohol?" and "In the past year, have you or your partner felt the need to cut back on drinking or drug use?" The comparison standard measure used was a modified version of the Composite International Diagnostic Inventory (CIDI) including the sections for alcohol and drug use (World Health Organization, 1993). The CIDI prevalence for alcohol abuse was 13.9%, 3.2% for drug abuse, and 15.7% for either. The screening questions had a sensitivity of 10-13%, depending on which question was used. The investigators concluded that the screen identified relatively few of the substance-abusing parents, but that whose would otherwise have gone unidentified.

A fourth paper reported on screening for intimate partner violence (Dubowitz, Prescott, Feigelman et al., 2008). The purpose was to estimate the prevalence of intimate partner violence (IPV) and to determine the effectiveness of a brief screening instrument for detecting IPV. The three screening questions were: "Have you ever been in a relationship in which you were hurt or threatened by a partner?" and "In the past year, have you been afraid of a partner?" and "In the past year, have you thought of getting a court order for protection?" A total of 12% answered positive to at least one of the PSQ screening questions. These responses were compared to the Revised Conflict Tactics Scale (CTS2) (Straus, Hamby, Boney-McCoy et al., 1996). On the CTS2, responses varied from 9% reporting a physical injury to 76% reporting psychological aggression. The sensitivity was 29%.

The authors noted that it would have been better if the sensitivity of the PSQ questions had been better, but there were several possible reasons why it was low. IPV is a very sensitive subject, but identifying those who are willing to admit the problem and seek help may be a benefit to them and to their children. Although one hopes that screening will identify as many folks with the problem as possible, it is likely that those who do not disclose the problem in a clinic setting are unlikely to engage in treatment. It is also probable that for many sharing such sensitive information, and in a setting where they are unaccustomed to discussing their problems, is a slow and perhaps lengthy process. Dr. Dubowitz hopes that in the SEEK model, a valuable message is communicated ("We care about you, too!") and perhaps

a seed is sown. Parents may eventually recognize that this is a setting where they can obtain help.

The overall result of the SEEK project resulted in lower rates of child maltreatment in terms of fewer child protective services reports, fewer instances of possible medical neglect documented as treatment non-adherence, delayed immunizations, and less harsh punishment reported by parents (Dubowitz, Feigelman, Lane, & Kim, 2009).

In general, these papers examining the SEEK Parent Screening Questionnaire showed many positive results. Screening for risk factors for child maltreatment and family disruption can be accomplished in primary pediatric care. Without such screening, risk factors would likely be unrecognized in all but the most severely affected families. Screening for sensitive information is difficult and requires rapport between the screener (in this case, the pediatrician) and the parent. The investigators have shown that this exists in primary pediatric care. Recognition of the problem for which screening is conducted also serves an educational function in which the pediatrician and child's caregiver can talk about the risk factors that could affect the parents and their child(ren). It also provides the opportunity for the parent to consider further evaluation regarding an identified problem. While the percentages on sensitivity may be confusing to the reader, there are several overall points that can be made. Even though the sensitivity may be low, it is worthwhile to identify even small numbers of parents who need help with the risk factors identified — if this leads to them being helped.

There are many ways to administer screening questions. Several of those methods were used in this study: face-to-face, by computer, and paper and pencil. Each has its advantages and disadvantages (Kim, Dubowitz, Hudson-Martin, & Lane, 2008). An important advantage of the parent responding to the PSQ while waiting for their child to be seen is the efficiency saving time, a serious concern in a busy pediatric practice. Recruitment and retention of study participants was said to be challenging (Dubowitz, Feigelman, Lane, & Kim, 2008). Some did not return to complete the study protocol. The unwillingness of the participants to admit certain problems is likely to produce underestimates of the true prevalence of the events; this is to be expected. The study showed that screening for problems in an attempt to provide safer environments for children can result in helping parents and pediatricians identify risk factors and suggest ways of addressing these problems. Most importantly, the studies have shown the SEEK model of enhanced pediatric primary care to be a promising approach for preventing child maltreatment. Hopefully, it will also promote children's health, development and safety.

**Key Points**

Screening for risk factors for child maltreatment and family disruption can be accomplished in primary pediatric care. Without such screening, risk factors would likely be unrecognized in all but the most severely affected families.

The SEEK project resulted in fewer child protective services reports, fewer instances of possible medical neglect documented as treatment non-adherence, delayed immunizations, and less harsh punishment reported by parents.

Screening also serves an educational function in which the pediatrician and child's caregiver can talk about the risk factors that could affect the parents and their children.

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SECOND INTERVIEW WITH HOWARD DUBOWITZ, MD

# A Safe Environment for Every Kid:
# The SEEK Study

*By James E. McCarroll, PhD*
*January 2010*

***Dr. McCarroll: In your last newsletter interview you talked about your Safe Environment for Every Kid (SEEK) project in which you studied screening by pediatricians in private practice for risk factors such as depression, substance abuse, domestic violence and harsh punishment. Where has that project gone from that point?***

Dr. Dubowitz: It has gone quite a ways (Dubowitz, Feigelman, Lane, & Kim, 2009). It is built on an earlier study where we had applied the same preventive model in a West Baltimore University-related clinic. Being a pediatrician, I have been especially interested in prevention. Most American kids get regular check ups, particularly in the first three years of life. Infants and toddlers are usually seen every two or three or so months. These checkups present a terrific opportunity for physicians and sometimes nurses to know what is cooking in the kid's home and family environment. For some time, pediatrics has acknowledged that it is not enough to narrowly focus on just the child. If mom is depressed or the parents are using drugs or there is violence, that can have an enormous impact on children's health, development, and safety. So, we have been testing a model of modifying pediatric primary care to consider screening for some of these major risk factors that we know are pretty prevalent and strongly associated with both child abuse and neglect. Aside from preventing child abuse and neglect, the hope has been that by identifying and addressing these problems, like mom's depression, that we can improve children's health and development. So, this project has a broader frame than preventing abuse and neglect. It shifts the paradigm to one of promoting children's health and development.

***Dr. McCarroll: How did you target your screening?***

Dr. Dubowitz: We set up a randomized trial in a clinic serving about 9,000 kids and where pediatric residents had their half-day a week "continuity clinic." We randomly divided the clinic days: two days were intervention clinics and two were control clinics. Within the interventions clinics, every parent bringing in a kid under six years of age for a checkup was supposed to receive the Parent Screening Questionnaire to complete while waiting for

their child to be seen.. That is a very important point because we know clinically if one is going to screen only when there is evidence of violence or signs of depression, one is going to miss an enormous amount. These are problems that are often well masked. In the brief intro to the screen, we say, "We are asking everyone these questions." We indirectly convey "It is not because of the way you look or because we think you are acting as though you are high on drugs, but these are common problems facing lots of families and so we are asking everyone." Aside from this clinical intervention, all of these families were eligible to participate in the evaluation of SEEK; a subset were recruited.

### *Dr. McCarroll: How does the clinician establish enough rapport to ask these questions?*

Dr. Dubowitz: The whole effort occurs in the context of a relationship. Generally speaking, pediatricians and parents have nice relationships. Parents usually like their kid's pediatrician. It is very much for that reason that we saw this as a terrific opportunity. This may begin prenatally, but then there are these repeated visits over time in which, hopefully, a relationship and rapport are established, which should help someone disclose difficult, sensitive information. We are very careful to strike an empathic tone. On our screening questionnaire, we tell the parent that we are concerned that children be in safe environments. We are also conveniently building on something that has been long established in pediatrics - an interest in kids' safety. Usually, safety has been discussed in terms of bike helmets and smoke alarms and the like. It is stretching that paradigm a little bit to think about other risks that might compromise children's safety, health, and development; it is building on the concern about a child's environment.

### *Dr. McCarroll: One of the issues you spoke of in the last interview is the impact of children witnessing domestic violence. I wondered how you inquired about domestic violence with patients.*

Dr. Dubowitz: That has been interesting because there is no clarity on the best way to ask about it. Depression has been researched best, domestic violence very little. So, we have worked with different questions. We finally decided to ask the following: "Have you ever been in a relationship in which you were physically hurt or threatened by a partner?" "In the past year, have you been afraid of a partner?" "In the past year, have you thought of getting a court order for protection?" We have analyzed how different screening questions perform against the Conflict Tactics Scale (CTS), a measure of how intimate partners resolve conflict (Straus , Hamby , Boney-McCoy, &Sugarman, 1996). We found relatively low sensitivity, but quite good, as

you would expect, specificity. [*Editor's note*: Sensitivity means the ability of a test or screening instrument to detect the outcome variable when it is present, e.g., in this case, domestic violence. Specificity is the opposite: the ability of a test to indicate that, in fact, the outcome for which screening is conducting is not present. In this study, the screening instrument was very good at determining when there was no domestic violence, but not so good at detecting its presence.]

**Dr. McCarroll: Do you think it comes as a surprise to parents that parents' difficulties can affect their kids or do they think that the kids are in some way immune from that?**

Dr. Dubowitz: I can answer that a little indirectly. We were concerned that parents might resent our approach and think we were just being nosy. But, at least anecdotally, we did not find that to be a problem. The first study probably involved three or so thousand families and the second study more like four or five thousand. Our experience has been positive. We hypothesized that parents might even appreciate being asked these questions. In the first and second studies, we had measures of parental satisfaction with their kid's pediatrician hypothesizing that this interest in how they were doing would add to parents' satisfaction. In the first study, in a very high risk population, we found some evidence that parents actually did appreciate it. In the second study, which was a rather high functioning middle class suburban population for the most part, we found that it really did not make much difference. We did not find a problem or a benefit.

**Dr. McCarroll: It may be that those in the lower income and lower socioeconomic group were happy that somebody anywhere was concerned about them.**

Dr. Dubowitz: I think so because I know it is appreciated when a clinician communicates to these parents, mostly moms, "I care about you; you are important, too." I am guessing that it is something they do not often hear.

We are just finishing the second study. We have answered some of the preliminary impressions. As in the first study, it appears that we were able to reduce child abuse. We measured child abuse and neglect three ways: by parental self-report, by review of the kid's medical records, and by child protective services reports. In the first study, all three measures favored the intervention group. We were excited about that. In the second study, mothers in the intervention group reported less psychological aggression and minor physical assaults toward their children. There were, however, very few CPS reports and problems documented in the children's medical records and no

significant differences between the groups.

There are important questions about identifying intimate partner violence. Even though you would like a screen that is very sensitive and picks up most folks who are affected, is it still better than nothing to identify one in five or even one in ten? Some would argue that it is. The problem is that neither we nor anyone else has clearly shown that identifying these folks in health care settings really leads to improved situations. There is a recent paper by MacMillan (MacMillan, Wathen, Janieson, et al., 2009) where they quite clearly argue, as does the US Preventive Services Task Force (2004), that short of showing that there is a benefit, we do not have a solid basis for screening for that problem. In pediatrics there are now perhaps half a dozen papers including our own showing that women will disclose this information. Sometimes, the rates are reasonably high, perhaps about 20%, but we are still stuck in not demonstrating that that leads to help for them or for the child. We looked at how many of them got services; the numbers were small. There can be a complicated journey from identifying a problem, to the person acknowledging it, to then receiving help and being helped.

*Dr. McCarroll: One of the issues I have addressed in these re-interviews is to ask what gaps occur in your work that you would like to see filled. I believe you have just identified a major one: the ability to get people into treatment and have an effective treatment for things that you identify and know are dangerous.*

Dr. Dubowitz: Absolutely. I think how to encourage folks, how to motivate them to get the help we think they need is such a big issue. In the second of the SEEK studies we included motivational interviewing in our training of about 100 pediatricians and pediatric nurse clinicians. It was probably not enough, but it is a skill that I think would be great if folks were better at it. But, even then, this is such a big challenge. I talked to a psychologist last week about our findings and she asked "How long is the follow-up period?" I said "Well, in the second study, 12 months." And she said, "Well, that may not be long enough." You know, someone hears that they have a problem and ideally, you would want to follow them for two or three or more years. [*Editor's note*: See Hettema, Steele, & Miller (2005) for a review of motivational interviewing.]

*Dr. McCarroll: Thank you for your interview. We will be watching for more of your exciting work on children and family maltreatment.*

Dr. Dubowitz: You are welcome. And, thank you for your interest.

**Key Points**

There has been little clarity about how to ask parents about the occurrence of domestic violence.

In our parent screening questionnaire, we asked three questions:
- "Have you ever been in a relationship in which you were physically hurt or threatened by a partner?"
- "In the past year, have you been afraid of a partner?"
- "In the past year, have you thought of getting a court order for protection?"

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# Highlights of Recent LONGSCAN Project Findings

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 11, Issue 3, March 2010*

The long-term effects of the maltreatment of children are among the most persistent and difficult questions to answer in the child maltreatment arena. With the Longitudinal Study of Child Abuse and Neglect (LONGSCAN), Dr. Runyan and colleagues have undertaken a series of studies to answer these questions. In 1990, the Office of Child Abuse and Neglect (then the National Center on Child Abuse and Neglect) committed funds for the LONGSCAN (Runyan & Litrownik, 2003). This project is a consortium of five independent prospective studies designed to examine the long-term consequences of child abuse and neglect (Runyan Curtis, Hunter, et al., 1998). The five sites are widely distributed across the United States: Eastern, Southern, Midwest, Southwest, and Northwest.

Children enrolled in the study were recruited at four years of age or younger. The samples include maltreated and non-maltreated children, children at high risk of maltreatment, and children placed in foster care. The goal of LONGSCAN is to follow the approximately 1,300 children and their families until the children become young adults. Maltreatment data are collected from multiple sources. Children and their caregivers have been regularly assessed at approximately 2-year intervals using face-to-face interviews and standardized instruments, some of which were created for this study. Yearly telephone interviews are also conducted on a subset of the study population incorporating factors at the child, parent, family, neighborhood, and larger community levels. Data collected at each interval include exposure to maltreatment, age-specific potential risk and protective factors, and age-

appropriate outcomes such as the domains of mental health, behavior, social functioning, school, and employment.

Ecological-developmental theory (Belsky, 1980; Bronfenbrenner, 1977) has been the basis for the selection of research questions, measurement, and analyses. This theory is based on the knowledge that children's response to maltreatment and intervention varies by age, developmental level, and the context of the maltreatment. In addition to ecological-developmental theory, a social-developmental model (Catalano & Hawkins, 1996) is a complementary framework for the investigations. This model hypothesizes that interactions with others mediate the influences of individual and social factors on outcomes.

The findings of LONGSCAN will provide a scientific basis for policy-making, program planning, and targeting service delivery by increasing our understanding of the following:

■ The child, family, and community factors which increase the risk for maltreatment in its different forms;

■ The differential consequences of maltreatment, depending upon its timing, duration, severity, and nature, and upon the child's age and cultural environment;

■ The child, family, and community factors (e.g., chronic exposure to violence, parental substance abuse) that increase the harm (measured by age-appropriate negative outcomes) caused by different forms of maltreatment;

■ The factors that increase the probability of positive child outcomes despite maltreatment and other adverse life circumstances;

■ The strengths and weaknesses of various societal interventions such as child welfare programs, foster care, mental health services, parenting classes, etc. Some of the sites are involved in intervention research and evaluation of services, expediting the integration of research findings into policy and practice.

The LONGSCAN investigators and others who have used the datasets have produced a large volume of publications. Many of these are available on the LONGSCAN website. [Editor's note: See websites of interest.] Two recent publications focus on the importance of early childhood maltreatment, one on later aggression (Kotch, Lewis, Hussey, et al., 2008) and on adolescent sexual behavior (Black, Oberlander, Lewis, et al., 2009). Early childhood neglect (birth to age 2 years) predicted child aggression scores at ages 4, 6, and 8 years (Kotch, Lewis, Hussey, et al., 2008). Boys had higher aggression scores than girls, younger children had higher scores than older children, and more caregiver depressive symptoms were associated with higher ag-

gression scores. Surprisingly, early abuse, later abuse and later neglect did not predict later aggression at later ages beyond 8. The authors noted that the effects of juvenile violence are a serious concern, and on a worldwide basis. The authors have shown that neglect may have profound and long-lasting effects on the child, especially if it occurs early in development.

The relationship of childhood maltreatment to adolescent sexual behavior is an important public health question. Analyses of the LONG-SCAN found that all types of childhood maltreatment predicted adolescent engagement in sexual intercourse (Black, Oberlander, Lewis, et al., 2009). Emotional distress, as measured by the Trauma Symptom Checklist (Briere, 1996), mediated the relationship between maltreatment and sexual inter-course at age 14, but not at age 16. The authors concluded that maltreated children are at risk for early sexual behavior, but by age 16, other factors ac-count for it.

Many publications from the LONGSCAN include descriptions of the relationship of maltreatment to various health and social outcomes. Other studies include the risks for child maltreatment in different environ-ments, ethical issues, costs and other economic issues, parenting and care-taking, development, foster care, prevention, type of maltreatment, long-term outcomes and many others. This very comprehensive effort to collect longitudinal data across a variety of domains will provide child maltreat-ment researchers with much material for analysis and study over many years to come.

**Key Points**

Ecological-developmental theory is based on the knowledge that children's response to maltreatment and intervention varies by age, developmental level, and the context of the maltreatment.

The goal of LONGSCAN is to follow approximately 1,300 children and their families until the children become young adults

Early childhood neglect (birth to age 2 years) predicted child aggression scores at ages 4, 6, and 8 years

All types of childhood maltreatment predicted adolescent engagement in sexual intercourse.

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**LONGSCAN principal investigators**

The following are the LONGSCAN principal investigators and the focus of studies at each of the five sites.

- *Howard Dubowitz, MD,* is Professor of Pediatrics and Director of the Center for Families at the University of Maryland School of Medicine, Baltimore. His site focuses on a cohort of children drawn from three Baltimore pediatric clinics serving children with non-organic failure to thrive, children of drug-abusing or HIV-positive mothers, and low-income, inner-city children. Site-specific objectives of this study are the developmental impact of chronic neglect, the mediating influence of home interventions, and the importance of fathers in children's adaptive, academic, and social development.

- *Diana English, PhD*, is the Director of Research for the Child Welfare Research Group at the School of Social Work, University of Washington, and the Director of Research and Development for the Child Welfare League of America. Her site focuses on a cohort study of children (ages 1-4), consecutively classified as moderate risk by Child Protective Ser-

vices offices in Seattle. This study will yield data about the risk assessment process and allow an examination of the impact of social service and mental health interventions.

■ *Jonathan Kotch*, MD, MPH, is Professor in the Department of Maternal and Child Health, School of Public Health at the University of North Carolina at Chapel Hill. His site focuses on infants identified as high risk by the state public health department's infant tracking program. These children constitute a birth cohort, recruited not for maltreatment history, but identified because of extreme poverty, young maternal age, single parenthood, and low birth weight. A control group of unreported children matched for gender, race, social class, and family composition is also included in the research. Of special interest to this study is the extent to which family stress and social support predict child maltreatment and subsequent child outcomes such as school failure, adolescent pregnancy, substance abuse, and criminal or violent behaviors.

■ *Alan Litrownik, PhD*, is Professor of Psychology at San Diego State University. His site focuses on a cohort study of maltreated children who were placed in foster care in the first 18 months of life and followed until age 4. This study will examine kinship vs. non-family foster care, the consequences of re-unification, and the utilization and impact of health care and mental health services.

■ *Richard Thompson, PhD*, is the Director of Research for the Juvenile Protective Association in Chicago, IL, and Assistant Professor at the University of Illinois at Chicago. His site focuses on comparing the life course of infants whose families are receiving comprehensive services after a report of child maltreatment to infants of similarly-reported families who have only received follow-up by the state welfare agency and to a control group up of matched infants. This cohort is drawn from among the most violent neighborhoods in Chicago and will examine the differential impact of experiences of child abuse or neglect versus witnessing violence from the time of infancy.

INTERVIEW WITH DESMOND K. RUNYAN, MD, DRPH

# The LONGSCAN Project

*By James E. McCarroll*
*February 2010*

*Dr. McCarroll: You are one of the principal investigators of the LONGSCAN (Runyan & Litrownik, 2003). This landmark study is badly needed. What have been the major topics of interest to your group?*

Dr Runyan: First, we have looked at the antecedents and consequences of abuse over time. Secondly, we have been involved in developing a set of statistical growth modeling procedures to look at trajectories of the effects of maltreatment. Are the children who were abused early the same kids that continue to be abused? Does most of the risk happen to a smaller group of kids? Are there kids who have a lot of maltreatment early and then nothing later on and another group of kids who were doing pretty well early on and then get maltreated later? A third set of questions is related to fathers and the role they play. A fourth set is focused on social capital. An example is related to the impact of kids' psychological development and later school completion and work history.

*Dr. McCarroll: How did you arrive at your classifications of the types of maltreatment?*

Dr Runyan: We re-coded all the Department of Social Services (DSS) records using the system we developed for LONGSCAN, the Modified Maltreatment Classification System (MMCS), as opposed to taking DSS codes because there was a fair amount of disagreement.

*Dr. McCarroll: In your classification of maltreatment, what did you find in the DSS records on the histories of maltreatment?*

Dr Runyan: That is one of the issues we are wrestling with. The May 2005 edition of Child Abuse and Neglect [Volume 29, Number 5] was devoted to the LONGSCAN and included measurement issues. So much of the literature just lumps abused kids together and compares them to non-abused kids. We have DSS records of all different kinds of things over time for each of them, but also at age 12, 14, 16, and 18 we have asked the kids about their own experiences. It turns out that for many of the kids who told us they were sexually abused, the authorities had no idea they had been sexually abused. The other group that is a little harder to understand is the group of kids where social services said they were sexually abused, but the kids said,

no, they were not. So, there is that lack of concordance. Overall, the concordance figures look pretty high because most kids were not sexually abused and neither they nor DSS said so (Runyan, Cox, Dubowitz, et al., 2005). It is really intriguing to think about the kids who were abused and were not telling anybody about it or only told us about it.

*Dr. McCarroll: The Army only codes sexual abuse as severe. Are you making finer distinctions of sexual abuse?*

Dr Runyan: That is an interesting question. A lot of people have published about how sexual abuse is the most destructive of the different forms of abuse. That is not what we found. So much of the impact of sexual abuse is determined not by the sexual abuse itself, but by the response of the people around them, particularly the mother. It gets hard to sort out and decide, "Well, this is worse than this." For some kids, being fondled or having to cope with an exhibitionist is incredibly tough for them. The traditional response is adult horror at child sexual involvement, which I share, but at the same time, what I think is salient and horrific about sexual abuse may not be shared by the kids who are the victims when we are trying to look at outcomes.

*Dr. McCarroll: That is terribly complex. Is this true in any other type of maltreatment?*

Dr Runyan: I am currently looking at the kids' mental health functioning at different ages to see which of the forms of exposure to violence or maltreatment is most salient in terms of its impact on later depression, anxiety, or aggression. For example, Jonathan Kotch (Kotch, Lewis, Hussey, et al., 2008) has published a paper showing that neglect in the first two years of life is related to aggression at ages 4, 6, and 8. (See Review of LONGSCAN Research and Building Bridges to Research for more information about this study.) Our data has also shown that aggression at earlier ages is not associated with subsequent adolescent or adult aggression, but aggression at age 8 is predictive of older child and adult aggression.

At age 8, it looks like witnessing domestic violence is far more destructive for kids' mental health than either sexual abuse or physical abuse; there was no relationship between neglect and depression and anxiety. When we repeated the same analysis with the kids at age 12, psychological maltreatment was the most destructive for the kids. In a sense, all abuse is psychological maltreatment. When an eight year old kid or younger is exposed to domestic violence, I think that is actually a form of psychological maltreatment. The person who protects you from the world and is your rock is not safe herself. There is a lot more work to be done on refining the definition and measurement of psychological abuse, but it does seem to be promising.

*Dr. McCarroll: How did you categorize neglect?*

Dr Runyan: Our system has two categories of neglect: failure to provide and failure to supervise. But, even those two categories may not capture all that we want. At this point we are not actually seeing a lot of adverse impact from neglect but, the lack of precision of measuring is part of the complexity. We are looking at parental monitoring and trying to measure family functioning, such as unreasonable parental expectations, in an attempt to find ways to improve the definition of neglect.

*Dr. McCarroll: One needs to think about the nuances of childhood and adult maltreatment.*

Dr Runyan: That is right. When we looked at measurement we ended up sorting out severity, type and the chronicity. Did it happen lifelong or was it episodic? Was it at one point? Did it happen early in life or later in life? All those seemed to lead to different outcomes.

*Dr. McCarroll: What kinds of outcome data are you collecting?*

Dr Runyan: We collect data in an annual telephone interview with the parents about their contact with social services in the last year. We also ask the parent whether the child has been hospitalized or has been seeing the doctor or other professionals for mental health or special education services. We have completed data collection to age 14 and are not quite done with age 16. We have about 900 14-year olds, 760 16-year olds and 400 18-year olds so far.

*Dr. McCarroll: What new data will you present? Is anything being collected at ages 16 and 18 that has not previously appeared?*

Dr Runyan: We have gone back and asked about employment and work, school completion, and, at ages 16 and 18, asking the kids for their own self-reports about their maltreatment. The report that will be really useful is at age 18 when we do not have to tell them that we have to share information with social services.

*Dr. McCarroll: One of the results that might come out of this is some sense of a life trajectory based particularly on early abuse.*

Dr Runyan: That is a topic that we are interested in describing. A lot of people think that kids who are maltreated are going to have a bad outcome. We want to address risk. Right now it looks like about 35% of our kids escape pretty unscathed. About a similar percentage do not escape and are pretty severely affected. The other 30% do not look red hot either. We are excited about looking at the 35% that look really pretty good on all our mea-

sures. Were those kids looking pretty good all the way along? Are there kids that looked bad earlier and then that looked better? We are trying to follow those pathways.

***Dr. McCarroll: You also have non-maltreated kids, too?***

Dr Runyan: Right. However, over the course of the study many of those non-maltreated kids have been maltreated. So, out of the original cohort of 1,354 kids, we have 188 kids who have never had any maltreatment reports.

***Dr. McCarroll: What do you think has quick applicability to the maltreatment field? Has anybody picked up on any of your findings to either change their policy or procedures or statutes?***

Dr Runyan: I think what is most applicable is the impact of fathers. Even the kids who live in "single families without fathers" have father figures. There is some real applicability to social services, to think more carefully about that. If you just ask the simple demographic question, "Is there a father in the home?" the answer is "No". When you ask the kids if they have somebody who is like a father, all the kids name somebody. Howard Dubowitz (2006) has published a number of papers on fathers.

***Dr. McCarroll: Have any findings from LONGSCAN surprised you?***

Dr Runyan: The first big surprise to me is how little impact we could find for neglect. I was also surprised by the strength of the impact of domestic violence exposure. Our data suggest that it is important for the kids' own needs that we address that. We really cannot afford to operate separately from the folks who worry about domestic violence. We really need to be working with them.

***Dr. McCarroll: Thank you for your work and your leadership on the LONGSCAN study. It will be an important database for researchers and practitioners for years to come.***

Dr Runyan: You are welcome.

**Key Points**

I am currently looking at the kids' mental health functioning at different ages to see which of the forms of exposure to violence or maltreatment is most salient in terms of its impact on later depression, anxiety, or aggression.

Even the kids who live in "single families without fathers" have father figures. If you just ask, "Is there a father in the home?" the answer is "No". When you ask the kids if they have somebody who is like a father, all the kids name somebody.

Our data suggest that it is important for the kids' own needs that we address the impact of domestic violence exposure. We cannot afford to operate separately from the folks who worry about domestic violence. We really need to be working with them.

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# Domestic Violence

The contributors to this section cover a wide variety of domestic violence topics. Lee Badger and Mary Ann Forgey have separate interviews and research, but both are related to the assessment of domestic violence, particularly in a military environment. Among Dr. Forgey's research interests is the effect of domestic violence on military women. Dr. Badger has studied the use of standardized clients in medical research and applied her knowledge with Dr. Forgey to develop an evidence–based domestic violence assessment curriculum for the Army.

Jacqueline Campbell is an international authority on the assessment of dangerousness, particularly the risk of homicide, for female domestic violence victims. She also studies the effects of domestic violence on women's health in civilian and military environments.

Kevin Hamberger has devoted much of his research to developing typologies of domestic violence offenders. His work has been important in learning about the role of anger in male offenders and the role that anger plays in personality disorders, particularly those offenders with borderline personality organization and borderline personality disorder.

Kathleen Kendall–Tackett has studied the effects of domestic violence on women's health. She has worked extensively in women's health on topics that are not traditional. For example, she recently completed a study on the relationship between breastfeeding, fatigue, sleep deprivation, depression, and trauma history in new mothers.

Suzanne Swan is one of the few researchers to tackle the topic of women's violence. This research has focused on the context of women's violence related to their victimization by their male partners, their experiences of childhood trauma, depression, anxiety, posttraumatic stress symptoms, and substance use. She has recently started a program to prevent dating violence on a university campus.

Daniel O'Leary has also tackled a difficult topic, that of adult psychologi-

cal abuse (or psychological aggression). This type of maltreatment has been difficult to define, but its effects are thought to be as harmful or more harmful in some circumstances that physical violence. His research has addressed the context of psychological abuse and its relation to verbal arguments and physical abuse.

# Using Standardized Clients for Problem Assessment

*By John H. Newby, PhD*
*Joining Forces Joining Families Vol. 10, No. 2, August 2007*

Dr. Badger discusses the use of standardized clients (SCs) to improve clinical competence. SCs are used in both training and testing environments. The testing environments can range from examining students at various levels of training to "high stakes" evaluations such as admission to advanced training programs in medicine and for licensure. Measures of student and standardized client performance have been developed, but there is little consensus on the merit of these measures due to the complexity of the concepts, costs, and different clinical situations. The psychometric issues required in using SCs are the same as in the development of other tests. Among these are reliability, validity, scoring, cut-off points, and standard setting. However, the picture becomes more complicated when using SCs because one may measure both the SC and the trainee or examinee.

### Dr. Newby: What led you to study standardized clients (SCs)?

Dr. Badger: When I became a member of the faculty of a medical school, I saw SCs enacting an astonishing range of roles with multiple signs, symptoms, and behaviors. I also saw the possibility of their use in research. My first project was an investigation of physicians' assessment skills in the recognition and management of depression in primary care settings (Badger, deGruy, Plant, et al., 1994; Badger, Plant, deGruy, et al., 1994). In this study, a panel of six SCs, each with a different presentation and level of depression, were presented to about 50 primary care physicians. Although detection was related to a greater amount of information gathered, inquiry about the DSMIII-R symptoms was generally low, and in no case was sufficient

information acquired to make a formal DSM-III-R diagnosis of depression. The findings suggested that the detection of depression by primary care physicians was low. I was later approached by a group at Dartmouth Medical School to participate in a study that used undisclosed SCs to study the recognition and management of depression in primary care. Most recently, with a colleague at a school of social work in a study funded by the Fund for the Advancement of Post Secondary Education in the U.S. Department of Education, I applied SC methodology to the teaching of social work practice to MSW students.

***Dr. Newby: What do we know about the reliability and validity of SCs?***

Dr. Badger: The reliability and validity of SCs are dependent on the accuracy of the case scenarios (validity) and the consistency with which the SC enacts the scenario (reliability). The case scenario is the scripted narrative to be enacted. The signs and symptoms must be consistent with each other and with the disorder or problem that is being portrayed. The only way to ensure this internal validity is to select real cases. If the narrative is based on a real case, it cannot be argued that the signs and symptoms are incompatible or that the narrative has conflicting components. Reliability is also performance-related. The SC should enact the role as scripted every time in exactly the same way.

***Dr. Newby: How do you train SCs?***

Dr. Badger: The training of SCs is very straightforward. Coaching generally involves three people: the coach (or researcher or teacher) who is in charge of the project, the SC, and the clinician who nominated the actual case for use as an SC role. Only the clinician knows the actual behavior, tone, and affect of the client that is to be portrayed.

***Dr. Newby: Are there specific steps to structure case scenarios and prepare SCs for portraying their roles?***

Dr. Badger: The most important thing is to be absolutely clear about the purpose of the simulation. You have to decide whether you want to illustrate a case of the greatest prevalence, if you want to portray a case that is atypical, or if you want to illustrate specific risk factors. After you are absolutely clear about the research or educational objectives and what kind of case you want to develop, you will ask clinicians to nominate cases. The next step is to develop the SC narrative from the agency or medical record, including all facts relative to the assessment and treatment. The narrative should contain a detailed social history, psychiatric and medical history, current symptoms, physical signs and anything that might be relevant to the assessment and

to your educational or research purpose. Finally, use the narrative to write the SC script. It should contain a list of positive and negative cues, all extracted from the narrative, to provide the SC with guidelines for responding to questions. Other than the opening statement, SC roles are usually not verbatim scripted. If there are parts you want to script verbatim, these must be carefully crafted to sound true to the role. You want the SC to be natural in making comments. You do not want to over-script them.

***Dr. Newby: What are your thoughts about using professional versus non-professional actors?***

Dr. Badger: I am very much in favor of using individuals who are not professional actors. I have used actors in the past and, while they are very good at learning the roles, most actors are trained to project from a stage. When you put them in a situation that would be equivalent to a therapist making an assessment, they overact. They do not seem natural; they appear to be acting. I have used professional actors on a couple of occasions for student evaluation, but I was not satisfied with them. I have used well over 40 ordinary community people in one project or another and they are remarkable in terms of how well they can take on a role and play another person for a day.

***Dr. Newby: What are the differences between role-play scenarios or other experiential instructional techniques, and using SCs?***

Dr. Badger: Role-play is a very old tradition. It has been used with some success for students in developing and rehearsing their skills in the presumed safety of the classroom. However, in contrast to SC methodology, role-play really lacks authenticity and internal validity and has additional educational disadvantages. There are lots of methods of using role-play, but usually students enact roles about which they know little or nothing. Very often they do not have any of the background or experience to understand situations from the client's perspective. Even worse, they may disclose personal information that they might later regret.

***Dr. Newby: Would you comment on your current Army Family Advocacy Research with Dr. Mary Ann Forgey, who is also from the Graduate School of Social Service at Fordham University?***

Dr. Badger: The purpose of our study is to develop and evaluate the effectiveness of a training curriculum in evidence-based spouse abuse assessment and intervention planning using SC training and evaluation methodology. The effectiveness of the curriculum will be judged by the extent to which the training program leads to the accurate identification of violence

patterns, risk factors, and the development of assessment-driven differential intervention plans.

*Dr. Newby: How will that research improve assessments?*

Dr. Badger: SCs will be useful because we want to make assessment and intervention curricula that are evidence-based. We searched the literature and identified risk factors and the patterns and types of abuse. We can now present SC cases that will best illustrate the empirically supported risk factors, consequences, and patterns of abuse. Through the use of SCs, we will be able to control what we present to trainees in a way that we could not using either role-play or real clients. Our purpose is to make this curriculum portable so that it can be used at any installation that would like to benefit from it. At this point we will pilot test it at Fort Bragg. During the late summer of 2007, we will recruit, coach and train our SCs before testing the effectiveness of our curriculum.

*Dr. Newby: Other important aspects?*

Dr. Badger: SCs can simulate client-clinician interaction with a high degree of realism. SCs eliminate the threat to students or trainees of unintended personal disclosures that happen when they are asked to enact therapist and client roles. SCs can be incorporated into a wide range of curricular areas, such as assessment of mental health issues, services to children, and intimate partner violence. Very importantly, SCs offer the researcher or the instructor control over the appearance, behavior, and content of teaching cases. SCs can ensure diversity among racial, ethnic, age, gender, religious, sexual orientation, and socio-economic groups, and have a level of control that you cannot possibly have in using role-play only. Another advantage of using SCs is that when the simulation is over you can ask them about their sense of the interaction and get their feedback. It gives the therapist in training an enormous advantage to get all of this feedback. The use of SCs is highly acceptable to students and trainees as a teaching tool.

*Dr. Newby: Thank you Dr. Badger. We look forward to your research involving the use of SC in the assessment and planning of interventions for interpersonal violence that occurs in the Army.*

Dr. Badger: You are welcome.

**Key Points**

Standardized clients can be used in both training and testing environments to improve clinical competence.

The reliability and validity of standardized clients are dependent on the accuracy of the case scenarios (validity) and the consistency with which the standardized client enacts the scenario (reliability).

You have to decide whether you want to illustrate a case of the greatest prevalence, if you want to portray a case that is atypical, or if you want to illustrate specific risk factors.

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# Knowledge into Action: Brief Review of Research of Mary Ann Forgey, PhD

*By John H. Newby, PhD*
*Joining Forces Joining Families, Volume 9, Issue 2, April 2006*

How is research-based knowledge of intimate partner violence being used by practitioners to facilitate the assessment process? Dr. Forgey seeks to answer this question by exploring the extent to which child welfare social workers are using research-based knowledge about intimate partner violence in their risk assessment process. Using a focus group format, she plans to ask child welfare practitioners in a large metropolitan area 1) what they find critical to assess in intimate partner violence, 2) why they assess this specific content, 3) how they collect their information, and 4) the role that this information plays in their assessment, formulation, and intervention processes.

Her interest in exploring how research knowledge is integrated into practice also has an international focus. As a recipient of a Fulbright Scholar Award that took her to Dublin, Ireland, Dr. Forgey explored the extent to which Irish social workers integrate domestic violence research into their assessment process. She plans to compare data collected from U.S. child welfare workers with the data she collected in Ireland. The cross-national comparison will identify the similarities and differences between the two countries regarding the use of research knowledge in the assessment process, and the supports and obstacles that were encountered. The comparative analysis will further enhance the development of creative training strategies and assessment tools to strengthen practitioners' ability to implement evidenced-based assessment in intimate partner violence.

Dr. Forgey stresses two important points. First, it is critical that we begin to look at how practitioners integrate research knowledge into intimate part-

ner violence interventions. Second, there is a need to better understand what research-based knowledge is not being used and why. Her research is designed to shed light on both of these issues.

INTERVIEW WITH MARY ANN FORGEY, PHD

# Domestic Violence: Understanding the Patterns, Consequences, and Risk Factors

*By John H. Newby, PhD*
*Joining Forces Joining Families, Volume 9, Issue 2, April 2006*

**Dr. Newby: How did you get interested in domestic violence research in the military?**

Dr. Forgey: While the family advocacy program coordinator in Wiesbaden, Germany, in the 1980's, I saw a range of domestic violence which made me question the idea that it was a unitary phenomenon. That practice experience sparked my interest in research on the patterns of violence within the Army. I believe research that identifies the patterns of violence can depict a more accurate picture of what is happening and, therefore, is more helpful for practitioners in planning services. Different patterns call for different responses.

**Dr. Newby: Much has been written about incorporating evidence-based information into domestic violence interventions. What is evidence-based practice?**

Dr. Forgey: The current notion of evidence-based practice has focused mostly on the practitioner's use of intervention approaches that have empirical evidence of effectiveness. There has been a lot of debate about what constitutes empirical evidence. Some individuals interpret empirical evidence narrowly and only consider the evidence of effectiveness emanating from formal research studies. Others have a broader definition of empirical evidence and include evidence from actual practice. This is often referred to as practice wisdom, expert opinion or authoritative knowledge. I do not believe we can rely on formal research evidence alone. We need to incorporate practice wisdom, the systematic observations that practitioners make about approaches that they see as effective.

**Dr. Newby: How is evidence-based practice distinguished from evidence-based assessment?**

Dr. Forgey: Evidence-based assessment is really one aspect of evidence-based practice. Evidence-based practice involves all phases of practice including engagement, assessment, contracting, and intervention. We need to focus on the assessment phase of practice by making sure that areas explored

during the assessment process are informed by up-to-date research and that our interpretations of the data collected are also informed by this research.

*Dr. Newby: From your experience, how is domestic violence research being incorporated into assessments and interventions?*

Dr. Forgey: The tool most frequently used to help the practitioner incorporate domestic violence research into assessments and interventions is a protocol. A protocol provides guidance about what information to explore and often includes some standardized instruments. However, too often protocols are not practitioner-friendly. To practitioners, a protocol can feel more like a noose than a helpful guide. Protocols, for the most part, have paid attention to what information to gather, but not to the process by which it is gathered. Getting reliable information from clients is not just about the right questions, but also about how and when they are asked. This is why practitioners need to be more involved in the development of protocols.

*Dr. Newby: What are some of the contextual factors that should be considered in the assessment and treatment of domestic violence?*

Dr. Forgey: There are three main areas of exploration necessary to understand the context of violence: (1) the pattern of violence, (2) the physical and psychological consequences of the violence, and (3) the multi-level risk factors involved. The pattern of violence includes such factors as type, level, frequency, motivation, meaning and direction. Direction refers to whether the violence is unilateral or bi-directional and whether the bi-directional violence is asymmetrical or symmetrical. We also have to explore the physical and psychological consequences for each partner. The other areas of exploration are the multi-level risk factors: the individual, the family, and the socio-cultural risk factors for domestic violence that have been identified through research. For example, is there substance abuse involved? Is there a righteous attitude about violence on the part of the perpetrator? Is there head injury? Is there a history of violence in the family of origin? Do one or both partners have rigid sex role attitudes? Are there cultural supports or impediments for the violence? Are there stressors such as unemployment involved? Are there informal or formal support systems in each of the partner's lives? Exploring these areas requires openness to the various causal theories of domestic violence.

*Dr. Newby: Are you describing the particular process that you use for linking assessment data to improved domestic violence interventions?*

Dr. Forgey: Exactly. This type of assessment in which you are using research on patterns, consequences, and risk factors to inform the areas you

explore will yield important information about what type of interventions would be most helpful. Unfortunately, the assessment process is often by-passed or the information gathered is ignored. There is often just one model of batterer intervention available in many communities and only the interventions available are provided. We need to plan interventions based on the assessment that we have conducted.

**Dr. Newby: Would it be helpful to have a theoretical or conceptual framework within which to base assessment and interventions?**

Dr. Forgey: We need to be open to many theoretical perspectives when we are trying to gather information for assessment, and when we try to interpret this information to understand a particular case situation. There are at least five theoretical perspectives about the causes of domestic violence.

The feminist perspective focuses specifically on male-to-female violence and contends that factors that support male dominance in society are at the root of the problem. Feminists see the empowerment of women through the provision of resources such as housing, jobs, and strong legal sanctions for violent behavior such as arrests, incarcerations, and orders of protection as the most effective strategies to address male-to-female violence.

The social-cultural perspective recognizes both male and female violence and explains domestic violence as a result of broader structural issues within society that cause stress. Patriarchy, poverty, racism, societal isolation, and societal acceptance of violence are among these structural issues. Strategies to address these issues are advocated by this perspective.

Intra-individual theories look at personal characteristics that could help explain the violence. Substance abuse, personality disorders, and psychopathology have been put forth as causal or risk factors for violence. Intervention strategies try to address those specific dysfunctions.

Social learning theory contends that violence is a learned behavior and is transmitted from generation-to-generation. Intervention strategies focus on unlearning the violent response and learning non-violent responses. Clients learn ways to combat violence-producing cognitions by substituting new ones and behavioral skills related to communication, stress management, and help seeking.

Finally, family systems theory sees a couple's inability to deal with relationship issues as the root of the problem. According to this perspective the escalation of relationship conflict often culminates in a violent response from one or both partners. So preventing the escalation of conflict by changing the couple's interaction pattern is the major intervention from this perspective. During the data-gathering phase of assessment, we need to be open to exploring the variables associated with each of these theoretical perspectives.

*Dr. Newby: What was the context or patterns of violence found in your recently completed study of violence against Army women married to civilian husbands?*

Dr. Forgey: We found that 60% of all the violence reported was both bidirectional and of equivalent severity. However, when we looked at the other 40%, the enlisted female was much more likely to be the victim of unilateral violence (Forgey & Badger, 2006). They were also four times more likely to be victimized by minor unilateral violence, and three times more likely to be subjected to severe violence and injury as a result of unilateral violence from male partners. They were two times more likely to experience asymmetrical bi-directional violence. This means that the violence perpetrated against them was at a higher level than that which they perpetrated. One of the most significant findings was that the enlisted females in the bi-directional severe violence groups reported a significantly higher level of depression and had significantly higher rates of child sexual abuse histories. We need more research in the area of bi-directional violence.

*Dr. Newby: Are you planning further research on domestic violence in the Army?*

Dr. Forgey: I would like to examine the extent to which practitioners are using intimate partner violence research on patterns, consequences, and risk factors to inform their assessments and to develop tools and training methods to better support practitioners in the knowledge-to-practice transfer. I would also like to pilot a training method using standardized clients to see if this would help practitioners understand and apply research on intimate partner violence to the assessment process.

*Dr. Newby: Thank you, Dr. Forgey, for this interview.*

Dr. Forgey: You are welcome.

**Key Points**

Getting reliable information from clients is not just about the right questions, but also about how and when they are asked.

There are three main areas of exploration necessary to understand the context of violence:
- The pattern of violence,
- The physical and psychological consequences of the violence, and
- The multi-level risk factors involved.

Exploring the patterns, consequences, and risk factors for domestic violence requires openness to the various causal theories of domestic violence. If we too rigidly adhere to one theory over another, we may not be open to exploring all the patterns, the consequences, or the risk factors that do not support our particular theory.

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**INTERVIEW WITH MARY ANN FORGEY, PHD, AND LEE BADGER, PHD, MSW**

# The Development and Evaluation of an Evidence-Based Domestic Violence Assessment Procedure for the Army

*By James E. McCarroll, PhD*
*February 11, 2010*

Drs. Forgey and Badger conducted a project to develop improved assessment procedures for Army social workers responsible for domestic violence assessment interviews. The project, entitled The Development and Evaluation of a Training Curriculum in Evidence Based Spouse Abuse Assessment, was conducted from October 2006 to December 2008. The following description of the project and its phases is the editor's abbreviated version of the executive summary of the researcher's final report (Forgey & Badger, 2008).

The rationale for the project was based on the assumption that US soldiers returning from Iraq and Afghanistan are dealing with a myriad of health, mental health and substance abuse issues that put them at high risk for a range of relationship problems, including intimate partner violence (IPV). Increased understanding about how to assess and intervene in IPV among returning soldiers and their families is critical. In response to this need, this study first developed an IPV evidence-based assessment protocol and training curriculum for Army social workers and subsequently evaluated both using standardized client and evaluation methodologies.

The study involved five phases:

- Development of an expert panel to consult on current IPV and research issues.

- Revision of current Army spouse abuse procedures based on a review of the research literature.
- Development of the training curriculum and training evaluation tools using standardized client methodology.
- Implementation and evaluation of the pilot training curriculum.
- Analysis of curriculum effectiveness, revisions to the training curriculum and dissemination planning.

**PHASE 1: Development of an Expert Panel**

The expert panel consisted of persons from both the Army and from academic institutions with a strong history of IPV research and/or practice. The expert panel consulted on all phases of the study. A total of five meetings were held with the expert panel during the course of the study.

**Phase 2: Revision of current Army spouse abuse procedures based on a review of the research literature.**

An extensive literature review was conducted on patterns of IPV, risk factors and consequences in both civilian and military populations in order to develop an evidence-based assessment protocol. Based on the literature review and a review of the Army's current IPV assessment form, the expert panel recommended essential content to explore in an IPV assessment. The expert panel also recommended specific standardized measures to use within the assessment process. The result of this process was the development of four IPV assessment forms (Intake, Review of Pre-Interview Information, Structured Interview, and Formulation) and an Interview Process Guide.

**PHASE 3: Development of the training curriculum and training evaluation tools using standardized client methodology.**

Following the development of the IPV assessment protocol, the study moved into the third phase: the development of a pilot curriculum to train social workers in the implementation of the evidence-based assessment protocol. The pilot curriculum consisted of four components: a didactic component, experiential component, and pre-test and post-test components for curriculum evaluation. Tools to evaluate the effectiveness of the training, an IPV knowledge test, and an interview content and process checklist were also developed during this phase.

The didactic component of the pilot curriculum focused on what to explore in the assessment of IPV, the empirical basis for this exploration, and how to best explore this content using evidence-based assessment methods and interviewing skills. The literature review conducted during Phase 2 informed the content presented within the didactic component. A DVD of a

demonstration IPV assessment interview was also produced for use during part of the didactic component. In the demonstration DVD, the Principal Investigator conducted sequential interviews with a standardized client wife and husband pair using the new evidence-based assessment protocol.

The experiential component of the pilot curriculum was designed to provide an opportunity for the participants to practice conducting evidence-based assessments with standardized clients. These standardized clients enacted client roles based on real case material from Army records. Four case scenarios, involving a total of eight husband and wife client roles, were developed from archived Army case records that fit typical Army IPV clients, in demographics, violence type, and risk factors.

## PHASE 4: Implementation and evaluation of the pilot training curriculum

During this phase of the study, the pilot curriculum was implemented by social workers from an social work clinic at an Army installation. Eight volunteer social workers received the pilot curriculum from the investigators over a three day training period. Three days prior to the social worker training, eight standardized clients received intensive training in the enactment of their client roles.

## PHASE 5: Analysis of curriculum effectiveness, revisions to the training curriculum, and dissemination planning.

The effectiveness of the pilot curriculum was measured by analyzing differences in participants' pre-training and post-training IPV knowledge and IPV assessment interviews. A knowledge test, made up of twenty true-false and multiple choice questions based upon the empirical IPV literature, was administered at pre-test (before the training) and at post-test (immediately following the training). Questions addressed IPV patterns, risk factors, consequences, and the assessment process. Following each of the twenty questions, there was a rating scale to indicate how confident the social worker was in her answers.

Knowledge test results indicated that the participants' knowledge about IPV patterns, risk factors and assessment methods increased from pre- to post-test. A paired t-test comparing the pre-test and posttest scores, despite the small sample, showed a close to significant increase from pre-test to post-test on the correct answers (t=2.25, p=.059) and a significant increase in the confidence scores (t=4.64, p=.002).

The videotaped interviews were analyzed using a qualitative research data analysis software system. An assessment interview checklist was developed for the purpose of creating a code list and attaching scores, or ratings,

to the videotaped assessment interviews. Per-item codes for the various content areas within the assessment interview (Presenting Incident, History of IPV, and Background Content Areas) were created. In addition, per-item process codes were created for four interview segments (opening process, presenting incident process, background information process, and closing process). Once the interview was coded, two independent raters observed all interview segments pertaining to the particular content or process item. The raters were blind to the pre- or post-test status of the interview being observed. The ratings were of three types, measured along a three point scale (0, 1, 2) for each item: quantity rating (the amount of exploration), quality rating (the thoroughness of the exploration of the information) and critical content rating (the thoroughness of exploration of content areas critical to a thorough understanding of the particular case). Interviewing skills were rated in terms of quality, that is, how well they were used.

Analysis of the rating results of the pre-test and post-test assessment interviews indicated that at post-test the participants' exploration of the majority of evidence-based risk factors for intimate partner violence increased in both quantity and quality. The quality ratings for all of the interviewing process skills showed an increase at post-test. Content and skill areas that did not improve at post-test were also highlighted as part of the analysis.

Based on these results, revisions were made to the Assessment Handbook, Trainer Manual, Participant Manual and Case Manual. Revisions aimed to strengthen IPV assessment knowledge and interviewing skills that had not improved at posttest. A major curriculum revision involved the expansion of the curriculum from a 3-day to a 5-day model. This expansion will allow more time for the participants to review and analyze their videotaped interviews in relation to the content explored and the interviewing skills used. Key teaching points for each case scenario were also developed for the trainers so that they could more systematically integrate the research knowledge from the didactic component into this review process.

Due to the evidence of the pilot curriculum's effectiveness, the expert panel recommended dissemination of the revised 5-day training curriculum to all Army Family Advocacy Program social workers by the Army. Plans for this training are in progress.

**Key Points**

US soldiers returning from Iraq and Afghanistan are dealing with a myriad of health, mental health and substance abuse issues that put them at high risk for a range of relationship problems, including intimate partner violence (IPV).

Drs. Forgey and Badger conducted a project for the Army to develop improved assessment procedures for Army social workers responsible for domestic violence assessment interviews.

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INTERVIEW WITH MARY ANN FORGEY, PHD, AND
LEE W. BADGER, PHD, MSW

# Research Procedures in the Development and Evaluation of an Evidence-Based Domestic Violence Assessment for the Army

*By James E. McCarroll*
*Interview conducted 11 February 2010*

*Dr. McCarroll: In your previous interviews in the Joining Forces Joining Families Newsletter, you described concepts that you used in your research on the development and evaluation of the training curriculum in evidence-based intimate partner violence (IPV) assessment that you recently completed. [Editor's note: See Dr. Forgey's interview on evidence-based domestic violence research and Dr. Badger's interview on the use of standardized clients in education and research programs.] I would like to hear your thoughts on highlights of your recent research.*

Dr. Badger: You hear a lot about evidence-based practice being applauded by many disciplines, but I think it is important that people know how to go about actually developing it, which we did in our project.

Dr. Forgey: Also, what is different about this project is that it is an example of evidence-based practice by an organization, rather than the individual practitioner. In this instance, the Army developed an evidence-based assessment protocol for use by its practitioners. It was really an organizational effort.

Dr. Badger: This approach makes logical sense, rather than having each practitioner working as an island and applying the evidence solely to his/her own micro-practice.

Dr. Forgey: What is also somewhat unique about this project is that it had input from an expert panel made up of both researchers and practitioners.

*Dr. McCarroll: Let's talk about your trials and triumphs in each phase of the project.*

Dr. Forgey: A critical element was the development of the expert panel to begin the work, the first phase. The next phase was the review of the literature, and, based upon that review, revising what the Army was currently doing with regard to domestic violence assessment. The third phase was the development of the assessment protocol and the training curriculum, the latter using standardized client methodology. In the fourth phase, we imple-

mented the curriculum. Phase five consisted of the analysis of the effectiveness of that curriculum.

Dr. McCarroll: We can discuss each one of them. One sees many literature reviews. People might say, "Haven't people already done this?" How did you do it and what did you learned by your approach?

Dr. Forgey: There were wonderful reviews in 2001 of the risk factors for male-to-female and female-to-male violence including physical, sexual, and psychological abuse (Schumacher, Slep, & Heyman, 2001; Black, Heyman, & Slep, 2001; Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001).We built our literature review on their work and then focused on the IPV risk factors, that have been identified since that time, with a particular focus on military related risk factors.

### Dr. McCarroll: What did you pursue subsequent to those reviews?

Dr. Forgey: Some of most important risk factors identified subsequent to the 2001 reviews included traumatic brain injury and posttraumatic stress disorder. We also explored the literature on deployment and its relation to domestic violence. We really concentrated on the military-specific literature and military-specific risk factors for our protocol.

Dr. Badger: The literature review had several chapters. In addition to the content that needed to be explored in an assessment, we also needed to look at information on structured versus unstructured interview techniques, assessment of lethality, and how standardized instruments are used. All these were researched factors that ultimately went into the decisions about the optimum interviewing process.

Dr. Forgey: We divided the literature review into two major parts. One was to answer the question of "What does a social worker need to explore?" The second question was "How do you go about asking about domestic violence and its risk factors?" This second question brought us into the literature on the standardized measures that exist for the different risk factors and how useful they might be in an assessment interview. It also helped us answer the question of how best to assess the level of risk, the level of danger. One of the debates that we had was to what extent should standardized measures be used? Should the social worker just administer the actual standardized measure during the interview or should the inquiry about a particular risk factor take place in a different way?

### Dr. McCarroll: How did you solve that problem?

Dr. Forgey: We made the standardized measures that exist for the various risk factors (e.g. PTSD, TBI, substance use, depression) available to the

social workers in a supplemental guide to the protocol. But we left it to their clinical judgment as to when to use the actual instrument in the interview. For example, it was clear during the interview that the service member was experiencing some symptoms of PTSD, the social worker may at that point decide to administer that particular standardized measure.

Dr. Badger: Rather than just have it happenstance that the social worker would choose one of the risk assessment instruments to assess the level of danger or lethality, we developed a checklist of all of the common items found on selected risk assessment instruments that have been found to be valid and reliable.

Dr. Forgey: The expert panel did not think there was any one risk assessment instrument in particular that we should use since none of the existing risk assessment instruments had been validated for a military population. Instead we developed a checklist of the common items on risk assessment instruments that had the best evidence of effectiveness. The checklist was a tool to help workers evaluate the level of risk based on what they had learned about the client's situation. But, as its name implies, it is a checklist and not a scoreable instrument.

Dr. Badger: This checklist was one of the most highly regarded parts of the protocol by the social workers. They loved having that at the end as part of the formulations process when they summarized what they had been doing and what they had learned. They found it extremely helpful.

Dr. Forgey: I want to stress that the checklist was part of their formulation process. Following the interview the social worker was asked to analyze and synthesize the information gathered during the interview. An actual formulation form was developed to assist them in this analytic process. Imbedded in the formulation form was the checklist to help them assess the overall level of risk in this case.

Dr. Badger: The formulation form also served as a summary of the hour-long social worker's interview. At this point their head is swimming with all this information. The formulation form was a way to summarize and capture that information in one place.

Dr. Forgey: Also, what can not be stressed enough is that the formulation form was an analytic tool to help the social workers identify the major intervention issues and to determine the level of risk. The checklist that was a part of the formulation form was designed to help them think about the level of risk

Separate from the formulation form there was also a structured interview outline that included the interview content recommended for their exploration. It was developed as a cheat sheet for the workers to use while conducting the interview. It also got a lot of praise from the workers. They

recommended that we actually laminate it because they wanted it at their side during the interview.

Dr. Badger: I think they had also grown accustomed over the years to having a great deal of paper work on their lap during the actual interview and they were at first uncomfortable with the fact that we were suddenly presenting them with a whole different way of behaving that was more or less paperless during the time of the interview.

Dr. Forgey: The problem, though, and we could see it coming, was that in spite of being freed from doing all that paperwork during the interview itself, they still needed time subsequent to the interview to record all they had learned. Often, what we heard from them is that they do not always have the time right after the interview to gather their thoughts, summarize what they learned and complete the formulation part of the assessment. That is an issue that still needs to be resolved. If workers do an interview where they are freer to use their clinical skills to explore certain areas, then they have to have time after the interview to summarize and analyze what they learned.

Dr. Badger: They were really quite excited about using their clinical skills more during the interview process. They found that they could conduct interviews without depending upon all that paperwork to guide them.

Dr. Forgey: That gets us to the development and implementation of the assessment training curriculum, the third and fourth phase of the project. After we developed the assessment protocol, we then had to develop a curriculum to train the social workers in how to use it, phase three. In phase four we implemented this training curriculum.

We developed an evidence-based assessment protocol. But, as I said earlier, instead of just giving it to the workers, we were faced with the question, "OK. What would be the best way to train them in the use of it?" That is where the standardized clients came in. There was also another important issue with the development of the curriculum: we wanted the workers to become familiar with what we had learned from our literature review so that they would have a better appreciation of why they were exploring certain areas. So, in addition to the use of standardized clients in the training, we built in a didactic component in addition to the experiential component that informed them as to "the why" of the assessment.

Dr. Badger: For example, in the content area: "Why am I asking about alcohol?" "Why am I asking about brain injury?" "What is the research evidence for including this?" Hopefully, we were developing more critical thinkers. They were not asking just because they had to ask, but because they had a better understanding why a topic was important. That was a struggle with the curriculum. How do you teach practitioners? They are practitioners because that is what they want to do. They do not want to be researchers.

Dr. McCarroll: What were the critical points in teaching them to work with standardized clients in the training program?

Dr. Forgey: Most importantly, we developed realistic cases that were based on real case material and grounded in the research literature.

*Dr. McCarroll: Your curriculum consisted of cases that were written to reflect the current Army family advocacy program clients and standardized clients. You did a pre-test consisting of a knowledge test for their understanding of the evidence and interviews of the standardized clients by the social workers to assess their baseline assessment skills. The pre-test was followed by a didactic component and then an experiential component using standardized clients. At the end, there was a post-test that included both a knowledge test and an assessment interview. Is that correct?*

Dr. Forgey: Yes. And as part of the training curriculum, the new assessment protocol was also presented to them. Interwoven into this presentation was the research evidence for the decisions made within the protocol about what content to explore and the best way to explore it. Our purpose was to make them more informed practitioners as to why and how they were exploring certain areas with the hope that they would have a better appreciation for the protocol itself. Once they understand the basics of the protocol, we then had them practice interviewing using the protocol with the standardized clients.

Dr. Badger: The evaluation of the training was complex. All of the social workers completed the knowledge pre- and post-test. Half of the social workers did the pre-test interviews. The other half did the post-test interviews. We used the same cases for pre- and post-tests, but the interviews were done by different social workers. But, we were not specifically evaluating the social workers; we were evaluating the training. It is best not to think in traditional evaluation research language when the sample is just eight people. But, we did evaluate the training.

All the assessment interviews were videotaped for two reasons. First, for evaluation purposes, but also for them to review their work. We evaluated 16 hours of videotaping very systematically using a qualitative research analysis software package

Dr. Forgey: Key to the analysis process was the development of an interview checklist that allowed the research assistants to evaluate the information obtained during the interview and the interviewing skills used. In other words, to evaluate the content and process of the interview we evaluated what they learned during the interview about the dimensions of violence, the risk factors in each particular case, and how they learned this information — what interviewing skills were used. Since we developed the cases

we knew everything that was in them about the pattern of violence and the kinds of risk factors in that case. By using the interview check list, we could evaluate how much of this information the social worker was able to obtain during the interview.

It is also important to mention that we tried to ensure that the cases selected were as typical as possible of family advocacy cases in relation to the demographics, patterns of violence and risk factors. We analyzed the data from the Army Central Registry to come up with the most typical case profiles.

Using standardized client methodology in the training curriculum also meant that we had to select and train the eight standardized clients to take on the roles of husband and wife in the four cases. We selected the standardized clients to match the demographic characteristics of the cases. They also had to have some knowledge of the military, either from being in the military or being the spouse of a military member, so that they could more realistically portray these clients.

*Dr. McCarroll: We have discussed the role of the expert panel, your literature review, the development of the assessment phase and the formulation, the selection and training of standardized clients, the training of the social workers, and the evaluation of the curriculum.*

Dr. Forgey: The final step was our recommended changes to the curriculum based on the analysis of the knowledge test and interview data, as well as the feedback received from the social workers. One of the major recommended changes based on this analysis was that that the training needed to be five days, not three. More time was clearly needed for the social workers to review their standardized client interviews and more time was also needed to integrate the didactic training material, especially about risk factors, back into the case interview follow-up discussion.

Dr. Badger: That is really critical. One of the problems of teaching about risk factors in the classroom is that it is just that. It is not real life. When you have a standardized client in front of you and they are very persuasive, it is like having a real client. Then, suddenly, it does matter.

Dr. Forgey: Both the didactic and experiential components were equally important but more integration of them was needed. The up-front didactic presentation of the research evidence about violence patterns and risk factors set a foundation. This foundation was then built upon by having a live interview with a standardized client where the social worker can actually experience some of the research information conveyed in the didactic component. The subsequent discussion of the live interview is where the true integration of the didactic and experiential component can happen. As the

worker discusses what they learned or didn't learn about the particular pattern of violence or risk factor(s) during the interview, the research evidence about that pattern or risk factor can be woven into that discussion. If the curriculum is lengthened from three to five days, we would have more time to have these kinds of integrated discussions.

**Dr. McCarroll: But, what you are also bringing out is how you used standardized clients. You are talking about training people to work with a real situation and a real live person.**

Dr. Forgey: Yes, we are. There could also be other delivery formats for this type of training. We delivered this training in a total face-to-face format. The subsequent discussion of each videotaped interview, however, does not necessarily have to be done face-to-face. The social workers could analyze and discuss their interviews in the comfort of their offices. They could do their own analysis and share it with their co-workers on-line.

**Dr. McCarroll: You could also think about having an interactive system where they could ask you questions about content or method as they analyzed their interviews on-line.**

Dr. Forgey: Yes, this would be another possibility and the military is certainly an organization that has a lot of expertise in the area of on-line learning.

**Dr. McCarroll: Thanks to both of you for your time and for your diligent work in accomplishing a very complex and demanding project.**

Dr. Forgey/Dr. Badger: Thank you. You are welcome.

**Key Points**

You hear a lot about evidence-based practice being applauded by many disciplines, but I think it is important that people know how to go about actually developing it, which we did in our project.

One of the debates that we had was to what extent should standardized measures be used? Should the social worker just administer the actual standardized measure during the interview or should the inquiry about a particular risk factor take place in a different way?

The formulation form was an analytic tool to help the social workers identify the major intervention issues and to determine the level of risk.

If workers do an interview where they are freer to use their clinical skills to explore certain areas, then they have to have time after the interview to summarize and analyze what they learned.

One of the problems of teaching about risk factors in the classroom is that it is just that. It is not real life. When you have a standardized client in front of you and they are very persuasive, it is like having a real client. Then, suddenly, it does matter.

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# Abuse of Active Duty Military Women

*By James E. McCarroll, PhD, David M. Benedek, MD, and Robert J. Ursano, MD*

Dr. Campbell has pursued a wide variety of research interests with a focus on understanding domestic violence. She has an extensive bibliography including such topics as domestic violence during pregnancy (Campbell, Garcia-Moreno, & Sharps, 2004), health consequences of intimate partner violence (Campbell, 2002), lethality and other risks of domestic violence against women (Campbell, 2004), and abuse of military women (O'Campo, Kub, Woods, et al., 2006).

Decades of research have demonstrated that women who have been abused report a higher prevalence of health problems, including mental health symptoms, than non-abused women. Campbell's review of this topic (2002) described the health consequences of physical or sexual assault as increasing the incidence of injury, chronic pain, gastrointestinal and gynecological diseases, depression and posttraumatic stress disorder (PTSD). She also noted that intimate partner violence has been found worldwide in 3-13% of pregnancies with detrimental outcomes to mothers and infants. She recommended increasing assessment and intervention in health care settings for intimate partner violence against women.

Much of Dr. Campbell's research has been on the prediction of the risk of homicide of women. She helped develop the Danger Assessment (DA) screening instrument. Her recent research on the murder of women is based on a 12-city study of women who were killed or almost killed by an intimate partner (Campbell, Webster, Koziol-McLain, et al., 2003; Campbell, 2004). Based on her research, Campbell gives suggestions for safety plan-

ning and risk assessment for the criminal justice and health care systems, and for advocates. She notes three types of risk that are commonly assessed, but urges caution because they are often confused. These risks are: reassault, lethality, and safety. Abused women themselves are good predictors of reassault, but usually the prediction can be improved by the use of an instrument (Heckert & Gondolf, 2002). Importantly, she notes that if a woman's perception of risk is very high, her assessment is more important than any other factor. However, if it is low then a lethality assessment, such as with the DA, becomes more important since it gives her additional information that she might not have previously considered. In another commentary on risk assessment of severe interpersonal violence against women, Campbell notes that strategies for assessment are not either-or enterprises. In other words, the assessment instrument alone should not be the sole basis of decision-making at the present time. She recommends a combination of the judgment of an experienced professional, a well-validated instrument, and the input of the abused woman as the best approach to lethality assessment (Campbell, 2005).

While PTSD and depression have been studied as outcomes of abuse, their co-morbidity has received less attention. Campbell and colleagues (O'Campo, Kub, Woods, et al., 2006) studied the prevalence of PTSD and depression in abused and non-abused civilian and military women in a sample of 2,005 civilian and 616 military women. They found the prevalence of mental health symptoms was higher among abused than non-abused women. Thirty-four percent of abused civilian women and 25% of abused military women had symptoms of PTSD, depression, or both compared to 18% of non-abused civilian women and 15% of non-abused military women. Co-morbidity of PTSD and depression was more common in civilian abused women than in abused women in the military. The authors noted that military women are less likely than civilian women to have psychopathology because entrants for military service are screened for mental illness and those with mental health problems are likely to be discharged.

In a separate study of the same sample, Gielen et al. (2006) reported the beliefs of active duty military women about routine screening for domestic violence by health care providers and the mandatory reporting of domestic violence to commanders. At the time this research was conducted, reporting of domestic violence to commanders was mandatory. The majority of respondents supported mandatory reporting, but also recognized that there were negative as well as positive consequences in terms of safety, privacy, autonomy, and conflicts between personal and professional (career) priorities. However, abused women were much less likely to agree with mandatory reporting. The authors concluded that much more work needs to be done

on gaining an understanding of the complexities of women's perceptions of domestic violence reporting policies in the military.

**Key Points**

If a woman's perception of risk is very high, her assessment is more important than any other factor. However, if it is low than a lethality assessment such as the DA, becomes more important since it gives her additional information that she might not have previously considered.

Dr. Campbell notes that strategies for assessment are not either-or enterprises and recommends a combination of the judgment of an experienced professional, a well-validated instrument, and the input of the abused woman as the best approach to lethality assessment.

Thirty-four percent of abused civilian women and 25% of abused military women had symptoms of PTSD, depression, or both compared to 18% of non-abused civilian women and 15% of non-abused military women.

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**INTERVIEW WITH JACQUELYN C. CAMPBELL, PHD, RN, FAAN**

# Abuse of Active Duty Military Women

*By John H. Newby, MSW, PhD*
*Joining Forces Joining Families Volumne 9, Issue 4, October 2006*

***Dr. Newby: How did you become involved in the study of intimate partner violence (IPV) in the military?***

Dr. Campbell: My first studies of domestic violence were of homicide against women. I found that the majority of women who were killed in this country were killed by a husband, boyfriend, ex-husband, or ex-boyfriend. I was collaborating with someone who was active duty Army when a request for proposals came out regarding the health of active duty military women. I was interested in how much abuse these women were experiencing. Up until then, research focused on active duty male service members abusing their civilian spouses. There was almost nothing in the literature about the abuse of active duty military women. Data for that study were collected from January 1998 through October 2000.

***Dr. Newby: Would you give us a brief summary of that research?***

Dr. Campbell: We found that the prevalence of physical and sexual IPV among the military women sampled was 21.6% during their military service. It was not well known at the time that military women experienced abuse. During military service, perpetrators of abuse were: other active duty military members (43.2%), civilians (18.5%) and retirees (38.4%). Emotional abuse is not included in the 21.6% rate of abused women. In our survey of military women, in about 60% of the abused women, there was an overlap of at least two different types of abuse, physical and emotional, physical and sexual, or emotional and sexual. About 22% of the women experienced all three kinds of abuse. We also found that during military service IPV was more prevalent among enlisted women (30.6%) than officers (14.5%) and those with lower levels of education (high school=25.0%, post-graduate=15.0%). It is interesting to note, however, the percentage of IPV reported by officers, since a common belief is that such violence only occurs among the enlisted ranks.

***Dr. Newby: What do you think about the reliability of your findings considering the limitations of your study?***

Dr. Campbell: I would love to conduct the study again now that there is a DoD confidentiality policy. Our biggest limitation was a requirement by

the institutional review board that we had to have a statement in the consent form that the research records could be reviewed by the participant's commanding officer. As a consequence our response rate was very low (13.2%).

***Dr. Newby: Did they feel that it would be held against them or just did not want the information to be known.***

Dr. Campbell: They were afraid of being considered less competent if they had a record of abuse even though they had been victimized. They also believed that having a personal record of being abused would hurt their chances for promotion.

***Dr. Newby: Are there any specific risk factors for military women that could lead to violence?***

Dr. Campbell: One risk factor was being separated or divorced. However, the cross-sectional aspect of the study did not tell us if the separation or divorce came before or after the IPV. We know from civilian studies that separation from an abusive partner may cause an escalation of abuse. Active duty military women and their commanders should be made aware of this danger. As I mentioned before, we saw an increased risk for women in the enlisted ranks, although there was still considerable abuse among officers. We also saw an increased risk for women who had three or more children. When there is a lot of stress in the household abusive situations can be exacerbated.

***Dr. Newby: Are the risk factors different from what you would find in the civilian community?***

Dr. Campbell: Oftentimes, in the civilian community we find lower income related to recent abuse. If women do not have sufficient resources it is harder for them to escape from an abusive relationship. The low income factor may not be as important in a military context because of the economic floor below which we hope most military families do not fall. We do not see the degree of poverty that we see sometimes in the civilian world.

***Dr. Newby: What were some of the physical health and mental health consequences of IPV that you found in your study?***

Dr. Campbell: We saw almost exactly the same pattern of physical health consequences for active duty women as we did among civilian women. Symptoms clustered around stress-related problems such as gastrointestinal symptoms and more overall physical symptoms. We also saw more chronic pain among women who were abused. The other cluster of symptoms that we saw included gynecological problems probably related to forced sex.

There were also neurological problems such as headaches and other symptoms that were not so clearly defined.

### Dr. Newby: Were there any distinct mental health consequences?

Dr. Campbell: We saw a different pattern of mental health consequences for the active duty women than we saw for the civilian women. The prevalence of mental health symptoms was higher among abused than non-abused women in both samples and also higher among the civilian sample compared to the military sample. Additionally, 34% of the abused civilian women versus 25% of the abused military women had symptoms that met criteria for a major depressive disorder, posttraumatic stress disorder (PTSD), or the co-occurrence of PTSD and depression. That compares with 18% and 15% of non-abused women in civilian and military groups, respectively. Military women, more than civilian women, were pretty resilient relative to mental health consequences.

### Dr. Newby: What were the results of your research that addressed active duty females' perceptions of the positive and negative consequences of mandatory reporting and routine screening for IPV?

Dr. Campbell: About 57% of women thought that routine screening or the routine assessment for domestic violence in health care settings was a good idea, and 48% thought that there should be mandatory reporting. Non-abused women were more in favor of mandatory reporting than abused women. Both military and civilian women thought that they ought to be able to control the reporting process. The military women wanted to determine whether the abuse would be reported to the commander or military police. A powerful dimension of that research was its evidence-based link to the formulation of a confidentiality policy in DoD. During my time as a member of the congressionally appointed Defense Task Force on Domestic Violence, I used the data from our study to help persuade the committee to make a recommendation to give victims more say in whether or not domestic violence is reported. Starting in January 2006, there is now for the first time a restrictive reporting policy that applies to health care providers as well as domestic violence advocates. The reporting of domestic violence is restricted to those the victim specifically designates unless there is a likelihood of imminent harm to someone, child abuse, a subpoena for a directly relevant case, or a relevant disability hearing. Otherwise, neither the commanding officer nor the military police nor anyone else is notified of domestic violence if the victim so chooses. This is an example of an important policy change based, in part, on our research.

***Dr. Newby: Were there other barriers to the self-reporting of IPV by active duty women.***

Dr. Campbell: Yes. If a woman was on active duty and her husband was civilian, she wanted her partner to become non-violent without the risk of him getting a criminal record. If she was married to an immigrant, she was fearful that the reporting of IPV could possibly hurt her partner's chances of obtaining citizenship. Children may also serve as a barrier to self-reporting. Accordingly, women often feel that the reporting of IPV will negatively affect the perception of them as parents by various authorities.

***Dr. Newby: Are these barriers different from those experienced by civilian women?***

Dr. Campbell: The major difference for active duty military women was the role of the commander. If her partner is also active duty military, she may be afraid that he is going to be thrown out of the military. She may not want his career to be ended. She just wants the violence to end. It takes a woman a while to realize that these two goals may be incompatible.

***Dr. Newby: Would you comment on the possible overlap of IPV and sexual assault issues among active duty military women?***

Dr. Campbell: Many women are not only physically abused by their partners; they are also being forced to engage in sexual activities. It really is sexual assault or rape even though the assault is done by an intimate partner. In our study, 33% of the physically abused women also reported being forced into sex by the same partner. This type of sexual assault can be a very common part of intimate partner violence. There is a lot of shame that goes along with it and it is difficult for a woman to admit that she is being raped by the person who is supposed to love her. Our questioning of victims should focus on "forced sex" rather then using rape or sexual assault language.

***Dr. Newby: What are your current research interests relative to IPV?***

Dr. Campbell: We have been looking at the occurrence of workplace violence relative to particular health-related outcomes. I would like to replicate that in the military. I am also interested in our returning combat-exposed male veterans and whether those veterans who have PTSD are more likely to abuse their wives and children. Also, now that we have large numbers of combat-exposed females, I would also like to know whether there will be an increased risk for these women as either perpetrators or victims of domestic violence. One other thing I would like to study is whether or not the new DoD restricted confidentiality policy encourages more active duty women to come forward and report intimate partner violence. I would like to deter-

mine if the policy is really increasing the perception of safety by active duty military women.

**Dr. Newby: Do you think the policy of providing soldiers and their families with post-deployment classes, briefings, counseling and other interventions will decrease the potential for negative repercussions?**

Dr. Campbell: I certainly hope so. Oftentimes it is the non-abusing families that step forward and become involved in those programs. Unfortunately, families that need the services the most often do not ask for help. We need to determine how best we can reach them. I do hope that our current post-deployment interventions to help and support military families are effective. Sometimes we find that what we think is going to be helpful is not. There is a need for much more research in this area.

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**Key Points**

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In our survey of military women, in about 60% of the abused women, there was an overlap of at least two different types of abuse.

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The prevalence of mental health symptoms was higher among abused than non-abused women in both samples and also higher among the civilian sample compared to the military sample. Military women, more than civilian women, were pretty resilient relative to mental health consequences. However, if they had been abused, they still experienced significantly elevated mental health symptoms.

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# Review of Research of L. Kevin Hamberger, PhD

*By James E. McCarroll, PhD, and David M. Benedek, MD*
*Volume 11, Issue 2, July 2009*
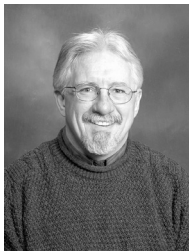
In a series of studies, Hamberger and colleagues have examined personality patterns of batterers and non-batterers using a dual approach. The first involves studying batterers only; the second compares batterers and non-batterers. These approaches yield different results. In the former, possible differences between batterers can be examined; in the latter, one can attempt to find differences between batterers and non-violent persons. To date, his research on batterer characteristics has been exclusively on males because during the time of data collection not enough female batterers had been identified for study.

Both personality and psychopathology are related to spouse abuse. An early study of personality correlates of 99 men who battered their partners and were part of a domestic violence abatement program found three categories of personality profiles reflecting general tendencies: schizoidal/borderline, narcissistic/antisocial, and dependent /compulsive personality disorders (Hamberger & Hastings, 1986). Only about 12% of batterers showed no psychopathology. They concluded that there was no general batterer personality profile, that the majority of batterers showed evidence of disordered personality profiles, and that both personality types and psychopathological processes must be considered among the factors related to spouse abuse. This research was extended to comparisons between domestically violent and non-violent men (Hamberger & Hastings, 1991). The domestically violent group included men who were alcoholic and non-alcoholic. Both alcoholic and non-alcoholic abusive men showed higher levels of borderline personality organization than nonviolent men.

Hamberger and colleagues continued to pursue batterer typology in a larger study of 833 men who were court-referred for evaluation prior to participating in a domestic violence counseling program (Hamberger, Lohr, Bonge, & Tolin, 1996). They found three main clusters of batterers, which largely replicated the typology work of Holtzworth-Monroe and Stuart (1994). Cluster 1 was characterized as dependent-submissive, passive-aggressive negativistic, and avoidant; cluster 2, as narcissistic, antisocial-aggressive, and histrionic-gregarious; cluster 3 was non-pathological. The non-pathological men generally had the lowest maximum violence and their violence was restricted to intimate relationships. The antisocial and passive-aggressive men did not differ in maximum violence. However, antisocial men were the most generally violent and had the most police contacts. Passive-aggressive and dependent men had the highest frequency of violence.

Batterers, particularly those with borderline personality organization, generally struggle with anger and hostility (Hamberger & Holtzworth-Monroe, 2009). Anger is a common feature of domestic violence. However, anger, hostility, and aggression are different concepts: anger is the emotion, hostility is the attitude, and aggression is the behavior (Del Vecchhio & O'Leary, 2004). Anger is infrequently mentioned in psychiatric diagnosic nomenclature. In DSM-IV (American Psychiatric Association, 1994), anger is not a diagnosis or more than part of a criterion for a mental disorder (e.g., post-traumatic stress disorder (p. 428), intermittent explosive disorder (p. 612), and borderline personality disorder (p. 654).

Hamberger and Holtzworth-Monroe (2009) report that abusive men are more hostile than non-abusive men. Anger is frequently seen in batterers with borderline personalities, but also in depression and anxiety disorders. Abusers have anger and hostility directed at themselves, but also less anger control. Particularly important to the expression of anger in abusive men is the tendency to label and interpret their partner's behavior with negative intent. They note that these attributes occur in situations that most would interpret as only moderately provocative, situations that non-violent men would be likely to overlook or at least not react strongly. They ask the question as to whether batterers are mentally ill. In terms of personality disorders, at a minimum, the answer seems to be that many are.

It is important for clinicians to know how anger and aggression are related to violence. Psychologists who work with personality profiles and have expertise in domestic violence have demonstrated a fair degree of interrater reliability for sorting batterers into profile types, particularly borderline-dysphoric and antisocial/narcissistic (Lohr, Bonge, Witte, Hamberger, & Langhinrichsen-Rohling, 2005). This research represents a beginning effort

to determine whether providers can be taught to use personality profiles to categorize the abusive clients — a necessary condition for being able to subsequently design treatment based on individually assessed needs.

In conclusion, Hamberger's research indicates that batterers are a heterogeneous group, particularly in terms of the relationship between their typology and violence as well as anger and hostility. For example, while many batterers show high levels of anger and aggression, some show lower levels than non-violent men. Hamberger speculates that this finding may be due to the fact that many batterers are superficially pleasant, but also that they deny or deceive when anger is inquired on self-report measures (Hastings & Hamberger, 1988; Hamberger & Holtzworth-Monroe, 2009). Whatever the pattern of personality, alcohol tends to increase violence severity and frequency. It is noteworthy that Hamberger found no alcohol-abusive men in his non-violent samples (Hastings & Hamberger, 1988). Because of the complexity of violent behavior, treatment is also complex. Given that most partner-violent men seemed to have some form of psychopathology consisting of personality disorder, depression, anxiety, dysregulation of affect, and substance abuse, treatment may call for specific approaches that target each of these factors.

**Key Points**

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Anger is frequently seen in batterers with borderline personalities, but also in depression and anxiety disorders. Abusers have anger and hostility directed at themselves, but also less anger control.

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Batterers, particularly those with borderline personality organization, generally struggle with anger and hostility.

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Hamberger's research indicates that batterers are a heterogeneous group, particularly in terms of the relationship between their typology and violence as well as anger and hostility

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INTERVIEW WITH L. KEVIN HAMBERGER, PHD

# Intimate Partner Violence: Function, Treatment and Typologies

*By James E. McCarroll, PhD*
*Volume 11, Issue 2, July 2009*

***Dr. McCarroll: How did you enter the field of intimate partner violence research?***

Dr. Hamberger: In the very early literature on intimate partner violence there were two concepts from the predominantly feminist model that gave me pause. The first was that all men are at risk of battering. The second viewed psychopathology as not being part of the battering spectrum. My own clinical observations revealed many individual differences. Jim Hastings, one of my research colleagues, and I sought to highlight that heterogeneity within the population with which we were working. [Editor's note: See review of Hamberger and Hastings research in the review of Dr. Hamberger's research.] Our goals were to demonstrate that batterers (abusive men) constitute a very heterogeneous population and to look at the frequency of psychopathology in our clinical samples.

***Dr. McCarroll: Does the term batterer describe only the man who is the severe, pathological abuser or does it refer to a broader range of abusive behavior?***

Dr. Hamberger: I view battering as a factor in determining how violence works in the relationship, not as the overall severity of the violence. In a particular relationship, pushing and shoving may function to dominate or control the victim in the same way that more severe violence may function in another relationship.

***Dr. McCarroll: What is the focus of the power and control model today?***

Dr. Hamberger: In clinical samples, we tend to see a predominance of male-to-female violence. Male-to-female intimate partner violence is related to and stems from broader sociopolitical forces that tend to place women in a second-class status. That second-class status is reinforced within an individual relationship through the application of force, abuse, and controlling behaviors. It may not be the whole story. One theoretical perspective does not adequately explain all of intimate partner violence.

*Dr. McCarroll: Is anger management the recommended treatment for batterers?*

Dr. Hamberger: Most state standards would argue against anger management as a treatment for batterers because it is too narrowly focused on the batterer's lack of skill in managing anger, and not enough emphasis is placed on using violence as a tool of power and control. The predominant model is psychoeducational using a cognitive-behavioral skills-based approach in which the primary focus is on the function of violence to dominate and control an intimate partner. Studies show that abusive men, on average, do show more anger and hostility relative to nonviolent men. One needs to be mindful of anger issues when assessing men for treatment as well as performing treatment with them.

*Dr. McCarroll: In your early work, you were not able to find enough female batterers to include in your analyses. Is this still the case?*

Dr. Hamberger: A larger number of women are now being arrested as either the sole perpetrator or as part of a dual arrest scenario. Recent arrest rates indicate that women constitute upwards of 20-25% of all people arrested for domestic violence. My research on female perpetrators has focused on motivation for using force against their intimate partners rather than on personality characteristics and psychopathology.

*Dr. McCarroll: Do dual arrest policies require the arrest of persons who engage in violence for self-defense?*

Dr. Hamberger: That has not been adequately sorted out. Most state laws regarding mandatory arrest discourage dual arrest and promote determination of the predominant physical aggressor, but there is little research to guide determination of the predominant physical aggressor. My research on motivations for use of intimate partner violence by men and women reveals that about two-thirds of men are using violence primarily to dominate and control their partner. About 17% of men report self-defense or retaliation from a prior assault as a motivation. We see the mirror opposite with women. About two-thirds report their primary motivation for violence is self-defense or retaliation, and about 17-19% report domination and control. Motivations such as retaliation and self-defense may not prevent a person from being arrested, but are still important for the clinician to consider when planning treatment.

*Dr. McCarroll: Do you think batterer treatment works, and if so, how?*

Dr. Hamberger: The evidence across the two or three meta-analyses that I have read looks promising, but not conclusive. There is a small, but signifi-

cant effect size in batterer treatment. However, one can find a lot of flaws in the research that argue against strong results. We have not looked carefully at matching treatment to the characteristics of abusive men including readiness to change, trauma history, alcohol and drug abuse, and the need to deal with a broad spectrum of treatment issues such as recidivism. The anger management interventions alluded to earlier also need to be considered as part of a broader intervention for emotion regulation.

**Dr. McCarroll: How would you advise clinicians to think about using the results of your typology research?**

Dr. Hamberger: I have used the information from typologies more to assess aspects of risk of premature termination and recidivism. Borderline, dysphoric men are at a high risk of dropping out of standard treatment. We have also found that dropouts are at a higher risk of recidivating than completers. That information can inform the female partner's safety planning and decision-making. We need to ramp up our expertise in pretreatment assessment and in developing treatment plans that are more in line with the client's needs and personality style rather than just applying a "One size fits all" model.

**Dr. McCarroll: When do you involve a non-battering spouse in the treatment?**

Dr. Hamberger: Primarily, I involve the victim-partner in collateral contacts early in the abusive partner's assessment and at the end of his involvement in treatment. I gather information about the violence from her point of view, provide community resource information, conduct safety planning, discuss risks, and establish a set of criteria for ongoing contact, if necessary. We do not involve the most disordered and severely violent people in couple counseling. Couple counseling appears to be appropriate primarily when both partners are willing to attend and for people who commit less severe levels of violence, not for those with the severe pathology that we might see in the borderline-dysphoric and antisocial-narcissistic typologies.

Another problem for couple counseling is that batterers as a whole tend to over-interpret and see their partner in a certain way such as "She's doing this on purpose," or "She's always doing this to disrespect me." In contrast, there are less drastic interpretations such as "She's just misbehaving right now" or "We're just having a difference and it's not a big deal." We would also challenge him to think about the fact that he immediately jumps to the conclusion that his partner is likely to cheat on him and to change that type of thinking, too.

***Dr. McCarroll: Since it may not be a good idea to include the spouse in the treatment of a batterer, how do you bring their over-interpretation of cues into therapy?***

Dr. Hamberger: In batterer treatment, we frequently talk about various interactions that men are having with their partners. That is part of the on-going homework. When they feel upset, when they feel angry, when stressors are in their relationship, they are asked to record their thoughts about what is going through their mind as they experience such a situation. Then they bring that homework into the treatment with them and we go over it.

***Dr. McCarroll: Thank you for your insights and your contribution to our newsletter.***

Dr. Hamberger: You are welcome.

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**Key Points**

I view battering as a factor in determining how violence works in the relationship, not as the overall severity of the violence. Pushing and shoving may function to dominate or control the victim in the same way that more severe violence may function in another relationship.

Most state standards would argue against anger management as a treatment for batterers because it is too narrowly focused on the batterer's lack of skill in managing anger. Not enough emphasis is placed on using violence as a tool of power and control.

The predominate model of batterer treatment is psychoeducational using a cognitive-behavioral skills-based approach in which the primary focus is on the function of violence to dominate and control an intimate partner.

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INTERVIEW WITH KATHLEEN KENDALL-TACKETT, PHD

# Trends in Interpersonal Violence (IPV)

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 10, Issue 2, August 2007*

*Dr. McCarroll: Drawing upon your new and comprehensive book, what should we know about the mental health effects of interpersonal violence (IPV) (Kendall-Tackett & Giacomoni, 2007)?*

Dr. Kendall-Tackett: In our new volume, we have a section on leaving abusive relationships. What struck me about this area was how long it took people to recover from living in an abusive relationship. Women have elevated levels of depression and PTSD even a year or longer after they leave. Women leaving relationships may be substantially poorer and they may be trying to balance multiple harms. For example, they may decide that staying in an abusive relationship is less risky than becoming homeless with their children.

*Dr. McCarroll: What is new in the way risk assessment is being approached?*

Dr. Kendall-Tackett: There has been much more empirical work on risk assessment in recent years. For example, lethality is much more systematically approached than in the past. The development and validation of measures has improved over past practices, which tended to be based on what people thought would work.

*Dr. McCarroll: What do we know about women's violence?*

Dr. Kendall-Tackett: Importantly, women can be violent, but the extent and type of women's violence is argued. You may see similar rates of women committing violence, but often it is in self-defense and it tends not to be as physically injurious as violence perpetrated by men.

***Dr. McCarroll: What have been the trends on the use of evidence-based interventions?***

Dr. Kendall-Tackett: Practice is moving much more toward an evidence-based model. I think this is a good trend, but I think that sometimes we can be so evidence-based that we miss something really obvious right in front of us. The evidence is only as good as the questions we ask.

***Dr. McCarroll: Do strength and resiliency factors add to our knowledge?***

Dr. Kendall-Tackett: Many of our domestic violence models are based on a pathology approach to women in these relationships. A structured coping model may be better. Often the women are trying to balance multiple possible harms. We need to acknowledge the fact that there is some coping going on, but it may not be in the form that we are used to seeing or think is the best. Instead of focusing on "Can't this woman cope?" we need to find out why she is staying in that relationship and what are the resources we can bring to help her. Maybe she realistically knows that if she leaves this relationship she is going to be killed. Overall, she may have some positive feelings about the relationship, but just want the abuse to end.

***Dr. McCarroll: Are the legal issues changing?***

Dr. Kendall-Tackett: It is not clear that mandated arrest is a good idea. The consensus seems to be that this is not necessarily an effective policy, and can be punishing to women. Not only does mandatory arrest increase the likelihood of possible physical reprisals once the perpetrator is out of jail, but many women feel re-victimized by the system. It also does not allow the woman's input into the decision. Sometimes these policies backfire and reinforce the powerlessness that some victims feel.

***Dr. McCarroll: So, the solution is not exactly clear, but at least to keep the woman's point of view in mind instead of making decisions for her?***

Dr. Kendall-Tackett: Yes, there is still some debate about how to put this into practice. An example is mandatory screening. I am hesitant about mandatory screening, at least in health care settings, mainly because we cannot be sure of the qualifications of the people who are doing it. It can increase the danger for women if done poorly (e.g., within earshot of the perpetrator). But screening is also an area where we can empower women. It is important to take into account women's assessment of their risk. Women are actually pretty accurate in their assessments about the danger they are in. We need to give the women the freedom to disclose in health care settings. Another problem in health care settings is what screeners are to do with the information. Are you going to expose her to some potential danger by ask-

ing if she is being abused or if she feels safe in her own home when you do not have a plan in place to protect her? Medical personnel will not screen if they do not have some place to refer the clients. This should be considered when an institution entertains plans for mandatory screening.

*Dr. McCarroll: What about the effects of adverse childhood experiences (ACEs)?*

Dr. Kendall-Tackett: The concept of ACEs, rather than focusing on a single type of abuse, allows you to branch out into a broader framework in considering the effects of maltreatment on children. One type of ACE is parental mental illness, including depression. Depression impairs parenting and one possible consequence is child neglect. Studies on maternal depression show that disengaging from their children is one possible response.

*Dr. McCarroll: What do you see developing in terms of the intersection of child and spouse abuse?*

Dr. Kendall-Tackett: The biggest development is that the child abuse and domestic violence communities are talking to each other. I think for a long time they have been very separate. Child protective services are developing policies in cases where there is IPV. In the past, these communities were suspicious of each other because of coming from different frameworks, but that is starting to change and people see the overlap in protecting women and protecting children.

*Dr. McCarroll: What do we know about long-term health effects associated with maltreatment?*

Dr. Kendall-Tackett: We have learned that abuse survivors have higher rates of heart disease, diabetes and other diseases. There is a lot of evidence from the immunology field that having been exposed to a traumatic event or experience, the immune system is primed to respond to ensuing, stressful situations. This has been linked to heart disease, diabetes, and even cancer. Depression and hostility also activate the immune response. These health effects can continue long after the abuse has ended.

*Dr. McCarroll: Where do you think the field is going? What do you think is the direction for the next 20 years of research?*

Dr. Kendall-Tackett: I think what we are probably going to see is more intervention studies, particularly in health care settings. I think we will also look more at the physical health effects—not only those related to current injuries, but the long-term health effects. I think we are going to have more complex, but realistic models of the victim's experience by looking at both negative outcomes

and resilience factors. And I think we will see more evidence-based interventions.

**Dr. McCarroll: *Thank you***

Dr. Kendall-Tackett: You are welcome.

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**Key Points (Did you know?)**

A recent study on screening for IPV in health care settings found that women preferred self-completed approaches over face-to-face questioning (MacMillan, Wathen, Jamieson, et al., 2006).

The risk for anxiety disorders, major depression, and substance dependence were found to be three times as high in the offspring of depressed parents as in the non-depressed parents (Weissman, Wickramaratne, Nomura, et al., 2006).

Adverse childhood experiences, including child abuse and neglect and household dysfunction, seem to begin to affect a child's health even early in a child's life (Flaherty, Thompson, Litrownik, et al., 2006).

A recent study found that posttraumatic stress disorder was significantly associated with vascular, musculoskeletal, and dermatological problems (Dirkzwager, van der Velden, Grievink, & Yzermans, 2007).

**Additional Key Points**

Many of our domestic violence models are based on a pathology approach to women in these relationships. A structured coping model may be better.

Women leaving relationships may be substantially poorer and they may be trying to balance multiple harms. For example, they may decide that staying in an abusive relationship is less risky than becoming homeless with their children.

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**REVIEW OF RECENT RESEARCH OF KATHLEEN KENDALL-TACKETT, PHD**

# Sleep, Fatigue, and Trauma History in New Mothers

*By James E. McCarroll*
*February 2010*

Dr. Kendall-Tackett's interview features her recent research on sleep and fatigue in mothers (Kendall-Tackett & Hale, 2009). The study was conducted based on recent news reports about mothers co-sleeping with their infants and warning that bed sharing increases the risk of accidental strangulation (Shapiro-Mendoza, Kimball, Tomashek, et al., 2009). Kendall-Tackett and Hale felt that more empirical data was needed on mothers' sleeping practices. They also thought that a broad range of advice was given to mothers about safe and unsafe practices of families. Thus, their point was to learn what average families are doing in various areas of family and baby safety.

A second concern was to address whether nighttime breastfeeding increased the risk of postpartum depression. Their study examines the relationship between nighttime breastfeeding, sleep deprivation, maternal fatigue and depression while accounting for other depression risk factors such as trauma history, postpartum pain, and lack of support. Their thought was that these and other factors could compromise nighttime sleep and increase daytime fatigue.

The study was conducted via an online survey that was begun in July 2008. The sample consisted of mothers with infants from 0-12 months of age. About one-half of the mothers who responded represented mothers were from the United States. Others were from Canada, the European Union/ Eastern Europe, Australia and New Zealand, the Middle East, Central and South America and Africa.

The average age of the mothers was 31 years; they were primarily Caucasian, 70% had a bachelor's degree or higher, 91% were married, and 97% were living with a partner, and income was said to be well distributed (from less than $15,000 to more than $150,000 per year).

As Dr. Kendall-Tackett notes in her interview, data analysis is still underway. Preliminary analysis was conducted in three areas: where babies sleep, mothers' self-reported fatigue, and mothers' history of psychological trauma (Kendall-Tackett & Hale, 2009). The largest percentage of mothers (44%) reported that their infants slept in another room and 32.6% said their babies

slept in their beds, 16.6% had babies in a crib or bassinet in their room, and 4.8% had their babies in a co-sleeper. Bed sharing was highest among African-Americans (52%) and Mexican-Americans (51%). The percentage of Caucasian mothers was 48%.

Mothers' self-reported fatigue varied from "very" to "not at all" and varied by feeding method. About 29% of breastfeeding mothers rated their energy on most days as very good or excellent compared to about 19% of mothers who formula fed or who used a combination of feeding methods.

Trauma history is also a predictor of fatigue as it often compromises sleep quality. They found that about 52% of respondents had experienced at least one type of traumatic event, and one-third had been exposed to parental substance abuse, mental illness, or intimate partner violence. In addition, 13% reported rape or other sexual assault as teens or adults and about 25% reported some type of sexual trauma. About 59% of the sample reported that they had been depressed, with about 35% of the mothers reporting three or more episodes. However, almost all of the mothers reported a happy, stable, and safe relationship with their current partner. [*Editor's note*: See Dr. Kendall-Tackett's interview for more details about this study.]

**Key Points**

Kendall-Tackett and Hale (2009) recently completed a study on the relationship between nighttime breastfeeding, sleep deprivation, maternal fatigue and depression in new mothers.

Trauma history is a predictor of fatigue as it often compromises sleep quality. About 52% of respondents of their respondents had experienced at least one type of traumatic event, and one-third had been exposed to parental substance abuse, mental illness, or intimate partner violence.

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# Effects of Adverse Experiences on New Mothers

*By James E. McCarroll*
*January 2010*

*Dr. McCarroll: Your last interview was on the health effects of domestic violence. Have you have continued to pursue that path?*
Dr. Kendall-Tackett: I have.

*Dr. McCarroll: Your conducted a study recently in which you collected data from new mothers who had been sexually abused or assaulted and women who had not been abused. In that study, you asked these women to report their experiences with sleep, depression, fatigue, and breastfeeding.*
Dr. Kendall-Tackett: We did a big survey of sleep and fatigue in new mothers. I asked quite a few questions about trauma history because it impacts sleep. When you are talking about a new mother everybody assumes it is the baby that is keeping them awake and I think what our data really show is that that is by no means the case.

*Dr. McCarroll: Would you talk about your sample. How did you recruit them?*
Dr. Kendall-Tackett: It was generated by contacts from talks that I gave, e-mails, and lists within the breastfeeding community. People from all over the world cooperated. We thought we would only get mothers from Australia, New Zealand, Great Britain, the United States, and Canada, but we also got mothers from Eastern Europe and Africa. We have mothers from 59 countries.

*Dr. McCarroll: Would you explain your sexual trauma data? Your major theme seems to be the effect of sexual assault or abuse on childbearing women.*
Dr. Kendall-Tackett: We collected data from almost 1,000 women who are sexual abuse or assault survivors. I asked them if they had ever been sexually abused as children or sexually assaulted as a teen or an adult. We had women who had experienced both. One of the variables we looked as was the length of time it takes to get to sleep. It is a strong predictor of postpartum depression. The more trauma history they had, and in the case of the

sexual assault, the more recent it was, the longer it took them to get to sleep at night. Women who had been sexually assaulted had a hard time both getting to sleep and staying asleep. It did not seem to be related to baby care. All the women in the sample had babies 0-12 months old. Our data has not yet been published, but we are currently working on that.

*Dr. McCarroll: You also asked about psychological or emotional aggression. You asked questions like if a parent swore at them, made them afraid, hit them hard enough to injure them, and whether their family felt close.*

Dr. Kendall-Tackett: The relation of these items to sleep was also really striking.

*Dr. McCarroll: One of your major themes seems to be the effect of previous sexual assault or abuse on childbearing women. Your study included four groups in which you compared family of origin experiences and the women who were sexually assaulted and those who were not assaulted. What is the major issue you would communicate about sleep for this group of people?*

Dr. Kendall-Tackett: We sometimes we overlook sleep problems. For example, sleep quality may make post-traumatic stress disorder symptoms worse. A lot of times if you can address sleep, other things get better. Asking about sleep problems is a convenient entry point when talking to a patient or client.

We are also going to be able to tell a lot of things about the relationship of adverse childhood experiences (ACEs) to mothering. About half of our sample reported at least one type of ACE. We have information on their pregnancy, labor and delivery, sleep, and depression. We will have a lot to report.

*Dr. McCarroll: In your sample, you found that the women who had a history of both rape and sexual assault reported that their family was not a source of support. What do you think about that?*

Dr. Kendall-Tackett: First of all, it is very sad. But, I think it also gives the people who work with them some ideas of "How can you bolster a mom's existing support?" Often, it is not going to be her family of origin. But, we also asked about was their relationship with their current partner. We asked "Do you feel like your partner really loves you?" and "Do you feel like you can trust your partner?" The reason for asking these questions is because the relationship with the partner affects sleep quality. About 93% of them answered "Yes" to both questions. They thought that their partner loved them and they trusted their partners. They were also highly likely to indicate that the quality of their relationship with their partners was "excellent." These

women had chosen to go down a different path than how they were raised and had found nurturing relationships.

*Dr. McCarroll: There is a lot of complexity in the way you can look at relationships between families and childhood experiences, such as rape and abuse.*

Dr. Kendall-Tackett: I have had a number of women tell me over the years that their families never knew or asked even though their behavior changed and sometimes changed radically. Even when they were not sexually abused in their families, I think it was missed because the families were so impaired in other ways.

*Dr. McCarroll: What surprised you in this study?*

Dr. Kendall-Tackett: The main thing that really surprised me was how common are the adverse experiences and also what looks like the compounding effect of sexual assault. The women who were sexually assaulted had so many other bad things going on in their lives.

*Dr. McCarroll: Thank you for your time. I enjoyed learning about your work.*

Dr. Kendall-Tackett: You are welcome. Great to talk with you, as always.

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**Key points**

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We sometimes overlook sleep problems. For example, sleep quality may make post-traumatic stress disorder symptoms worse. A lot of times if you can address sleep, other things get better. Asking about sleep problems is a convenient entry point when talking to a patient or client.

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What really surprised me from our study was how common are adverse experiences and what looks like the compounding effect of sexual assault. The women who were sexually assaulted had so many other bad things going on in their lives.

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# Women's Violence: Research of Suzanne Swan and David Snow

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 9, Issue 1, January 2006*

Women's violence in intimate relationships is not well understood. Swan and Snow (2002) note several factors that add urgency to the need for a greater understanding of women's violence. First, in more than 100 studies of intimate partner violence, women report as much physical aggression as men. This finding is not the whole story. Although surveys find that the number of women and men who report using physical aggression against their partners is equivalent, women are more likely to report being injured. Women are also more likely to be subjected to sexual assault from intimate partners. Finally, mandatory arrest policies in some states have resulted in increasing dual arrests in which the criminal justice system treats both members of the couple as perpetrators. When dual arrests occur without a careful analysis of the history of violence in the relationship, some women who were violent in self-defense are criminalized. Swan and Snow argue that women's violence needs to be examined in the context in which it occurs, which often includes violence against them.

Dr. Swan and her colleagues have published a series of articles on women's violence (Swan & Snow, 2002; Swan & Snow, 2003; Swan, Gambone, Fields, et al., 2005; Swan & Snow, 2006). Their model proposes that women's violence occurs in the context of their victimization by their male partners, their experiences of childhood trauma, and as a consequence of depression, anxiety, posttraumatic stress symptoms, and substance use. The studies by Swan and Snow were derived from a sample of 108 women who had used some form of physical violence against a male intimate partner within the last 6 months. The women provided descriptions of their own violence and

that of their partners. The sample revealed that ninety-nine percent had committed at least moderate physical violence, 57% had committed severe violence, 54% had injured their partner, 28% had used sexual coercion, and 86% used some form of coercive control. Women committed equivalent levels of emotional abuse as men. However, almost all of the women were also victims of violence. Only 6 of the 108 experienced no physical victimization or injury from their partners. Although a high percentage of women committed violence, their male partners committed significantly more of the severe types of violence: sexual coercion, coercive control, and injury (Swan & Snow, 2002).

Swan and Snow (2002) developed a typology of the different types of abusive relationships in which women were violent. Their typology consisted of the following types of relationships: women as victims (34%), women as aggressors (12%), and mixed relationships (50%). There were two types of mixed relationships. The first mixed type was called mixed-male coercive (32%). In this type, the female used more severe violence than the male partner, but the male partner was more controlling (coercive). In the mixed-female coercive type (18%), the male was more severely violent, but the female partner was more controlling. Four percent of the participants could not be classified.

Overall levels of violence were highest in the victim and aggressor types. In both the victim and aggressor types, there was a large disparity between partners' frequency of abuse. This suggests that the most dangerous and violent relationships are those in which there is a very different distribution of power favoring one partner. Little is known about male victims: what is his level of fear, how much does he modify his behavior to avoid angering his partner, what is the extent to which he feels controlled by her, and what is his sense of disempowerment and helplessness? Swan and Snow believe that, in the majority of relationships, women do not instill fear in men or succeed in controlling their behavior.

Swan and Snow (2003) examined behavioral and psychological differences among women in the four typologies. The women in the women as victims group fared the worst. They had the highest levels of harmful drinking and suppressed anger, and little anger control, as well as high levels of depression, anxiety, and posttraumatic stress symptoms. Their primary motive for violence was self-defense and they had the highest frequency of injuries. Women in the aggressor group were doing almost as poorly as the women in the victim group. Their levels of depression, anxiety, and posttraumatic stress symptoms did not differ from the victims. Aggressors had much higher levels of childhood trauma, which predicted female aggression.

Women in the mixed-female coercive group had the most positive find-

ings on almost all measures. They were the least depressed, had the lowest level of posttraumatic stress symptoms, and were the least anxious of all groups. They were the least angry and were able to control their anger more than other groups. They also experienced and inflicted the least amount of injury.

In the mixed-male coercive group, male and female partners were approximately equal in their use of violence, but the men were much more coercively controlling. Their outcomes were better than the women in the women as victims or the women as aggressors groups, but they did not fare as well as the women in the mixed-female coercive group.

Across all groups, childhood abuse and greater frequency of victimization from partners increased the likelihood of female aggression against their partners, as well as posttraumatic stress symptoms, and depression. Also, women with posttraumatic stress symptoms were more likely to express anger outwardly, which predicted an increased likelihood that they would use aggression against their partner (Swan & Snow, 2005).

Swan and Snow (2003) believe that their findings may be explained by the women's sense of control over their lives, their autonomy, and their sense of agency within their relationships. The women in the mixed-female coercive group seemed to have the most even balance of power and control with their partners. The women in the victim and the aggressor groups seemed to be the most worrisome. Even though the women in the women as aggressors group may appear to have the greater power in terms of their level of aggression, their poor outcomes (high rates of injuries, depression, and posttraumatic stress symptoms) may indicate little autonomy or control in their lives.

Swan and Snow (2003) suggest their aggression was used to try to create a sense of control. Swan and Snow (2005) believe that it is important for violence cessation programs to have women assess their safety in their homes and, when necessary, to develop safety plans. They also recommend that programs for domestically violent women assess posttraumatic stress symptoms since these symptoms predict anger directed outward as well as aggression. They suggest that women will have difficulty reducing their violent behavior until they are no longer being victimized and have received treatment for posttraumatic stress symptoms and other trauma-related disorders.

The study of women's violence is important to the Army. The Army Central Registry recognizes both men and women as victims and perpetrators of domestic violence. Whether abuse is unilateral or bilateral, the causes and consequences of men's and women's violence are likely to be different. A better understanding of the causes and dynamics of both male and female violence will help the Army Family Advocacy Program (FAP) make better

decisions about case substantiation and treatment of both victims and perpetrators.

Today's military life with its high level of operational tempo and frequent, long, and hazardous deployments adds additional dimensions to the stress of relationships for both male and female soldiers and their family members. These dimensions add to the context in which men's and women's violence occurs and should be considered in assessing case substantiation, treatment, and follow-up of FAP clients.

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**Key Points**

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Although surveys find that the number of women and men who report using physical aggression against their partner is equivalent, women are more likely to report being injured.

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The model by Dr. Swan and her colleagues proposes that women's violence occurs in the context of victimization by their male partners, their experiences of childhood trauma, and as a consequence of depression, anxiety, posttraumatic stress symptoms, and substance use.

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INTERVIEW WITH SUZANNE C. SWAN, PHD

# The Nature and Patterns of Women's Violence

*By James E. McCarroll*
*January 2006, Volume 9, Issue 1*

***Dr. McCarroll: It is important for the Army to understand the nature and patterns of abuse by both men and women for developing more effective prevention and treatment. As a scholar of women's psychology, how does domestic violence fit into women's studies?***

Dr. Swan: I think it has been there for a while. Lenore Walker wrote in her classic book "The Battered Woman" (Walker, 1979) about how some of the women that she interviewed tried to use violence to defend themselves against their partners. Straus and Gelles, in the their national surveys of domestic violence (Straus & Gelles, 1986) asked men and women about using physical violence against their partners and found that about the same number of women and men used violence. But, people have not been comfortable talking about women's violence until recently.

***Dr. McCarroll: What are the current discussions about women's use of violence?***

Dr. Swan: Many feminists are now saying, "Of course women can be violent". We do not have to view women solely as victims, women can have agency in these situations.

***Dr. McCarroll: When power and control are issues in a relationship, what are the implications of gender?***

Dr. Swan: It is more complex than we tend to think. Domestic violence also occurs in gay and lesbian relationships. We have all learned a patriarchal system of power and control. In a relationship in which one person has more power than the other, that position of power can give that person permission to abuse the other person.

***Dr. McCarroll: How do you differentiate between gender and sex?***

Dr. Swan: Sex is a pretty specific term where you are really talking about biological differences. Gender is everything psychological including the entire cultural overlay that we add to sex. I think it is an important distinction. People tend to exaggerate gender differences, i.e., "Boys do better on aver-

age in math than girls." Really the distributions overlap much more than they differ. The term gender is trying to get away from people's assumptions about differences that are based on sex and thought to be biologically determined. It is controversial. Some people argue that gender differences really are a result of brain structure and biology and genetics.

**Dr. McCarroll: *What does a clinician or health-care professional need to know about relationship violence?***

Dr. Swan: I think I would tell them that they are not going to find too many cases of female unilateral violence that would meet the criteria for intimate terrorism. (See Johnson & Leone, 2005, for a discussion of intimate terrorism.) Most of the time when they are dealing with women, both people are violent. At times, the violence by the woman is in self-defense, but that is not always the case. Sometimes the woman's violence is in response to the man's attempt to control her. She may not know what else to do. Our cultural notions of gender are that men should have more power and control in relationships. So, she is not going to be able to use power and control to equalize the distribution of power. I think some women use violence because that is all they know.

**Dr. McCarroll: *How do you view existing violence prevention programs for adults?***

Dr. Swan: I think education is helpful for adults to learn what is appropriate in relationships. Some people have grown up in homes where there was violence and do not know other ways of handling things. They might not define it as a problem or know what to do about it. At a minimum, let people know what resources are out there and give them a confidential way to access those resources.

**Dr. McCarroll: *What are the relationship implications of your research on typologies?***

Dr. Swan: The typologies are relational, but I think gender is always there. When you look at coercive control, you still find that it is much more common for women to receive it than to be coercive toward their partners. When they are coercive, they seem to be less effective than men. When we interviewed women about how they might try to control their partner's behavior, they would say something like, "Yeah, I told him he couldn't go out, but he would do it anyway. He would just laugh in my face and leave." I think many women, especially those in abusive relationships, would feel much more constrained if their partner tells them, "You can't go out." It's going to have more of an impact on them.

*Dr. McCarroll: How would you measure those typologies clinically?*

Dr. Swan: One could develop a list of criteria that a couple would have to meet to fit into a particular typology. I am really interested in a better understanding of coercive control and particularly how women do that. (While there is currently no accepted measure of coercive control, see Dutton and Goodman, 2005, for a discussion of the concept and their efforts at developing a measure.) In all societies, women have some ways of maintaining power and it is often indirect. Even women who are being terribly abused are doing something. They are not just victims. They are active agents trying to manage their situation. I am interested in learning more about that.

*Dr. McCarroll: Could you expand upon the differences in causes for men's and women's violence?*

Dr. Swan: In looking at the literature of motivations for using violence, the studies tend to find that women are more likely to use violence in self-defense than men. Men are more likely to use it to try to control their partner. But, I actually think that the motivations are really much more complex and people often have multiple motivations. Fighting back may not be only about self-defense, it may also be about retribution because the person is angry about experiencing this victimization. When we asked about motivations in some of my studies, about three out of four women said that they had used violence in self-defense and one out of three said they had used violence at least once to try to make their partner do something. Forty-five percent had used violence for purposes of retribution.

*Dr. McCarroll: We look forward to your future research.*

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**Key Points**

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In looking at the literature of motivations for using violence, the studies tend to find that women are more likely to use violence in self-defense than men.

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We have all learned a patriarchal system of power and control. In a relationship in which one person has more power than the other, that position of power can give that person permission to do abusive things to the other person.

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**REVIEW OF RECENT  RESEARCH OF SUZANNE C. SWAN, PHD**

# Context, Levels, Motivations, and Effects of Men's and Women's Violence

*By James E. McCarroll, PhD*
*May 14, 2009*

Dr. Swan has continued her research on the context of women's violence. Swan and colleagues reviewed the scientific literature on women's use of violence with male intimate partners to inform service providers in the military and civilian communities who work with abused women (Swan, Gambone, Caldwell, Sullivan, & Snow, 2008). They described the context of men's and women's use of violence (physical, sexual, psychological, sexual, coercive control and stalking), the level of violence (less serious and serious), the motivations and effects of violence, and how these differences may affect intervention for women. Their conclusions were that (1) men and women perpetrate similar levels of psychological and physical violence, but men perpetrate more sexual abuse, coercive control, and stalking, (2) low-level violence is about equally likely to be initiated by men and women, but when violence is serious, women are much more frequently to be victims and to be injured, (3) women's violence is more likely to be motivated by fear and self-defense, particularly less serious violence, and (4) women in mutually violent relationships are more likely than men to suffer negative effects. Women's violence appears to generally occur in the context of violence against them by their male partner. They concluded that because of the differences in motivation and behaviors in men's and women's violence that interventions for women that are based on models of male partner violence and not likely to be effective.

The context of men's and women's violence was studied in a sample of largely Hispanic male and female college students (Allen, Swan & Raghavan, 2008, online). Victimization and perpetration between intimate partners were approximately equal, but women's violence tended to be in reaction to male violence. Men were more likely to initiate violence and their partners to respond with violence. This study also explored sexist attitudes toward violence and gender roles of men and women, a topic that underscores the importance of understanding the cultural context in which violence occurs. Such research will be of increasing importance as the U.S. society becomes more multicultural.

Understanding help-seeking by women who use violence has had little

scientific scrutiny (Swan & Sullivan, 2008). In this study, of women who used violence against a male partner (94% of whom also experienced victimization) almost all the women utilized community resources in an attempt to manage the violence in their lives. One of the key findings of this study was that the use of resources reduced the likelihood of women's perpetration of violence. Social support was the most frequently used resource and support played an important role as a predictor of resource utilization. However, the majority of women were also struggling with many other social, personal, and mental health problems and they did not tend to use services provided by the local domestic violence agency. Rather, they used services such as the criminal justice system, housing assistance, substance abuse treatment and therapy. The authors pointed out how important it is for workers in the domestic violence field to recognize the linkages between domestic violence and other stresses and to work with other agencies, when feasible, to improve the lives of domestic violence victims. This is key finding for both researchers and practitioners: what services people use, how they use them, and how both can work together to improve the lives of abuse victims.

Swan and her colleagues further explored the context for women' violence and developed a scale for measuring such violence (Caldwell, Swan, Allen, Sullivan, & Snow, 2009). An exploratory factor analysis of the scale, "Motives and Reasons for IPV", identified five factors: expression of negative emotions, self-defense, control, jealousy, and tough guise. There were multiple motives for their behavior and all five of the factors were commonly given by the women. An average of 14 of 26 items on the scale was endorsed by the participants. The most frequently endorsed motive was the expression of negative emotions (e.g., "Because he made you angry."). Almost 90% endorsed motives of control, both reacting to control by their partner and women's attempts to control their partner. About 85% indicated that self-defense was their motive for aggression; about 70% used aggression to intimidate or harm their partner, a motive driven by the desire to be taken seriously; about 67% due to jealousy; and about 45% actually wanted to harm their partner.

Dr. Swan's work illustrates the importance of exploring the interpersonal context of violence. Her work and that of others increasingly demonstrates that rarely are either women or men only the victims of aggression. The relationships between perpetration and victimization are complex. There are significant gender and cultural differences that require more understanding. It is also increasingly clear that treatment models for domestic violence victims and offenders need to be tailored to the context of violence as well as the history of the individual and to previous relationships.

**Key Points**

Swan and Sullivan (2008) found that the use of resources reduced the likelihood of women's perpetration of violence. Social support was the most frequently used resource and support played an important role as a predictor of resource utilization.

The research of Dr. Swan and her colleagues increasingly demonstrates that rarely are either women or men only the victims of aggression. The relationships between perpetration and victimization are complex.

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# Victim-Perpetrator Relationships in Domestic Violence

*By James E. McCarroll, PhD*
*May 2009*

**Dr. McCarroll: What has been the overall direction of your work since the last interview in Joining Forces Joining Families?**

Dr. Swan: It is still the context of women's violence within the larger society as well as within the interpersonal context of their relationships.

**Dr. McCarroll: We discussed your research on typologies of the perpetrator-victim relationship in our first interview. Have you had a chance to follow up on that research by replicating or extending it?**

Dr. Swan: I have, but the analyses at this point are preliminary. The number of participants in the first paper was small, 108 women. In this newer data set we have 412. We tried to see if the four factors replicated. There was a lot of overlap, but they were not completely the same. However, that leads me to think that there is some validity to these factors.

**Dr. McCarroll: Where did you obtain your samples?**

Dr. Swan: They were community women in New Haven, Connecticut. They all had used violence against a male partner in the past six months. They volunteered in response to an ad and were not seeking treatment.

**Dr. McCarroll: Do you think that these factors apply to other populations?**

Dr. Swan: I would like to know that. I am probably going to work more with college populations at this point because of where I am right now. I think some of the same views might be there. For example, I think there are some couples who are using low levels of violence like that mixed female coercive group and are relatively better off. There are probably some other relationships where there is serious violence. But, because the population is younger and they have not been engaging in this behavior for 20 years, there will be differences.

**Dr. McCarroll: Then this would be largely then dating violence?**

Dr. Swan: Right.

*Dr. McCarroll: Your recent research on the context of men's and women's use of violence included sexual violence by women. Your questionnaire dealt only with the behaviors of the women. Do you have a sense of their motivation for engaging in sexual violence against their male partners? Dr. Swan: I would like to know that, too. We need to do some qualitative research because we do not know much at all about women's sexual aggression or the motives for it. I know that it goes on in college populations because students in my classes talk about it.*

*Dr. McCarroll: In a previous paper, you speculated that women's sexual aggression might be to frighten and intimidate men. Do you think still believe that?*

Dr. Swan: I thought that might be the case. I only have that one motive item related to sexuality – "To get turned on sexually…" I really was not sure how this would play out on the factor analysis. It ended up being a factor on the "tough guise" subscale but, the drinking and drug items were there as well. In that New Haven sample there was a subgroup of women who were involved in the drug culture and they were pretty tough folks.

*Dr. McCarroll: Do you think that women's sexual aggression is more an expression of intimidation and humiliation or for sexual pleasure?*

Dr. Swan: I think it is both. It is more complex than just a violent act in that it uses sexuality for the purpose of putting yourself over somebody or putting somebody down.

A nontrivial percentage of women had done some of those behaviors and more had been victimized, but a higher number than I would have predicted endorsed perpetrating some of those behaviors.

*Dr. McCarroll: One of the issues you found in your work with women's violence is the expression of negative emotions. Would you elaborate on that point?*

Dr. Swan: My sense is that a lot of the women in the sample were experiencing coercive control from their partners and they responded by becoming extremely angry, frustrated, fed up and not knowing what else to do, so they lashed out in violence. It seemed to me that there was some part of the sample that did not have a lot of control over their emotional lives and would become violent.

*Dr. McCarroll: Is negative emotion largely anger?*

Dr. Swan: Anger, frustration, and emotional hurt.

**Dr. McCarroll: Do you think that any in your sample of women were unilateral batterers or abusers and could be construed as female batterers in terms of being frequently and severely abusive?**

Dr. Swan: That is an interesting question. In one sense "No" because all of them were victimized in some way by their partners. When we think of batterers we think of someone who is extremely violent and controlling and who has a partner who is just totally under their thumb and is walking on egg shells around that person in order not to have them blow up. In my sample the ones who were the most violent also were very highly victimized.

**Dr. McCarroll: What do you see in terms of the gaps then that occur both in research and services on women's violence?**

Dr. Swan: It seems to me like the services are behind the where the research is. I have been out of that area for a little while now, but from what I can tell the main way that we deal with domestic violence still is by arresting people. We are not doing much with prevention. When people are arrested, we tend to treat women's violence and men's violence as the same phenomenon. This is like assuming that men are only perpetrators and women are only victims. So we put them into the same kinds of programs. Not everyone is doing that, but I think that it is still common in most places. We know something about the context of women's violence now from the research, but I do not think it is making its way prevention and treatment programs yet.

**Dr. McCarroll: What would you tell people if you had to address prevention and treatment issues for women?**

Dr. Swan: I will tell you a little about what I'm doing at the University of South Carolina with respect to prevention. We have a program that I have been doing for two years named "Changing Carolina." The basis of it is to involve college students, male and female, in the prevention of violence among their peers. We know that in the college-aged years (whether you're in college or not), dating violence tends to peak about that time, late teens and early 20s. On a campus like this one there are 25,000 people that age, all of whom are all away from home for the first time and developing serious relationships. So, there will be a lot dating and sexual violence going on. I am interested in having students feel like they can make a difference in violence prevention. We know that most students are not violent themselves and do not want it going on. I really tried to target men in the intervention. The 85% of men who are not violent can hold their peers accountable if they are using violence. But, a lot of men don't want to be the first one to speak up. We are hoping to create an atmosphere where students feel empowered to

speak and if they see something happening (like if they're at a party, they see a women who is drinking and maybe she's not very aware of what's going on and there's someone else who is trying to take advantage of her), that they would speak up and do something about that and not just look the other way. Bystander intervention is the formal name for it. So I have been teaching a class for the last couple of years where we train students to do that. If I can get some funding in for it, I would really like to bring bystander intervention training here. The University of Kentucky has a four hour training they do on a voluntary basis with students who are interested in doing it. The point of that is really to raise students' awareness about the violence going on around them and to have them become violence prevention advocates through daily behaviors really. They let their peers know that they are opposed to violence. So, if someone tells a joke about rape, hopefully people who have had this training would speak up and talk about why this is not appropriate.

**Dr. McCarroll: *Is there a website for your program now?***
   Dr. Swan: I have a little bit about it on my website.

**Dr. McCarroll: *Have you collected any data on it yet?***
   Dr. Swan: We have been collecting data through the class. I want to try to get a paper out about that this summer. It looks like it is doing the things we would like it to do in terms of hostility towards women. Sexism is one of the measures. So far, it looks like at the end of the semester people are more comfortable with intervening in violent situations and they feel more empowered that they can take an active role. The other piece of it that we are looking at is the extent that masculinity and men's expectations about what they have to do to be accepted by their male peers impedes their involvement in violence prevention. We talk a lot about that in the course I teach, which is called 'Men and Masculinity.' Among our measures are men's conformity to masculine norms. Scores tend to improve toward the end of the semester.

**Dr. McCarroll: *I think that your work on relationship typologies is really important. Other typology work has been largely mental-health and individual-male-batterer oriented (e.g., Hamberger & Hastings, 1986; Holtzworth-Monroe & Stuart, 1994; Hamberger, Lohr, Bonge, & Tolin,1996). If you were advising people who were working with women as either victims or perpetrators both, as your data show, how would you advise people to treat them? Would it be differently from men?***
   Dr. Swan: Yes. I think the key is to recognize that there is almost always

going to be both victimization and perpetration going on. If you are doing anger management with a woman and she is being victimized, then it does not seem like anger management is going to help much because she is still being beaten at home. If you are working with a woman through victim services and she is using violence herself, if you are not addressing the violence that she is using and the context for it, then it seems like will miss part of the picture.

*Dr. McCarroll: Thank you for being so generous with your time.*
    Dr. Swan: Thanks for having me again.

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**Key Points**

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My sense is that a lot of women in my study who experienced coercive control from their partners responded by becoming extremely angry, frustrated, and fed up. Not knowing what else to do, they lashed out in violence.

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We know something about the context of women's violence now from the research, but I do not think it is making its way prevention and treatment programs yet.

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# Adult Psychological Abuse

*By James E. McCarroll, PhD*
*Joining Forces Joining Families, Volume 11, Issue 1, March 2009*

Psychological abuse (also sometimes referred to as emotional abuse) is a distinct component of domestic violence. While adult physical abuse and sexual abuse are widely recognized as domestic violence, psychological abuse has received much less attention. The definition of psychological abuse is difficult, particularly in regard to satisfying both the mental health and legal professions (O'Leary 1999).

Hostility, in many forms, is psychological aggression. It is relatively common, even in happily married couples, particularly in young couples with or without marital discord (O'Leary 1999). But, psychological aggression is not the same as psychological abuse. O'Leary and others have distinguished between aggression and abuse on the basis of the frequency and intensity of negative remarks and threats.

The strict definition of psychological abuse is broad and often not clear. O'Leary (1999) defines it as acts of recurring criticism, verbal aggression, acts of isolation and domination toward an intimate partner. Non-verbal psychological abuse, such as stalking, can also be considered psychological abuse. Potentially abusive behavior can be grouped under the following four primary dimensions (O'Leary and Maiuro, 2001):

- 1. Damaging to partner's self-image or self-esteem through denigration,
- 2. Passive-aggressive withholding of emotional support and nurturance,
- 3. Explicit and implicit threatening,
- 4. Restricting personal territory and freedom.

In couples' therapy, psychological abuse is often recognized as a difficult issue with which to work. The seriousness of the effects of psychological abuse was shown in an early study (Follingsted, Rutledge, Berg, et al., 1990).

They studied six types of emotional abuse of 234 women with a history of physical abuse and related these types to the frequency and severity of the physical abuse. The six types were: verbal attacks, social or financial isolation or restriction, jealousy or possessiveness, threats of abuse or harm, threats to end the marital relationship or have an affair, and damage to or destruction of the woman's property. Ninety-nine percent of the women had experienced some form of emotional abuse and 72% reported experiencing four or more types. The most frequently reported type of abuse was ridicule, but threats of abuse, jealousy, and restriction all occurred to a large percentage of the women. Ridicule was reported as having a negative impact by the highest percentage and threats of abuse were the second most negatively impacting type. Seventy-two percent of the women reported that psychological abuse had a more negative impact on them than physical abuse. None of the individual types of psychological abuse was related to the frequency of physical abuse or severity of injuries. However, about half the women (54%) used the emotional abuse incident, particularly threats of abuse and restriction, to predict an occurrence of physical abuse.

The effects of psychological aggression compared to physical aggression were also reported in a community sample of couples (Taft, O'Farrell, Torres, et al., 2006). In this sample, psychological aggression victimization was associated with greater distress, anxiety, and physical health symptoms beyond the effects of physical aggression. Psychological victimization was also uniquely associated with higher levels of depression for women only. Possible distinct etiologies were suggested for male and female perpetrators and highlighted the need for different models of psychological aggression for men and women.

O'Leary and Maiuro (2001) reviewed measures of psychological abuse and measures derived from them. Eight measures that have been used are the Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, et al., 1990), the Index of Spouse Abuse (Hudson & McIntosh, 1981); Spouse Specific Aggression and Assertion (O'Leary & Curley, 1986), Psychological Maltreatment of Women (Tolman, 1989), Index of Psychological Abuse (Sullivan, Parisian & Davidson, 1991), Severity of Violence Against Women (Marshall, 1992), and the Dominance Scale (Hamby, 1996).

Psychological abuse has substantial negative health effects. Female gastroenterology patients with irritable bowel syndrome, a bowel condition without a known organic basis, reported significantly higher levels of emotional abuse, self-blame and self-silencing than comparison patients who had irritable bowel disease, a bowel condition with a known organic basis (Ali, Toner, Stuckglass, et al., 2000). Emotional abuse remained associated with irritable bowel syndrome even when physical and sexual abuse histo-

ries were controlled. The authors concluded that women who experienced emotional abuse may be more likely to develop response patterns of inhibiting self-expression and taking responsibility for negative events, all of which may lead to increased levels of stress affecting the gastro-intestinal system.

Psychological abuse was also associated with an increased risk of smoking in a cohort of white, well-educated, and employed women. Further, when it co-occurred with physical or sexual abuse, the risk was increased (Jun, Rich-Edwards, Boynton-Jarrett, et al., 2008). Dominance and isolation predicted increases in depressive symptoms over time in dating women. These effects were moderated by their levels of perception of interpersonal control (Katz & Arias, 1999). Psychological abuse and stalking contributed uniquely to post-traumatic stress disorder (PTSD) and depression symptoms after controlling for the effects of physical and sexual violence and injuries (Mechanic, Weaver, & Resick, 2008). In a study of living in a shelter, psychological abuse was a significant predictor of PTSD and intentions to leave the abusive partner even after controlling for the effects of physical abuse (Arias & Pape, 1999). Male-to-female psychological aggression has also been associated with distress in mothers and internalizing and externalizing behavior in children (Clarke, Koenen, Taft, et al., 2007).

Importantly, psychological abuse nearly always seems to precede physical abuse and thus prevention of psychological abuse may prevent later physical abuse and injury (O'Leary, 1999).

**Key Points**

Psychological abuse (also sometimes referred to as emotional abuse) is a distinct component of domestic violence.

Hostility, in many forms, is psychological aggression. But, psychological aggression is not the same as psychological abuse.

The strict definition of psychological abuse is broad and often not clear. O'Leary (1999) defines it as acts of recurring criticism, verbal aggression, acts of isolation and domination toward an intimate partner. Non-verbal psychological abuse, such as stalking, can also be considered psychological abuse.

In an early study of psychological abuse, 99% of the women had experienced some form of emotional abuse and 72% reported experiencing four or more types.

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Psychological abuse has substantial negative health effects.

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# Psychological Aggression and Psychological Abuse: Is There a Difference?

*By James E. McCarroll, PhD*
*Joining Forces Joining Families, Volume 11, Issue 1, March 2009*

### Dr. McCarroll: How would you explain psychological aggression?

Dr. O'Leary: Unlike physical aggression that is easily classified into various acts like pushing, slapping, and shoving, psychological aggression can run the gamut from behaviors such as refusing to talk to the person, giving him/her the cold shoulder, constant belittling, and/or controlling their whereabouts — almost keeping them imprisoned. There are many problems with the definition of psychological abuse. It is easier for the legal and mental health professions to agree on a definition of physical abuse because there is zero tolerance for unwanted physical aggression. Some form of psychological aggression against a partner is committed essentially by everybody at some time. Thus, if one wishes to differentiate between psychological aggression and psychological abuse, it is necessary to agree on what constitutes the boundary from one to the other. We have characterized four types of psychological abuse (O'Leary & Maiuro, 2001):

- Critical comments that damage a partner's self-esteem;
- Passive-aggressive withholding of support (the silent treatment);
- Threats of physical harm;
- Restriction of freedom.

### Dr. McCarroll: Do you differentiate between psychological aggression and psychological abuse?

Dr. O'Leary: In my clinical work, I do not generally try to distinguish between the two because it often is unclear where to draw the line. It is akin to the difference between physical aggression versus battering. You can easily categorize certain psychologically aggressive behaviors as abusive like taking the spark plugs out of a car or restricting money and checkbook access. However, if pressed, I would categorize recurring acts of any of the four types of psychological aggression described above as psychological abuse. Such recurring acts are likely to make a partner lose self-esteem and/or be fearful.

***Dr. McCarroll: Does psychological abuse predict physical abuse?***

Dr. O'Leary: Not necessarily, but it is the single best predictor, even better than alcohol. There are examples of actions taken to harm another person where there was not a verbal argument immediately preceding it, but these are the rare exceptions. Most acts of physical aggression follow a verbal argument or are in the context of a verbal argument. We know that people can experience a great deal of psychological abuse, even if it never occurs with physical abuse. We also know that it is associated with a great deal of relationship discord. You can predict that physical abuse will later occur if there is a tendency for people to have psychological aggression across time. In other words, it is the extent of psychological aggression that is predictive of whether a physically aggressive act will occur (Murphy & O'Leary, 1989).

***Dr. McCarroll: What is the trigger in which psychological aggression escalates to physical abuse?***

Dr. O'Leary: One of the triggers is alcohol or any substance that lowers inhibitions. Another trigger is if the argument taps into what is really at your core, your sense of who you are as a person or your firmly held beliefs and values.

***Dr. McCarroll: One of the missions of the Army Family Advocacy Program (FAP) is prevention. What should FAP personnel who give domestic violence prevention classes tell people about psychological abuse?***

Dr. O'Leary: My first task would be to tell people that psychological aggression is a serious issue. I try to tell mental health audiences the importance of reducing psychological aggression whether it is through relaxation, medication, relationship enhancement, or financial consultation. Anything that will reduce psychological aggression will make physical aggression less probable.

***Dr. McCarroll: How do you differentiate between verbal abuse and psychological aggression?***

Dr. O'Leary: Individuals who have a difference of opinion and who attempt to resolve their relationship differences can do so without being psychologically aggressive, i.e. calling their partner names, screaming at them or saying things to make the partner feel inferior. To differentiate assertion from verbal aggression, Curley and I developed a measure of spouse specific assertion and spouse specific aggression (O'Leary & Curley, 1986).

***Dr. McCarroll: How damaging is psychological abuse?***

Dr. O'Leary: There are a few descriptive studies where women who have

been physically abused or battered have also reported psychological abuse. They reported that the psychological abuse had a more negative effect than the physical abuse (Follingstad, Rutledge, Berg, et al., 1990; Arias & Pape, 2001). Anything that goes to the core of one's self-esteem, is most likely to be emotionally damaging to the person.

***Dr. McCarroll: Do you see people in your clinic who come in for help with purely psychological abuse or verbal abuse?***

Dr. O'Leary: We found that if you ask men and women to briefly describe their major marital problems, about 50% of men and 60% of women report communication. Lack of sexuality and personality style problems are reported as the next most frequent problems by both husbands and wives (O'Leary, Vivian, & Malone, 1992). Another form of psychological abuse, which is particularly damaging, is threatening to leave the relationship. When people come into therapy, we say that one of the ground rules is not to tell the other that you are thinking about divorce or you are threatening divorce. It just sets things back and instills more distrust.

***Dr. McCarroll: How do you measure psychological aggression?***

Dr. O'Leary: We use a variation of the Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, et al., 1990), a self-report of aggressive behavior, with potential clients for therapy. We ask them to describe any major arguments that have taken place. In the interview, we try to get a more detailed elaboration of what happened in the most recent incident and to get a sense of what both of them will own up to. Both men and women underreport negative things that they have done, though men tend to underreport more than women, particularly on the more serious aggressive acts. We have found that if you look at the agreement about psychological aggression or physical aggression it is not substantially different than agreement on positive activities like kiss your partner, engage in outside activities together, laugh together (O'Leary & Williams, 2006).

***Dr. McCarroll: The literature on psychological abuse seems largely to be about psychological abuse of women. Is there any literature about women as perpetrators?***

Dr. O'Leary: If you look at all the published studies on husband and wife interactions in marital assessments, women actually engage in more negative, more critical behavior than do men whereas men engage in more withdrawing-type behavior (Woodin, 2008). So, it would make some sense that women might score as high or higher on measures of psychological abuse. We know that on measures of psychological aggression like the Straus scale

and even on a scale like dominance and jealousy, women in our samples had scores that were essentially not different from those of men.

**Dr. McCarroll: Is adult psychological abuse recognized in state laws?**
Dr. O'Leary: In New York State it is. It is not uncommon to have orders of protection based on threats. When a person is alleged to have made threats against an individual's person or their animals, an order of protection can be initiated through the courts without any evidence of physical contact.

**Dr. McCarroll: Thank you for your time and your insights.**
Dr. O'Leary: You are welcome.

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**Key Points**

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O'Leary & Maiuro (2001) have characterized four types of psychological abuse:
- Critical comments that damage a partner's self-esteem,
- Passive-aggressive withholding of support (the silent treatment),
- Threats of physical harm,
- Restriction of freedom.

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Psychological abuse is associated with a great deal of relationship discord.

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Most acts of physical aggression follow a verbal argument or are in the context of a verbal argument.

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# Mental Health

This section addresses two of the most important mental health topics related to family maltreatment: depression and alcohol misuse. William Beardslee has had a long and very productive career in studying the role of depression in families. His research has included both the prevention and treatment of depression in children and adults. Particularly important in the current environment has been his work in adapting his interventions for depression in other cultures.

Christopher Murphy has addressed the role of alcohol in domestic violence. Alcohol is one of the biggest contributors to domestic violence as well as one of the most difficult areas of practice for domestic violence counselors.

Both Dr. Beardslee and Dr. Murphy address areas of needed intersection for family maltreatment in that both impact children and other systems of service delivery that often do not work together. Both emphasize the importance of a broad view of these problems, depression and alcohol misuse, as they impact the family.

# Depression in Children: An Emphasis on Prevention

*By James E. McCarroll, Ph.D.*
*Joining Forces Joining Families Volume 8, Issue 3, Summer 2005*

Dr. Beardslee has studied the mental health and resilience of children living in families affected by parental depression, poverty or violence. He has extensive experience in adapting interventions devised in one setting to other settings and has adapted the original preventive intervention approach for Latino families, for African-American families, and in other contexts. He has been especially interested in the protective effects of self-understanding in enabling youngsters and adults to cope with adversity and has studied self-understanding in civil-rights workers, survivors of cancer, and children of parents with affective disorders.
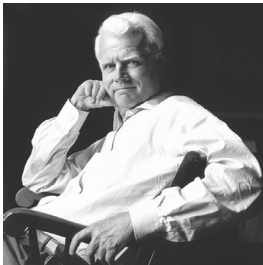
The study of childhood depression and the impact of parental depression on children is a relatively recent scientific endeavor. The following article summarizes Dr. Beardslee's research on educating a family about depression and facilitating their ability to talk about it and its effects in order to resume and strengthen healthy and meaningful communication and functioning.

An important part of Dr. Beardslee's work is building resilience in children of depressed and non-depressed parents. The interventions he employs are practical and can be applied by all levels of family advocacy personnel. Although not necessarily easy to implement, they have undergone rigorous scientific tests through a series of studies of randomized trials.

Children of affectively ill parents are more likely to have increased rates of psychiatric disorder and other negative psychosocial outcomes than children from homes with parents without affective illness (Beardslee & Glad-

stone, 2001). Beardslee sees the processes that underlie the emergence of health or illness as dynamic and influenced by developmental changes. In his view, it is these developmental influences as well as societal adversity (e.g., living in poverty, exposure to violence, job loss, and other social ills) that are critical to understanding the risk for and the prevention of depression.

Risk factors are events, characteristics, or conditions that make a negative outcome more likely (Carbonell, Reinherz, Giaconia, et al., 2002). Such risk factors (often referred to as multiple adversities by Beardslee) act concurrently to predict the onset of serious affective disorder in adolescents more than single risk factors. In families with multiple risk factors (e.g., number of child diagnoses, duration of depression in a family member, and number of parental non-affective diagnoses), 50% of the children became ill with serious affective disorders compared with 7% of children who became ill in families with none of these three risk factors (Beardslee, Keller, Seifer, et al., 1996).

Beardslee and colleagues in Finland investigated children's responses to low parental mood and found that their responses are sensitive to family dynamics (Solantus-Simula, Punamaki, & Beardslee, 2002; Solantus-Simula, Punamaki, & Beardslee, 2002). Four patterns were found among the children: active empathy with the parent, emotional over-involvement, indifference, and avoidance. Discrepancies in the children's perceptions of parenting and the parents' perceptions of child distress can be meaningful in understanding family interactions, child well-being, and child development. These differences in perception can be the basis of a discussion of family dynamics and lead to increased understanding of the effects of depression on children.

In a randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of parents with a history of depression, adolescents were given 15 sessions of cognitive restructuring therapy while the control group was given the usual HMO treatment (Clarke, Hornbrook, Lynch, et al., 2001). The cognitive restructuring was focused on identifying and challenging irrational, unrealistic, or overly negative thoughts, with a special focus on beliefs related to having a depressed parent. The usual treatment (control) group consisted of the randomly assigned study participants who initiated or continued any non-study mental health treatment or other non-health care services provided by the HMO or outside the HMO including medication. Those adolescents treated with cognitive restructuring techniques did better than adolescents treated with the usual treatment. Only 9% of the adolescents treated with cognitive therapy had a later depressive episode compared with 29% of those receiving the usual treatment during

a median 15-month follow-up period. Thus, brief cognitive therapy can reduce the risk for depression in adolescent offspring of parents with a history of depression.

In a series of studies, Beardslee and colleagues developed a family-based selective intervention program for preventing depression. These studies of the prevention of depression tested two preventive approaches, both of which can be used by pediatricians, internists, school counselors, nurses, and mental health providers (Beardslee, Gladstone, Wright, et al., 2003). Their research method was an efficacy trial of two manualized approaches. They targeted non-symptomatic, relatively healthy children and adolescents, between the ages of 8-15, at risk for future depression due to the presence children and adolescents, between the ages of 8-15, at risk for future depression due to the presence of significant affective disorder in one or both parents.

Families were randomly assigned to either a lecture group or a clinician-facilitated condition. The goals of both interventions were to (1) decrease the impact of family and marital risk factors, (2) encourage resilience in children through enhanced parental and family functioning, and (3) prevent the onset of depression or a related mental illness. The lecture condition consisted of 2 separate group meetings in which psychoeducational material was presented to parents about mood disorders, risk, and resilience and efforts were made to decrease feelings of guilt and blame in children. The clinician-facilitated condition consisted of 6 to 11 sessions in which separate meetings were held with parents, with children, and as a family in which the parents led a discussion of the illness and of positive steps that can be taken to promote healthy functioning of the children.

Both groups reported significant changes in child-related attitudes and behaviors and the amount of change reported increased over time. Parents in the clinician-facilitated group reported significantly more change than those in the lecture condition. Parents who changed the most in response to the intervention had children who also changed the most. Their most important finding was that greater parental benefit (changes in illness-related behaviors and attitudes) was associated with significant global change among children. These changes included enhanced understanding of parental illness and improved communication with parents. They concluded that the connection between parental change and child change was mediated through family change. The positive interaction between parents and children and the understanding of the illness by everyone in the family (e.g., information about mood disorders) equip parents to communicate information to their children and to open a dialogue with their children about the effects of parental depression. Providing parents with factual information regarding

risk and resilience in children, and linking this to family illness can result in behavioral change among parents that ultimately can translate into better functioning among children.

In a study of the relation between children's exposure to violence and mental health in a low income community, exposure to violence was correlated with internalizing symptoms (e.g., anxiety and depression), but more so for girls than for boys (Buckner, Bassuk, & Beardslee, 2004). Beardslee and colleagues hypothesized that the effects of violence on self-esteem and chronic danger might mediate the link between violence exposure and mental health symptoms. The task was to find a way to improve children's mental health in this environment. The mother's mental health was a strong predictor of children's mental health and behavior problems. Although the two most important variables in this study, the mother's mental health and the children's exposure to violence, are amenable to interventions, much more information is needed to design the most effective community interventions. For example, the role of the fathers in this sample was unknown and more information is needed about the differences in exposures and reactions of boys and girls to violence.

Previous studies of depressed adults and children have identified many risk factors. While studies of resilience have been much more recent and more limited than studies on risk, several important protective factors have also emerged. Protective factors are conditions or processes that moderate the negative effects of risk factors and decrease the risk itself, the effects of the risk factor, or enhance coping capacity. Adolescent protective factors were identified in a longitudinal, community-based study that were associated with resilient outcomes in adulthood. Significant protective factors included family cohesion, positive self-appraisal, and good interpersonal relations (Carbonell, Reinherz, Giaconia, et al., 2002).

Positive factors identified in other research on adolescents included high levels of family cohesion at child age 15, higher self-concept and self-appreciation, and spending more time in the company of others (Reinherz, Stewart-Berghauer, Pakiz, et a., 1989). In another study, resilient youth had greater self-regulatory skills, higher self-esteem, and more active parental monitoring (Buckner, Mezzacappa, & Beardslee, 2003). Self-understanding, commitment to relationships, and the ability to think and act separately from their parents also characterized adolescents whose parents had major affective illness (Beardslee & Podorefsky, 1988). These studies of risk and protective factors indicated that it was possible to identify children at high risk for depression.

Depression itself may also serve as a risk factor for additional adverse outcomes. From the National Longitudinal Study of Adolescent Health, it

was found that depression in boys (but not girls) predicted increased risk of acquiring sexually transmitted diseases (STD). The authors concluded that screening for depression among sexually active adolescents may identify many of those at risk for later STD (Shrier, Harris & Beardslee, 2002).

Dr. Beardslee advocates strongly for more mental health services, particularly for underserved populations such as those in poverty and who lack health insurance or lack coverage for mental health conditions. His view is buttressed by the powerful evidence amassed by his research and that of his colleagues on the prevention and treatment of childhood depression. Part of the approach to the problem of depression is to advance beyond psychiatric treatment and attempt to ameliorate adverse societal factors that predispose or directly contribute to depression. Among these conditions are poverty, exposure to violence, and social isolation. Successful prevention of depression would be of enormous benefit to society in terms of relief of the burden of suffering and associated negative outcomes thought to be associated with depression such as child and spouse maltreatment, substance abuse, and suicide.

The future of depression research may lie in better understanding of child and adolescent development and how much it can be modified by interventions. Current research on genetics and its interaction with the environment may someday lead to improved understanding of the genetic-environment interface and its relation to stages of development. It may be possible to identify critical periods in a child's development for intervention and tailor interventions based on the child's sensitivities and particular environmental risks. Also, advances in brain research and other organic mechanisms that can be treated pharmacologically may enhance the opportunities for intervention at many levels for children and adults (Beardslee & Gladstone, 2001).

The incidence and prevalence of depression in active duty military personnel and their families is not known. It is likely that many of the same risk factors identified in research on civilian communities are also present in the military. Such risk factors (multiple adversities) may be more concentrated in the current military environment of frequent, rapid, and hazardous deployments. We encourage military family advocacy program personnel to consider the possible role of depression in the treatment of families in which maltreatment has occurred and in violence prevention efforts where it is likely that a broader audience can be reached and prevent new cases of depression. Examples of such arenas are education classes for military personnel, the various parenting programs sponsored by the military and public education events such as depression screening.

**Key Points**

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Children of affectively ill parents are more likely to have increased rates of psychiatric disorder and other negative psychosocial outcomes than children from homes with parents without affective illness.

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Risk factors are events, characteristics, or conditions that make a negative outcome more likely.

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Protective factors are conditions or processes that moderate the negative effects of risk factors and decrease the risk itself, the effects of the risk factor, or enhance coping capacity. Significant protective factors included family cohesion, positive self-appraisal, and good interpersonal relations.

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The incidence and prevalence of depression in active duty military personnel and their families is not known. It is likely that many of the same risk factors identified in research on civilian communities are also present in the military.

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INTERVIEW WITH WILLIAM R. BEARDSLEE, MD

# The Impact of Depression on Children and Families

*By James E. McCarroll, Ph.D.*
*Joining Forces Joining Families Volume 8, Issue 3, Summer 2005*

Dr. McCarroll: We are pleased to introduce you and your work to the readers of Joining Forces Joining Families. We believe that the professionals who are committed to the well-being of our Army soldiers and families will find the subject of your interview to be timely. Would you tell us about the background of your work and how long you have been studying depression?

Dr. Beardslee: I started studying depression in 1979 with a small grant to look at the children of depressed parents. A larger study of preventive interventions for families facing depression began in 1984 and has continued to the present time.

*Dr. McCarroll: We use many different words, such as blue, down-in-the-dumps, and gloomy to describe a less than happy mood. What is clinical depression and how would you describe it?*

Dr. Beardslee: Any of us — parents, teachers and children— can have a bad day. We may even say, "I'm depressed." But, what we mean by clinical depression is a more long-term and persistent change in functioning characterized by feeling down and blue and not being able to shake it. In the diagnostic manual it is two weeks or more of one major symptom and five associated symptoms. In practice, in the real world, it is the difference between having a couple of bad days because of some event in one's life and bouncing back versus having a host of different adversities at the same time, getting down because of them, and then just not simply being able to get back on one's feet.

*Dr. McCarroll: How then does the individual know when treatment is needed?*

Dr. Beardslee: Studies have shown that depression is common. One in five Americans will experience a depression in their lifetime. Those with a high number of risk factors will experience even more, but only about a third of the time is depression recognized and professionally treated.

For the individual, I think it would be an awareness that something isn't right. If I am depressed, I don't feel the way I used to. I am not accomplishing things the way I used to. Often, one might be gripped by a persistent sadness, a sense of foreboding about the future. Some people have a sense that life is

not worth living; some feel suicidal. Very often depression comes after a major loss, after bereavement, after moving abruptly to a new community, not being able to establish social bonds, or after the loss of a job. The key is to say "It's not normal to feel hopeless and depressed." There is help available in the recognition and treatment of depression. We often tell families the first place to turn is the pediatrician or the family practitioner who will be able to recognize depression and make an appropriate referral if need be.

*Dr. McCarroll: Would you say that depression affects men and women differently?*

Dr. Beardslee: Depression in a parent has profound effects on the other spouse and on the kids, but probably in different ways. So often, men and women in families are in different roles. Often, women are the primary caretakers and run the household. If they get depressed, those routines get disrupted. With men, often out in the workplace, the work gets disrupted. So, although the depressions are diagnosed in similar terms, the effects on families depend on the role of the person.

*Dr. McCarroll: Do boys and girls manifest depression differently?*

Dr. Beardslee: There is a sex difference and it is very interesting. Before puberty, boys are three times more likely to be depressed than girls. After puberty, girls are about twice as likely to get depressed as boys. In adulthood, women are two times more likely to get depressed than men. I don't think we know why that occurs. We know that women are more likely to seek help and women are more likely to talk about their feelings, on average. The concern one has with boys is that they tend to shut off what is bothering them and either fight or get into trouble because of aggression or turn to substance abuse or develop other problems in adolescence.

The key for all of us who are concerned about youth is to recognize that depression is real and that it is treatable. There are very good treatments, among the best in medicine, among the best in psychiatry, for depression. Those of us who are professionals need to work very hard to make it easy for people with depression to get help.

*Dr. McCarroll: If a parent is depressed, how likely is it that the child will become depressed?*

Dr. Beardslee: If you compare families with depression and other adversities such as job loss or victimization by violence or bereavement to families with no depression then the rates of depression in the children of parents with depression are two to four times as high in adolescence to those with no depression. Why do I say "With other adversities in addition to depression?"

Because we have come to understand that depression in a parent often serves as an identifier of a constellation of adversities. We find that the families at greatest risk are those in which there are multiple adversities experienced at once. On the other hand, for depressed parents it means that if depression occurs without these associated adversities and if treatment can begin quickly then the prognosis for both them and the children is very good.

*Dr. McCarroll: If the parents are not depressed how likely is their child to become depressed?*

Dr. Beardslee: Kids can still get depressed in the absence of parental depression. In addition to having parents and other relatives with depression, there are other experiences that put children at higher risk for depression: undergoing loss experiences such as bereavement, loss of community, being the victim of bullying, having real trouble in school, and learning disabilities or hyperactivity. In adolescence, kids often become depressed after relationships fail or they fail in grades or in sports or some endeavor that they didn't do as well in as they thought they would. Most of the time, appropriate treatment can turn this around. Many kids with these problems do not become depressed, but kids with these problems do become depressed at higher rates.

Just to summarize, childhood and adolescent depression are largely unrecognized and untreated so parents need to be alert to the signs of depression and seek help. The signs are a real change in the usual way a child is behaving: a child who has become more irritable, who shows less interest in friendships or pleasurable things, and who is withdrawing (see Table 1).

*Dr. McCarroll: What can be done to prevent the children of depressed parents from also becoming depressed?*

Dr. Beardslee: That is what we have really focused on over the last 20 years. What we found is that we can help parents most by helping them get

**Table 1. Signs of Depression in Adolescents and Younger Children**

- Diminished interest in friends and friendships.
- Decline in school performance.
- Irritability.
- Aches and pains, especially in young children, and resistance to attending school.
- If any or a cluster of these signs persist for several weeks, it may signal depression and professional help should be sought.

back on track with being good parents. Many parents with depression feel overwhelmed. They feel they have irrevocably harmed their children and think that nothing can be done. That sense of helplessness and hopelessness goes along with depression. In fact, many people who have depression can be excellent parents and any parent with depression can do things to help their children. So, the first communication has to be one of hope. You can be a good parent despite depression.

What does a parent with depression need to do? Number one, get treatment for the depression. Getting treatment will help the energy and the good parenting come back. Secondly, work to build resiliency in children. We think that all parents can do this.

Building resilience is a basic aim of education, health care, and parenting. Resilience training is really tied to very specific actions. In our own work in the three core areas (kids' activities, kids' relationships, and kids' understanding), we take specific steps. The first is telling our kids what we are doing and the second is taking concrete actions. We ask families, for example, "How have your child's friendships been disrupted because of this move or because of this depression?" And then "What very concrete steps in your own life can you take to move this along?" We found that depressed parents welcomed the idea of building resilience and were frankly relieved and overjoyed to find that there were positive things that they could do (see Table 2).

### Table 2. How Depressed Parents Can Build Resiliency in Children

- Support your child's involvement in normal activities and routines such as going to school, to sports, to a place of worship, and so on.
- Do not let depression disrupt the usual patterns of your child's life.
- Build and support your child's relationships within the family and outside such as letting your children's friends continue to come to your home to visit and letting your children go to other houses.
- Provide an age-appropriate explanation for the way you are feeling so that your family can understand depression is a medical illness, and that your are receiving treatment to get better.
- Break the silence that often surrounds depression by having a family conversation that can help remove feelings of guilt, blame and confusion for both parents and children.
- Continue to have more conversations to sustain family communication that often facilitates the recovery process for the depressed parent and build resilience in children.

We often found that in families with depression, they were not talking to each other. We believe that the family can understand depression as a medical illness and can have a conversation about it that makes sense and helps remove the guilt, the blaming and the misunderstanding that so often occurs with depression. Our work has been very much to help families master depression by talking about it.

When the initial conversation about depression was successful it then often led to successful conversations about other things. Families learned that family meetings, strategically planned to talk about difficult issues, were very helpful. As families mastered depression they got back on track. They made peace with the illness and moved on the way one does with a medical illness. It is also important to note that explanations, however good, are never static when children are involved. As children grew older they drove the need for understanding depression anew, for new conversations and for understanding it differently.

Much to my surprise and to my real pride and pleasure, we did a long-term study comparing two forms of getting this prevention across: one, a lecture followed by a group discussion, and the second, a clinician-based intervention where a clinician works with the family over a few sessions to help the family hold a meeting. We found that these interventions led to long-term and sustained effects in the family's ability to understand the illness and in the family's ability to protect the children. So, we are confident that these approaches can help. The book I wrote (Beardslee, 2002) is for both clinicians and families to try to learn about these techniques. The basic point is that not only did we have these ideas, but we tested them in a randomized trial design and have been able to show sustained effects.

### Dr. McCarroll: What are your thoughts on how to deal with the combination of violence, depression, and alcohol?

Dr. Beardslee: That particular vicious cycle is toxic for the individual, toxic for the spouse, and toxic for families. People who have been injured by violence are likely to be depressed and likely to use alcohol to medicate themselves. I would say categorically as a psychiatrist, as a doctor, as a parent, and as someone who has worked with depression for years, alcohol inevitably makes depression worse. It is not a treatment; it doesn't help. So, recognizing that is a first step. Secondly, the key point about depression is that it is treatable and people feel dramatically different when they get treatment. When interpersonal violence occurs in a family, the first question to ask is "Are the individuals safe?" All of us in the caregiving professions first have to make sure that the environment is safe and then work on getting treatment

for alcoholism or talking through what the difficulties are or getting treatment for depression..

***Dr. McCarroll: What do you see as future directions for depression research and, particularly, with regard to violence?***

Dr. Beardslee: One thing that we have learned is that if a violent event occurs, we need to intervene very quickly to support those who have been victimized. Secondly, we need to spend more time thinking about effective prevention: recognizing when people are reaching the breaking point and trying to provide support for them. In psychiatry and in public health we are recognizing the value of preventive intervention. We are trying to put preventive intervention programs in place. There are certainly examples of this, such as home visitation and high quality day care that have reduced interpersonal violence and led to very positive outcomes. So, as we move forward, I believe we are going to see more effective treatments and more effective preventions that will help us.

***Dr. McCarroll: What else would you like to say to our readers?***

Dr. Beardslee: One, hope is always available. Two, the dominant fact of our mental existence as parents, and I speak as a humble parent myself, is the care of our children. Thirdly, I think that one of the important things about our work with depression in families is that it didn't improve as a result of just one conversation. It is a process we refer to as "breaking the silence." Parents had one conversation with the kids followed by another and another. Whether as a practitioner or as a parent, if you are thinking about using some of the things that we learned, say, "We don't have to do this all at once." Our first conversation with kids should be a successful one and we should make ourselves open to continued conversations as the time evolves.

***Dr. McCarroll: Thank you for sharing your thoughts with us. I believe that your eloquence and your optimism are very exciting and I thank you for your time.***

Dr. Beardslee: You are welcome.

**Key Points**

What we mean by clinical depression is a more long-term and persistent change in functioning characterized by feeling down and blue and not being able to shake it.

If you compare families with depression and other adversities such as job loss or victimization or bereavement to families with no depression then the rates of depression in the children of parents with depression are two to four times as high in adolescence to those with no depression.

We found that we can help parents most by helping them get back on track with being good parents. any parents with depression feel overwhelmed.

I would say categorically as a psychiatrist, as a doctor, as a parent, and as someone who has worked with depression for years, alcohol inevitably makes depression worse. It is not a treatment; it doesn't help.

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REVIEW OF RECENT RESEARCH OF WILLIAM R. BEARDSLEE. MD

# Extending Programs to Prevent Depression to Communities

*By James E. McCarroll*
*September 2009*

Dr. Beardslee and his colleagues have been extremely productive in conducting research on the prevention of depression. In our first interview with Dr. Beardslee, we summarized his research on the prevention and treatment of childhood depression and the impact of parental depression on children. He used an educational format to teach a family about depression and facilitate their ability to talk about its effects. This approach has strengthened healthy and meaningful communication and functioning in those families. He has extended his prevention interventions to additional locations in the United States and abroad including a population that is largely Spanish speaking. This approach was also used in the Boston area to depressed mothers whose children are in Head Start programs.

The program for depressed mothers (Family Connections of the Children's Hospital, a teaching hospital of Harvard Medical School, Boston) of children in Head Start is at *http://www.childrenshospital.org/clinicalservices/ Site2684/Documents/introduction_final.pdf*. It includes an explanation of why this program is important based on the following three principles: Head Start families are often in chronically adverse situations including poverty, exposure to violence, and social isolation; depression is a common reaction to such adversity; and these adversities and depression affect the ability of parents and Head Start staff to take care of children. Further explanation is given as to why it is important to treat depression in this setting, how materials help engage parents, why the focus on Head Start staff, and how the staff can better work with parents. Several papers are provided for staff as well as a brief description of four training modules.

Also on the website is background material for professionals. It describes why depression is a topic for early childhood programs, why and how to focus on childhood provider staff, and how the Family Connections program works. The material is also in Spanish at *http://www.childrenshospital.org/ clinicalservices/Site2684/mainpageS2684P7.html*.

In a recent study, Dr. Beardslee and colleagues compared two treatment programs (informational versus a brief clinician-based approach) for 105 families in which at least one parent suffered from depression and at least

one non-depressed child was in the 8 to 15 age range (Beardslee, Wright, Gladstone, et al., 2007). Both interventions addressed poor communication, misunderstanding, feelings of guilt and blame, and lack of recognition of depression. The informational intervention consisted of two lectures given to families without children present in a group format with additional consultation by the investigators, as requested by the families. The clinician-based intervention consisted of an average of seven sessions that included meetings with parents and children. Both interventions produced sustained effects approximately 4.5 years after enrollment. First, child and family functioning increased and internalizing symptoms decreased in both groups. Secondly, families in the clinician-based intervention had significantly more gains in parental child-related behaviors and attitudes in child-reported understanding of the parent's mood disorder. The authors concluded that brief family-centered preventive interventions for parental depression may contribute to long-term improvements in family functioning.

A multi-site (four U. S. cities) randomized control study of the prevention of depression in adolescents compared the intervention to usual care, non-study mental health or other health care (Garber, Clarke, Weersing, et al., 2009). The intervention was group cognitive behavioral (CB) therapy conducted for parents in eight 90-minute sessions plus six monthly sessions for adolescents whose parents who were currently depressed or had prior depression. The adolescents themselves had either a past history of depression, currently elevated but sub-diagnostic symptoms of depression, or both. The results were that the incidence of depressive episodes was lower during the 9-month follow-up period for the CB group than the usual care group and adolescents in the CB group had lower self-reported depressive symptoms than those in the usual care group. However, the presence of parental depression had an effect on the effectiveness of the interventions. The CB prevention program was more effective than usual care for adolescents whose parents were not depressed at baseline. For adolescents whose parent was depressed at baseline, there was no difference between the two groups in preventing the later incidence of depression. This important study has a number of important findings. It shows that the preventive intervention can be reliably and effectively delivered by different clinicians in different settings. It also shows that the CB intervention is a preventive program than can reduce or significantly delay the incidence of depression in offspring of depressed parents.

Extending his research on the prevention of depression to a low-income predominantly Latino population, Dr. Beardslee and colleagues provided the preventive intervention program (PIP) to nine families experiencing maternal depression (D'Angelo, Llerena-Quinn, Shapiro, et al., 2009). Mak-

ing the intervention culturally sensitive required extensive literature review, focus groups, pilot testing of the intervention manual adapted for this population, conducting the intervention in either Spanish or English, and the use of the contextual experiences of Latino families in the United States with special attention to cultural metaphors. While the numbers of families was too small for statistical analysis, the families found the intervention to be helpful with results similar to the intervention as applied in other U.S. populations. Personal stories were very important. People described day-to-day struggles to raise children in difficult environments with limited support as well as triumphs over adversity, personal and family resilience. Metaphors were found to be a useful way of talking about depression. This application of Dr. Beardslee's program is an important step in extending prevention research in a sensitive manner to an underserved population. Providing culturally sensitive programs is an important research and practice topic as the U.S. population continues to become more culturally diverse.

An analysis of the National Survey of Child and Adolescent Well-Being (NSCAW) examined changes in depression status and its relation to psychological aggression, physical assault, and neglect over an 18-36 month period by 2,683 mothers who retained custody of a child following a maltreatment incident (Conron, Beardslee, Koener, et al., 2009; NSCAW Research Group, 2002)). The NSCAW data were obtained from the National Data Archive of Child Abuse and Neglect at Cornell University (National Survey of Child and Adolescent Well-Being, 2004) *http://www.ndacan.cornell.edu*. Neglect was the most common form of alleged maltreatment (54.2%), followed by physical abuse (32.7%), and emotional abuse (10.7%). During the study period, 15.2% of the mothers experienced depression onset, 12.9% experienced the remission of an episode, and 7.4% experienced both onset and remission of depression. Overall, the onset of depression was associated with an increase in psychological aggression. In addition to changes in depression, the presence or absence of other factors frequently influenced acts of aggression or neglect: alcohol and drug dependence, employment status, the addition of an intimate partner to the household, exposure to intimate partner violence, and increases in child behavior problems. Not surprisingly, depression interacts with many personal and situational variables to increase or decrease child maltreatment. These findings show the need to consider the multitude of factors influencing families, particularly those that are amenable to prevention and treatment programs.

Dr. Beardslee is part of a team led by Dr. Patricia Lester of UCLA with substantial input from Drs. William Saltzman and Robert Pynoos of the National Child Traumatic Stress Network, which has been working with the United States Navy over a number of years to develop brief, prevention ori-

ented programs for military families facing multiple deployments.

Based on careful study of the stresses families face during deployment, the intervention, Project FOCUS, is a combination of an intervention for families with parents with AIDS developed by Drs. Mary Jane Rotheram-Borus and Patricia Lester, an intervention for family trauma developed by Drs. William Saltzman and Robert Pynoos, and the Family Talk Intervention developed by Dr. William R. Beardslee and his colleagues at Children's Hospital Boston. It uses a narrative approach and emphasizes both self-regulation and communication. It focuses both on practical strategies to deal with deployment and also on helping the families develop a single coherent narrative while understanding each other's experience. [*Editor's note*: See Saltzman WR, Babayon T, Lester P et al., (2009) for additional material by Dr. Beardslee and others on treating traumatized children.]

As noted in the interview in this issue, Dr. Beardslee participated in Institute of Medicine (IOM) panels that described the state of current research to prevent mental, emotional, and behavior (MEB) disorders in children and adolescents (O'Connell, Boat, & Warner, 2009). It is an exhaustive survey of current knowledge about the prevention of mental, emotional, and behavioral (MEB) disorders among young people (up to age 25). The perspective is developmental, from early childhood to young adulthood. This work has contributed to a better understanding of the achievements of prevention science and gives practical results that can be applied to a variety of programs to prevent MEB disorders. Highlights of the successes of prevention interventions include the prevention of child maltreatment, academic achievement, violence prevention, substance abuse, depression, anxiety, and mental health multiple disorders. It is also an excellent source of historical and statistical information on MEB disorders.

The IOM report provides a sophisticated view of risk and protective factors. For example, some variables that are characteristics of parenting can be a risk factor or a protective factor. Their review of studies of risk and protective factors and their implications can also be used for program development. Examples are how risk and protective factors influence each other over time and how risk and protective factors operate at multiple levels of analysis. High risk groups for prevention programs can be identified at multiple levels including individuals, families, and communities. Poverty, child maltreatment, and family disruption are particularly important risk factors that are associated with multiple disorders including MEB disorders, sexual behavior, substance abuse and others. Also, victimization, bullying, academic failure, association with deviant peers, and antisocial behavior are risk behaviors that have been linked to schools and communities. The authors discuss avenues to prevention for all of these risk factors for MEB disorders.

Environment and experience have powerful effects of brain structure and function. The IOM report includes a wide variety of additional information summarizing current knowledge in neuroscience including genetics, brain development, and neural systems to the development of prevention approaches. Interventions that modify experience and the effects of the environment have the potential to promote healthy brain development and to prevent mental, emotional and behavioral disorders.

This brief summary of the approach and results of prevention science to mental, emotional and behavioral disorders leaves out many of the additional important topics of the report. Specific information is given on family, school, and community interventions; methodologies for prevention research, development of infrastructure, costs, and other topics. This book is a valuable resource for data about prevention when one is asked to explain and defend prevention programs. Also extremely valuable are almost 100 pages of references of the contributions of others on which this book is based.

**Key Points**

Brief family-centered preventive interventions for parental depression may contribute to long-term improvements in family functioning.

A multi-site (four U. S. cities) randomized control study of the prevention of depression in adolescents showed that the cognitive behavioral intervention can be reliably and effectively delivered by different clinicians in different settings and can reduce or significantly delay the incidence of depression in offspring of depressed parents.

Poverty, child maltreatment, and family disruption are particularly important risk factors that are associated with multiple mental, emotional and behavioral disorders.

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SECOND INTERVIEW WITH WILLIAM R. BEARDSLEE, MD

# Preventive Interventions for Depression and Promotion of Resiliency in Children and Families

*By James E. McCarroll, PhD*
*September 2009*

**Dr. McCarroll: *In your earlier interview we discussed your research on the mental health and resilience of children living in families affected by parental depression, poverty or violence. You have described your work leading to the development of evidence-based intervention "breaking the silence" as a means to facilitate communication and functioning in families affected by depression. Have you continued your work on the prevention of mental health problems in families?***

Dr. Beardslee: We had a large grant from Head Start to develop an approach to depression in parents of children in Head Start (Beardslee, Avery, Ayoub et al., 2009). In Early Head Start, they estimated that the rate of depression is as high as 48% in mothers of kids ages 0-3. We took the same material that we used in our other studies and adapted it for much younger children. We approached this endeavor in stages. First, we set up teacher training. Once we trained the teachers, we coupled the training with in-class consultation and then, finally, teaching and training for the parents. It went very well. We eventually tested the programs in nine centers throughout Boston and got very good responses from the teachers. This material is available on the Web (*www.childrenshospital.org/familyconnections*).

**Dr. McCarroll: *You also developed to a program to prevent depression in low-income Latin families (D'Angelo, Llerena-Quinn, Shapiro, et al., 2009). This work addressed many community issues in preventing depression.***

Dr. Beardslee: I had the privilege of working with our team on developing the Latino version of the preventive intervention project, a three year effort. In developing this project, we worked with the Department of Mental Health Services. We carefully reviewed our original intervention methodology, reviewed the applicable literature, conducted focus groups with Latino clients, and then brainstormed what the intervention might look like. Then we actually conducted an open trial of the revised intervention for nine families.

Several things were really striking. One is that overall we were able to adapt the intervention effectively, but we also transformed it. Eight of nine clients were single parents; all were immigrants, many of them fairly recent immigrants. There were many challenges posed by having children who go to school in Boston and speak English in school and having parents who have come from a different country and culture and speak primarily Spanish. Some parents did not speak any English. If you think about having a family meeting where people are more comfortable in different languages, you get some sense of the challenge. It was also really striking how profoundly committed were these Latino clients to their families and, at the same time, how flexible were the members of our team. I am glad we were able to bring it to a successful conclusion.

I am interested in this process because we will face this situation again and again. We will have prevention or treatment interventions or other approaches to improving health that have been developed in English and usually in the dominant culture. Knowing how to apply it to another culture is going to be crucially important because we do not have the time or the resources to develop completely new interventions for each cultural group and, more positively, there is no reason that something that works well in one culture cannot work well in another.

*Dr. McCarroll: There are many interesting clinical implications from the intervention for low-income Latin families that might be generalized to others raising children in a stressful environment. The examples I found applicable are telling personal stories, focusing on resources in addition to depression and parenting, and deciding which concerns are most important to them. This paper also emphasized the importance of resilience. Do you find similar emphasis in the research communities of whose work you are aware?*

Dr. Beardslee: There is a growing awareness that when we talk about risk factors, whether these are the ones I have worked with, poverty and depression or others, we need always to bear in mind that in any population exposed to risk there is large variability in the outcomes. Many people do well despite the risk and those are due largely to protective factors and protective mechanisms. I was a member of an Institute of Medicine (IOM) panel that described the state of current research to prevent mental, emotional, and behavior (MEB) disorders in children and adolescents (O'Connell, Boat, & Warner, 2009). We found that most of the good preventions are built on an understanding of resiliency in people who face the risk condition and master that risk. So, it is much more prominent in the prevention area, but it is also important in many areas of traditional treatment and in the unfolding of various kinds of difficulties. It is vital to recognize that resilience occurs at

four levels: in the individual, in the family, in the care giving system, and in the larger community. There are factors in all four areas that can predispose people to do well even if they face risk or loss of risk.

*Dr. McCarroll: Resilience is difficult to define.*

Dr. Beardslee: That is true. Resilience may look different in different cultures and in different settings. Before we began to develop preventive interventions for families with depression, we did a large study of risk and resilience. We identified three qualities in the kids and one quality in the parents that were both resilient characteristics and amenable to change. On the kids' side, in the face of parental depression, they were able to activity engage in age-appropriate developmental tasks such as going to school or going to church, actively engage in relationships, and have some understanding of the parent's illness. These children did well. Correspondingly, those parents who were committed to being good parents despite the depression also did well. We now understand that there are much fuller and richer ways of understanding resilience. People talk about the capacity to self-regulate and also about dimensions such as having religious faith or having an active imagination. These are all aspects of resilience.

Similarly, we are much more aware of resilience in terms of care-giving systems. For example, there are ways to run public schools and day care centers that are effective and ways that are not. When those settings are well-run, they can do a lot to foster resilience. At the societal level, one of the big issues in mental illness is stigma. You can certainly think about ways that the community can engage in anti-stigma activities. Beyond that, of course, communities also differ in the amount of resources they have and in the resources families can access. We should be thinking about those larger community forces as having an impact on individual lives.

*Dr. McCarroll: It appeared to me that your preventive interventions apply to a number of levels of possible distress or disorder. Is this approach what one might have at one time called primary, either secondary or tertiary prevention?*

Dr. Beardslee: It is a little different. Primary, secondary, and tertiary prevention are the older public health terms. The IOM uses the terms universal, selected, and indicated. These are similar to primary, secondary, and tertiary prevention, but not the exactly the same concepts. Universal means the intervention is for everyone, selected is for high risk, and indicated is for those who are already manifesting some symptoms, but not yet to the level of disease or disorder.

*Dr. McCarroll: This terminology moves away from a disease model to a population model?*

Dr. Beardslee: I think we would say that. The reason that it is interesting is because we do not have a particularly good way of characterizing interventions across more than one generation or for family interventions. The interventions with which we have been engaged are selective preventions for the children in the sense that they are a high risk group and we are trying to prevent the emergence of depression or enhance the development of competence. On the other hand, if the parents are depressed we have included in the intervention helping them get treatment for their depression. Thus, we have included both straightforward treatment, but also added a component to strengthen and focus on their parenting. We think that this also has preventive effects for the kids, but it also has some positive effects on the parents. You might say that in the old model we were doing primary prevention for the kids because we were trying to prevent episodes of depression and secondary prevention for the parents in trying to help their depression get better and avoid complications. It is really more complicated than that, but that is how I see it. So, I prefer the terms universal, selective, and indicated.

*Dr. McCarroll: What do you think could be done on a large scale to build resilience, prevent depression, or otherwise help a population such as Army families who are struggling with managing their family in a stressful environment?*

Dr. Beardslee: That is a good question. In our work we have tried to think about population-based interventions from three points of view. First you have to determine the basic information that somebody might need about depression or about resilience and ways to deliver that information in different doses so everyone can have access to information. A second level would be a lecture-discussion group where people can have more information and then a third level for people who are having more difficulty or for people who are highly motivated. You think about the same principles in different sorts of interventions. For example, in our first major randomized trial for the prevention of depression we used two public health delivery mechanisms that can be widely applied: one was lectures in a group discussion format and the other was five or six sessions with a clinician. Another important point is to construct interventions that can be widely used by a range of disciplines. I think you are raising a question that we need to think much more fully about than we have.

*Dr. McCarroll: As you know, interventions for the military are on a large scale, are generally educational, and have to be fairly simple in order to have*

*fidelity. How would you think about constructing such interventions and for what targets? You probably cannot target everything at one time.*

Dr. Beardslee: I believe that you have to think about two dynamics. One is information sharing. How could you make information available? You could use the Internet to transmit information. We are now in the process of developing web-based training for the family talk intervention for the same reasons you have stated. We talked earlier about the Latino intervention. One of the things that we were very careful to do in that intervention was each time we met with those families, was to ask them, "What are you most concerned with right now?" I think the other side of effective broad public health information campaigns is to be able to time the access to information to what the person is most interested in at that time.

For example, the first aim of psychological first aid is to have that kind of program available at the time that people need it the most: right after the disaster or trauma. In a similar way, people who are raising young children need and want information about how to raise young children at the time they have young children.

**Dr. McCarroll: We have tried to adapt psychological first aid and to expand it from reacting to an acute stressor to building life skills.**

Dr. Beardslee: I think that is very important. You may draw people into a particular educational piece or intervention that is directed toward something that is fairly acute whether it is psychological first aid or getting treatment for a parental depression. But, then you want to use that opportunity to interest people in broader communication skills, healthy habits, stress reduction, and other things that they can do on their own. I think that the work on resilience is crucial because it is an easy way to reach people: "Here are some things that you can do that will strengthen you or strengthen your family or strengthen your children." This is preferable to threatening them by saying "Here are some things that if you don't do them there will be bad outcomes." People are going to respond and take more in when the risk is acknowledged, not minimized, but also when there is discussion of the positive aspects.

**Dr. McCarroll: You can think of all sorts of creative ways people could use the Internet. These may be more beneficial than an in-person program because people can work at their own speed and review the material again and again. I think that is the way to go on a lot of this material.**

Dr. Beardslee: I agree. Given the amount and volume of material that we are all dealing with, it makes a whole lot of sense to work when your time allows and at your own pace.

In the broader context of prevention research and evaluation, I mentioned the work I have been involved in with the Institute of Medicine (IOM). Periodically, IOM committees review a particular area of research or practice and write a report that has findings, conclusions, and recommendations. I was on the Board of Youth and Families and on two of their committees. One committee evaluated the prevention of mental illness in children and the other focused on parental depression. The approach has a very strong developmental perspective. We talk about risk and resilience across the span of childhood.

The Substance Abuse and Mental Health Services Administration (SAMSHA) has a website called the National Registry of Effective Programs (*http://www.nrepp.samhsa.gov*). Submitted material is reviewed and scored on a ranking scale in terms of the evidence. The committees usually used the standard of multiple randomized trials as the highest level of evidence, but there are many situations in which you cannot do that. One of the striking findings is that prevention science is much better than it used to be.

*Dr. McCarroll: Are you familiar with the U.S. Preventive Services Task Force http://www.ahrq.gov/CLINIC/uspstfix.htm/? It is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. An example of a preventive intervention that has been shown to be of high value in preventing injuries is the use of seat belts.*

Dr. Beardslee: I am familiar with that process. We have been trying to get CDC to take on surveillance in mental illness prevention. Trying to apply some of the processes and findings from the prevention of physical illness to mental illness is a really good idea.

*Dr. McCarroll: I have always thought that the individual is a mix of resilience and vulnerabilities, but I think that teaching and even clinical work may in fact tend to focus on one of those. Do you think there is any model that might be able to combine those two?*

Dr. Beardslee: I think they have to. A dynamic balance or interplay is really important. In the IOM report we talked again and again about developmental transactions. This requires some knowledge of the individual, knowledge of the surround, and of the interaction and it involves a resiliency perspective.

*Dr. McCarroll: So much of your work has ties to other areas such as adverse childhood experiences. How do you deal with them as risk factors in your*

*work, particularly on depression and on later development?*

Dr. Beardslee: We do consider that, but I would go further. The prevention of depression and its risk factors fall into two broad classes. One category is the specific risk factors for depression, such as having had a prior depression, having a family history of depression, or bereavement and loss. But, there are also non-specific risk factors such as poverty, exposure to violence, social isolation, and various forms of family difficulties. You get depression on the one hand with either class of risk factors, but you can also get depression through their interaction. After all, depression is almost always some combination of vulnerability and an adverse current event whether it is divorce or failure of some sort. So, when we think about the comprehensive prevention of depression, we also need to address both sets of risk factors, but in somewhat different ways. For the children who have parents who are depressed, we know a fair amount about the specific risks so we can mount specific preventions, but we also have to think about such factors as decreasing poverty and decreasing abuse and neglect in childhood because those are potent factors for poor outcomes in a variety of ways in adulthood. I think there are some things we can do about that.

*Dr. McCarroll: Do you think that your programs and your clinical interventions require a threshold level or can it apply to depression at a variety of levels?*

Dr. Beardslee: I think they can be applied at a variety of levels. We worked on depression because we thought that starting with something specific, something treatable, was a better approach than trying to address all the different risk factors at once. But, we have always done depression plus, which means depression and whatever goes along with it whether that is alcoholism or anxiety disorders or whatever. I think the answer to your question is that we are coming to more general perspectives based on building from the experiences with specific interventions. Here is one example. In the IOM report we make the point that if you look across a variety of intervention programs, you find very strong support for programs that enhance parenting. So, you can make the argument that we need to think about how to enhance parenting generally. Then you can select, depending on the particular situation, the dimension that you want to work on. Let me take it back to the military. Right now, we have a very large number of young soldiers and young families. These are people who join the military right out of high school or not too long thereafter. They tend to marry young and raise children. Therefore, it is a real opportunity to try to get some kind of parent education and preventive services to these families.

*Dr. McCarroll: Would you comment on the applicability of your work to PTSD?*

Dr. Beardslee: We have dealt with a number of people who have had both depression and PTSD. We did not exclude people who had both diagnoses. It is really striking to me that after the Oklahoma City bombing the rate of PTSD went up, but so did the rate of depression. Trauma can trigger depression as well as PTSD. The second point is that in our work, we have found that a narrative, talking about the experience one has gone through and mastering it, has been very important. This has certainly also been very helpful in working with families exposed to trauma and I think a family narrative is a useful approach. I have been involved with a new intervention, the FOCUS Intervention, which combines elements of the Family Talk Intervention with work by Mary Jane Rotheram Borus and Patricia Lester on families with AIDS and work by Bob Pynoos and Bill Saltzman on trauma. It is an intervention devised for military families facing multiple deployments and does have a strong narrative component.

*Dr. McCarroll: We all have a lot more work to do. Thank you for your contributions to mental health intervention and for this interview.*

Dr. Beardslee: You are welcome. I enjoy getting the word out on our work.

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**Key Points**

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Knowing how to apply a prevention or treatment intervention to improving health that has been developed in English and apply it to another culture is going to be crucially important because we do not have the time or the resources to develop completely new interventions for each cultural group. Most of the good preventions are built on an understanding of resiliency in people who face the risk condition and master that risk.

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It is vital to recognize that resilience occurs at four levels: in the individual, in the family, in the care giving system, and in the larger community. There are factors in all four areas that can predispose people to do well even if they face risk or loss of risk.

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In the face of parental depression, we identified three qualities in kids that were both resilient characteristics and amenable to change:

■ They were able to activity engage in age-appropriate developmental tasks such as going to school or going to church,

■ Actively engage in relationships, and

■ Have some understanding of the parent's illness.

■ These children did well.

■ Parents who were committed to being good parents despite the depression also did well.

The prevention of depression and its risk factors fall into two broad classes: specific risk factors for depression, such as having had a prior depression, and non-specific risk factors such as poverty and various forms of family difficulties.

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**BACKGROUND OF RESEARCH OF CHRISTOPHER M. MURPHY, PHD**

# Alcohol and Interpersonal Violence

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 10, Issue 4, September 2008*

The research of Dr. Murphy and colleagues has focused on the relationship of alcohol consumption to interpersonal violence (IPV). The studies reviewed here examine many of the risk factors associated with IPV and alcohol misuse.

In a study of partner violent and nonviolent alcoholic men, the partner-violent alcoholic men had more antisocial personality traits, greater alcohol problem severity, greater use of other drugs, higher relationship distress, and stronger beliefs in the relationship between alcohol drinking and relationship problems. Relationship distress and alcohol problem severity were independently associated with partner violence (Murphy, O'Farrell, Fals-Stewart, et al., 2001). The number of drinks consumed by the alcoholic husband in the 12 hours prior to a physical assault incident was significantly higher prior to violent compared to non-violent conflicts (Murphy, Winters, O'Farrell, et al., 2005).

In another study, rates of domestic violence by alcoholic men were compared before and after alcohol treatment. In the year before treatment, 56% of the alcoholic men had been violent toward their female partner (O'Farrell, Fals-Stewart, Murphy, et al., 2003). After treatment, partner violence in the alcoholic sample decreased to 25%, but remained higher than the comparison group (14%). Among alcoholics whose alcoholism remained in remission, the prevalence of violence was reduced to a level (15%) that was nearly identical with the non-alcoholic comparison sample.

Greater drinking by wives prior to violent conflicts has also been observed. Women in addiction treatment programs reported a high level of both victimization and perpetration of violence. They committed more vio-

lent acts and were more likely to commit severely violent acts than the men in these couples (Chase, O'Farrell, Murphy, et al., 2003).

Finding successful treatment for substance abusers has also been a focus of the research of Dr. Murphy and colleagues. Recent studies have found that behavioral couples therapy, an intervention that emphasizes sobriety, teaches communication skills, and increases positive activities has strong research support in improving relationships and decreasing domestic violence (O'Farrell, Murphy, Stephan, et al., 2003).

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**Key Points**

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In a study of partner violent and nonviolent alcoholic men, the partner-violent alcoholic men had more antisocial personality traits, greater alcohol problem severity, greater use of other drugs, higher relationship distress, and stronger beliefs in the relationship between alcohol drinking and relationship problems.

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The number of drinks consumed by the alcoholic husband in the 12 hours prior to a physical assault incident was significantly higher prior to violent compared to non-violent conflicts.

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Alcoholics in remission had about the same prevalence of violence (15%) as the non-alcoholic comparison sample.

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Greater drinking by wives prior to violent conflicts has also been observed. Women in addiction treatment programs reported a high level of both victimization and perpetration of violence.

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INTERVIEW WITH CHRISTOPHER M. MURPHY, PHD

# Domestic Violence and Alcohol Misuse

*By James E. McCarroll, PhD*
*Joining Forces Joining Families Volume 10, Issue 4, September 2008*

*Dr. McCarroll: Please tell us about your center for domestic violence counseling and your research on the relationship between domestic violence and alcohol use.*

Dr. Murphy: I have an appointment at the University of Maryland, Baltimore County (UMBC) and I also help coordinate a community-based counseling program for domestic violence offenders in Howard County, Maryland. About 80 to 100 abusive individuals come through our counseling program each year. My clinical work has been mainly in domestic violence treatment. I also collaborate with people in the VA system whose primary expertise is in substance abuse.

*Dr. McCarroll: People can be referred for treatment for violence or for alcohol abuse. How well does each program screen for the other problem and how well do they work together?*

Dr. Murphy: Surveys in both of those areas have shown that there is tremendous variation in the extent to which each program assesses for the other problem. There are some theories that help to explain why this is the case. In domestic violence, it has traditionally been thought that substance use is viewed as an excuse rather than a contributing factor and certainly not a cause of violence. Because of that, some domestic violence programs have rejected the idea that they can do much about the substance abuse or they have said that substance abuse is not something that they handle in their program. In the substance abuse field, there is a traditional belief that once the addiction is cured, all other aspects of one's life will start getting back on track.

*Dr. McCarroll: How would you advise a clinician working in the domestic violence field to assess for the involvement of alcohol misuse or abuse in domestic violence?*

Dr. Murphy: There are several methods that are very helpful. One is to use a general screening tool such as the AUDIT (Alcohol Use Disorders Identification Test) (Saunders, Aasland, Babor, et al., 1993). [Editor's note: The CAGE is also used for screening for problem drinking (Buchsbaum, Buchanan, Centor et al., 1991).] Although the AUDIT detects early signs of

alcohol dependence, we have found that it misses a lot of people who were intoxicated at the time of an abuse incident. The approach I take is to go over details of conflicts where there has been abuse and ask the person whether they had had anything to drink or were using any drugs at that time. We also ask how often they drink and how much they typically drink on weekdays and weekends to screen for unhealthy levels of alcohol consumption.

*Dr. McCarroll: If you find somebody who has a high level of drinking, but they were not drinking during the incident, what do you do with that information?*

Dr. Murphy: It is still valuable for them to have some type of intervention for a couple of reasons. First, they might be doing damage to themselves or others through that level of drinking. Second, their drinking may interfere with their getting benefits from domestic violence counseling.

*Dr. McCarroll: Is the person who drinks moderately more likely to be involved in domestic violence than one who does not drink?*

Dr. Murphy: There is no good evidence to that effect. It is binge drinking and chronically high levels of alcohol consumption that are associated with domestic violence. There are two different patterns of drinking among those with serious alcoholism: stable and unstable drinking. Unstable drinking applies to people with serious alcohol problems who do not drink the same amount every day, or may not drink every day, but who drink quite excessively at times. They also tend to drink outside the home. Stable alcoholic individuals tend to drink at home, every day, in roughly the same amount. We have found that domestic violence is more common among those with unstable drinking patterns. In our studies of persons with severe alcohol problems we have found that if they are able to achieve stable recovery or remission from their problem drinking, their domestic violence rates substantially decline and their level of risk looks fairly similar to demographically matched people in the population who do not have alcohol problems. This suggests that stable remission of drinking is a major protective factor against further domestic abuse.

However, risks may still exist. One risk is the limited success of alcohol treatment. People with antisocial personalities and longer histories of substance abuse tend to have poorer outcomes in addiction treatment. They might have continued risk for partner violence because they are less likely to remit in their substance abuse. It is also possible that even when they overcome their substance abuse they will continue to be controlling or abusive in their relationships due to generalized tendencies toward anger and violence.

*Dr. McCarroll: What are some differences between the populations seen in domestic violence treatment and those in alcohol treatment?*

Dr. Murphy: The vast majority of people in domestic violence treatment are court-mandated whereas alcohol programs have tended to be primarily voluntary or have a mix of mandated and voluntary clients. In actual practice, a lot of people in court for alcohol problems do not get referrals for domestic violence even when there is evidence or testimony that they have both problems. However, when domestic violence offenders are referred to addiction treatment programs, those programs would not always view the domestic violence client's drinking problems as warranting substance abuse services. For example, domestic violence offenders may not have many negative consequences of their substance abuse other than its negative effects on their family relationships. Also, substance abuse programs do not necessarily gather information from the relationship partner about substance abuse and violence.

*Dr. McCarroll: What are the goals of most substance abuse programs?*

Dr. Murphy: Abstinence is the goal for people with significant substance dependence disorders. Once they have a certain level of alcohol problems, it is unlikely that they could drink in a controlled fashion. There are also binge drinkers who come to domestic violence programs. They may get into trouble when they binge drink, but not have symptoms of alcohol dependence. Non-abstinence might be a reasonable goal for those individuals if they can regulate their drinking and have harm reduction as a goal.

*Dr. McCarroll: Do you find common barriers to treatment in most domestic violence offenders?*

Dr. Murphy: The first barrier is blaming the partner for the difficulties and problems and being very frustrated and angry at the system that put them there. Clients feel like they have been railroaded or they did not get a chance to have their part of the story heard by the police or the courts. It is often very hard for them to look at their own behavior.

*Dr. McCarroll: Many states mandate lengthy domestic violence treatment programs, six months and more. In the military, that option is limited by the frequency and length of deployments. What is the length of time necessary for an effective treatment for violence and for alcohol abuse?*

Dr. Murphy: In substance abuse, some brief interventions have good outcomes, particularly motivational enhancement therapy where the goal is to stimulate the individual to a self-directed change process. In the domestic violence field, we are still struggling to clearly identify effective interven-

tions. There is a general clinical sense that we need to see people for at least a few months to try to understand their problems and to give them some skills to supplant their abusive behavior. There is not much evidence to suggest that a one-year program is better than a six-month program or that a six-month program is clearly better than a three or four-month program.

**Dr. McCarroll: What is the distinction between motivational therapy and cognitive behavioral therapy?**

Dr. Murphy: Motivational therapy is less directive than cognitive behavioral therapy. It uses more reflective listening and focuses on the issues of why someone would want to change, the barriers to change, developing a plan for change, and stimulating movement through the stages of change. A lot of the original motivational interviewing is based on the five stages of change model (Prochaska, DiClemente, & Norcross, 1992). Motivational interviewing emphasizes a self-directed change process. Cognitive behavioral therapies tend to focus on the active ingredients of change. Once someone is motivated to change, they need to alter their thought processes and learn new behaviors such as example strategies to handle relationship disagreements and conflicts more constructively. We have studied motivational therapy as an early intervention for domestic violence offenders. A lot of clients are resistant when they show up for treatment and hostile toward the system and the treatment providers. We need a clinical strategy to get them past that initial resistance and hostility in order to open them up to some of the subsequent interventions that are more cognitive and behavioral. You may have the best cognitive behavior therapy in the world, but people are not going to benefit if they do not practice the listening and communication skills taught in the treatment.

**Dr. McCarroll: Can you use the stages of change model in both the domestic violence and alcohol fields?**

Dr. Murphy: Yes. It was originally developed in the addictions field. The model fits well for stopping smoking. It gets more complicated when you apply it to domestic abuse because you have another person involved in the relationship and a complex set of behaviors that might involve control, emotional abuse, physical assault, and other kinds of difficulties so it is not as simple to conceptualize as smoking.

**Dr. McCarroll: Do you think that a clinician can function effectively addressing both violence and alcohol misuse?**

Dr. Murphy: Yes. It would require evaluation of some of their assumptions. People in the domestic violence field might have to reevaluate some

of their thoughts like substance abuse is just an excuse for violence and by acknowledging that it might contribute directly to people's bad judgment and impulsive behavior. People on the substance abuse side might have to reevaluate the extent to which they believe that family relations may play a role in someone's addiction and not just think that all their clients' problems are as simple as a secondary consequence of their substance abuse. A lot of the clinical and counseling skills would be very similar in both these areas.

***Dr. McCarroll: Thank you for your insights.***
Dr. Murphy: You are welcome.

**Key Points**

There are two different patterns of drinking among those with serious alcoholism: stable and unstable drinking.

Binge drinking and chronically high levels of alcohol consumption are associated with domestic violence.

Stable remission of drinking is a major protective factor against further domestic abuse.

Some common barriers to treatment in most domestic violence offenders are blaming the partner for the difficulties and being very frustrated and angry at the system that put them there.

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REVIEW OF RECENT RESEARCH OF CHRISTOPHER M. MURPHY, PHD

# Review of Associations between Alcohol Use and Interpersonal Violence

*By James E. McCarroll, PhD*
*January 2010*

Dr. Murphy and his colleagues have continued to explore relationships between substance use (primarily alcohol) and intimate partner violence (IPV). It is well known that men with alcohol problems have a higher prevalence of IPV than non-abusing men (Leonard, 2005) and that alcoholism treatment lowers violence prevalence (O'Farrell & Murphy, 1995). A recent study of treatment-seeking female alcoholics and their male partners who received 5-6 months of behavioral couples therapy (BCT) found that IPV prevalence decreased significantly (31%) for the female patients compared to pre-treatment levels (68%). In yearly follow-ups, 45% of patients with violence were remitted at year 1 and 49% at year 2. In year 1, the violence prevalence among remitted female alcoholics was 22% whereas among the relapsed patients it was 38%. Year 2 results showed that the post-treatment reductions were stable: violence prevalence for remitted patients was 19.5% versus 29% among relapsed patients. They also found that male perpetrated IPV decreased after behavioral couples therapy (BCT).

The authors discussed the need for further study necessary to understand the basis of the reductions in IPV for alcoholic men and women and for their partners. The fact that reductions in IPV occurred even among the relapsed group suggests that there may other avenues by which BCT reduces violence other than through reducing substance abuse. Another suggestion was to find whether the BCT procedures aimed at improving communication and conflict resolution might impact the reduction in IPV in addition to the procedures directed at sobriety. In addition to other suggestions, future research might assess whether verbal interactions or arguments between the partners over drinking and problems related to drinking lead to escalation of violence and the nature of their violence. This type of investigation was termed contextualizing the violence.

The association between IPV and substance use problems is a critical issue for both study and practice. Murphy and Ting (In press) reviewed research on the prevalence of IPV before and after substance abuse treatment and among remitted and relapsed cases after treatment. Their review pro-

vides the results of a wide variety and large number of studies of the relationship between IPV and substance use. Some of the most important findings are summarized here.

- The annual prevalence rate of IPV was about three times higher among those who binge drink compared to abstainers (Kaufman-Kantor & Straus, 1987).
- Among newlyweds, alcohol use predicted male-to-female IPV independent of other risk factors (Leonard & Senchak, 1996).
- The general increase in IPV rates for those with alcohol problems is evident across ethnic groups (Cunradi, Caetano, Clark, et al., 1999).
- The risk of IPV is about double among those in the upper half of the distribution of alcohol consumption compared to those in the lower half (Lipsy, Wilson, Cohen & Derzon, 1997).
- High rates of IPV have also been found in treatment-seeking populations with alcohol abuse or dependence (see, for example, O'Farrell, Murphy, Stephan, et al., 2004).
- Similar results have been found in persons in domestic violence counseling programs. In one study, about 25% of persons in an IPV programs met the diagnostic criteria for alcohol abuse or dependence (Winters, 2005).
- Substance abuse predicts lower attendance and poorer engagement in IPV counseling (Ting, Murphy, Jordan-Greene, et al., 2009).
- Follow-up of persons who participated in IPV counseling found that those who reported frequent binge drinking were over three times more likely to re-assault a domestic partner and those who were drunk nearly every day were 16 times more likely to re-assault (Jones & Gondolf, 2001).

Murphy and Ting's review examines the effect sizes for the reductions in partner violence (physical and psychological) before and after treatment for alcohol problems. [*Editor's note*: Effect sizes were calculated as the mean difference from pre-treatment to follow-up divided by the pooled standard deviation of the two estimates, which takes the variability of the two estimates into account in the calculation of the effect size.] For physical assault, the reduction in the effect size for both male-to-female and female-to-male violence was small to moderate. [*Editor's note*: Husbands were the identified patients, not the wives.] The effect sizes for both partners for the reduction in psychological aggression were large, considerably greater than for physical assault.

For all studied reviewed, IPV was higher for relapsed cases. The risk of husband-to-wife assault was two to three times greater than for remitted

cases. These differences held for two years of follow-up.

In spite of the convincing findings of the relationship between IPV and substance abuse (primarily alcohol), Murphy and Ting cite many remaining unanswered questions. In several of the studied reviewed here, behavioral couples therapy (BCT) has been used to treat the substance abuse patient (usually the husband) (see, for example O'Farrell et al, 2004). The study by O'Farrell and colleagues (2004) found that enhancement in relationship functioning and reductions in alcohol consumption accounted for reductions in IPV after treatment. Nevertheless, questions remains regarding whether the reduction in IPV is due to relationship enhancement, reducing substance abuse, or to other aspects of change. Another subject of research may be to measure aspects of relationship violence not typically measured such as forms of controlling, coercive, and emotionally abusive behaviors. This suggests the need for further research on the changes in dyadic relationships that need to be addressed during treatment and how these changes may be manifested following treatment.

Finally, there is a need for integration of treatment of substance abuse and IPV as well as how to incorporate treatment for both partners of a relationship. As Murphy and Ting point out, both of these approaches are controversial. However, as shown by this review, much progress has been made in the understanding of the relationship between IPV and substance abuse.

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**Key Points**

- Men with alcohol problems have a higher prevalence of IPV than non-abusing men and alcoholism treatment lowers violence prevalence.

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SECOND INTERVIEW WITH CHRISTOPHER M. MURPHY, PHD

# Domestic Violence Counseling: Men, Women, and Substance Abuse

*By James E. McCarroll, PhD*
*January 2010*

**Dr. McCarroll: *In your last interview we talked about your work in domestic violence counseling. Many of your clients are court-referred for domestic violence and some of them also have substance use problems. Is that correct?***

Dr. Murphy: That is correct. I work mostly in a site in Howard County, MD. The vast majority of folks are court-ordered to treatment for partner violence. Some of them also have substance use problems. My background is in the field of domestic violence treatment. Some of my colleagues have done more research in substance use research, so we work collaboratively on a lot of these projects.

**Dr. McCarroll: *Are you starting to see more court-referred female domestic violence offenders?***

Dr. Murphy: We do have a small program for women who are court-ordered for partner violence. We tend to work with them separately from men. Some programs combine them, but that approach is controversial.

There is some sensitivity in the field as to whether some of the women we are treating may also be victims and whether they would have a difficult time being in a group with men. The tradition has been to hold separate groups for men and women. However, many of the same issues seem to come up in these groups. For example, there are very consistent problems in relationships, negative attitudes about the other gender, communication issues, poor listening skills, and poor problem solving skills. There are some other things that might be a little different. There might be differences in their willingness to talk about their histories of victimization. A lot of the women we see have histories of abuse in their own background. Many of the men do, too, but it tends to be discussed more openly in the women's groups.

The theories about the treatment of partner violence grew out of the battered women's and shelter movements. They were very much feminist-oriented in their perspective. The tendency has been to see issues of power and control and gender oppression as being very wrapped up in the whole problem of partner violence. So, a lot of the programs for men who are abusive involved a large component of looking at gender roles, gender attitudes,

and similar kinds of processes as promoting the controlling behaviors that lead to the abuse of women.

### Dr. McCarroll: Do you still follow that model?

Dr. Murphy: To some extent. My personal perspective is that violence in relationships is more equal than some of those theories would maintain. We now have good evidence that violence is common in lesbian and gay male relationships where the gender roles and dynamics would be expected to be different. Also, a lot of women are physically aggressive and assaultive with men. The perspective also depends on whether you look at the actual behaviors like slapping and pushing and shoving or whether you look at the effects of those behaviors in producing fear and injuries. When you look at the actual behaviors themselves you find a lot more gender equality in the prevalence of violence by men and women; when you look more at the effects of the behavior you tend to find more gender disparity. Another way to look at gender differences in aggression is to look developmentally at girls and boys where there is a big difference in aggressive and violent behavior. Boys are more aggressive in general than girls, but intimate relationships are the one area where we tend to see more gender parity in aggressive behaviors.

### Dr. McCarroll: Would you say that the need to exert power and control occurs in both genders?

Dr. Murphy: No. I would not necessarily say that. I think there are social and historical traditions that support men in feeling dominant and exerting a need for power and control, which is part of the feminist analysis of spouse abuse. But, there are other things that go wrong in relationships as well and contribute to abuse. A lot of what we look at and treat in domestic violence also includes inadequate self-regulation of emotion, impulsive behavior, poor communication, and poor problem solving.

I think the feminist theory might not be a complete analysis or fully applicable in all situations. These other problems that can lead to violence are also important, but are not well characterized by a power and control model.

### Dr. McCarroll: Do you see power and control issues by women?

Dr. Murphy: To some extent. There's a lot of variation within the population of women with whom we work. You could call their behavior controlling because it often involves things like intense jealousy and checking up on the partner. Some of those behaviors look very similar for women and men who are abusive, but some things look different. For example, women are more likely to describe their aggression as a way to communicate intense

frustration and anger. Sometimes it does not look so much like control as in forcing the other person to do what you want, but more a way of getting the point across of how upset the individual is. Although these things occur in both genders, we tend to see more of a tendency for women to use violence to vent frustration and anger and more of a tendency for men to exert dominance and control.

**Dr. McCarroll: To what extent do you focus on psychological aggression?**

Dr. Murphy: That is a very common part of almost all treatment programs for partner violence. We have to realize that the physical assault is just the tip of the iceberg. It is very important to help people become aware that they are also emotionally and psychologically abusing their partners and to have a clear sense of how this damages their relationship. Working on these more subtle forms of abuse also helps identify the need for enhanced communication and problem solving.

**Dr. McCarroll: Do you have a sense that the psychological violence is seen as harmful by your clients?**

Dr. Murphy: At the time that people describe these things, they sometimes seem immune or inured to their effects. However, if you interview formerly battered women after they have gotten out of their abusive relationships and ask them what was the most hurtful or damaging part of what they experienced, over three quarters of them say it was the psychological and emotional abuse more than the physical violence. Actions and words that are denigrating and humiliating are very common in abusive relationships and often produce more lasting emotional scars than physical violence. These attacks on self-esteem often leave the partner feeling very bad about themselves and can be very difficult to recover from.

We try to help people understand their underlying motivation for doing those things and try to figure out how they can cope with their own emotions and their relationship issues without needing to resort to words and actions that are hurtful, intimidating, or denigrating to the partner.

**Dr. McCarroll: Do you treat couples?**

Dr. Murphy: We occasionally do couples work, but only after the abusive partner has been through individual work to help them identify and address their controlling and abusive behavior.

**Dr. McCarroll: In your last interview you also talked about your work in domestic violence counseling and also about the relationship of substance abuse to domestic violence. Please discuss the differences between drug use**

*and alcohol use and how they relate to intimate partner violence (IPV).*

Dr. Murphy: Most of the research on drug treatment is on what we used to call hard drugs, specifically with people who are dependent on cocaine, heroin or other opiates or amphetamines. Drugs of that sort tend to be much more commonly the focus of treatment. Most of the research looks at a variety of different substance abusers. Of course, most people who abuse drugs sort are not abusing just one substance, but there are poly-substance problems.

### Dr. McCarroll: Is marijuana in the picture in terms of interpersonal violence?

Dr. Murphy: There are mixed findings. Laboratory research does not suggest that marijuana intoxication increases aggressive behavior. However, some studies find an association between marijuana abuse and partner violence. We have explained this finding through a general deviance model. In this model, folks who are prone to abuse a variety of substances, including marijuana, tend to have more impulsive behavior and anti-social characteristics and are therefore also more likely to be violent. But, in terms of the specific day-to-day associations between drug use and violence, what we know so far is that the stimulant drugs, particularly cocaine and amphetamines, seem to be linked more with the day-to-day tendency to be violent as compared to sedative drugs and marijuana.

The acute use of the opiate drugs tends not to be associated with an increased risk of violence. But, people who abuse drugs like heroin may be violent or engage in criminal activities in order to obtain money to get the substances. I am making a distinction here between the acute effects of the substance versus the general lifestyle problems that often go along with drug abuse. Stimulant drugs and alcohol have been much more specifically linked to violent behavior than some of the other drugs of abuse including marijuana and opiates.

### Dr. McCarroll: Do you see differences in the behavior of male and female alcoholics?

Dr. Murphy: There are some differences that are fairly well known at this point. For example, there are different patterns of onset of alcohol problems. Men are more likely to have an early onset that starts in adolescence and is correlated with antisocial and violent tendencies, whereas women are more likely to have a later onset in early to middle adulthood that is correlated with stress and trauma exposure. This latter pattern may be seen as drinking in response to life's problems and stresses. Both patterns occur in both genders, but the early onset antisocial pattern is much more common in men than women.

Another gender difference in alcohol problems is called a telescoping process where the time between the initiation of heavy drinking and the development of complications and problems with alcohol seems to be shortened for women. This might be due to differences in tolerance for alcohol or biological differences, but it does seem to be the case that men often consume unhealthy amounts of alcohol over longer periods of time before developing signs of dependence and life complications.

There are many different typologies of substance abuse problems, but no universally accepted statistical method for subtyping. Different methods come up with different groups. It also depends on the variables used to subtype individuals. For example, one might find different subgroups by looking at age of problem onset, correlated emotional and psychological problems, life stressors and living conditions, or the specific patterns of substance abuse. As research progresses my guess is that genetics will become an important element of that work, and that research will identify certain risk genes and then combinations of those genes with life experiences that lead to substance problems, but we are not at that level of understanding yet.

***Dr. McCarroll: In your recent paper (Schumm, O'Farrell, Murphy, et al., 2009), you talked about the need to contextualize violence. Would you explain what you mean by that?***

Dr. Murphy: The general issue involves the association of situational factors in the perpetration of violence. There is a tendency in the domestic violence field to think about men as always being perpetrators and women as always being victims or recipients of abuse. However, survey data in partner violence research shows that abuse is often mutual and that women perpetrate aggression in relationships. That raises questions: whether the violence has the same intention and whether it occurs under the same sorts of circumstances and conditions. For example, to what extent is violence in self-defense or reactive to the other person's aggression or is it pro-active in nature. So, there are questions about whether women's aggression is similar in motivation and effect to men's aggression.

Part of the issue about contextualizing our understanding of violence has to do with the extent to which both relationship partners have substance use problems versus only one of them. Most of the studies that have been done in this field look at couples where only one person is an identified drug or alcohol dependent individual and yet in the real world, there are a lot of couples where both partners are drug or alcohol-dependent. We have not adequately studied some of these patterns.

There is some evidence that there is more assortative mating in this area for women. People who abuse substances tend to find others who also do,

but that seems to operate even more for women. Women who have severe substance abuse problems are quite likely to be in relationships with men who have them also. When men are alcohol or drug-dependent, it is fairly common for them to have partners who do not abuse substances. These partners often fit more of a caregiver model of someone who is taking care of the substance-abusing man and often taking care of the household chores, childrearing, and family finances as well.

**Dr. McCarroll: Let's talk about treatment. I assume that your treatment is primarily with IPV clients some of whom have alcohol problems and some do not. How do you sort them into treatment groups?**

Dr. Murphy: In treating IPV clients, we tend to use adjunctive treatments for the substance users. Most commonly, the client receives both substance abuse intervention and group treatment for partner violence. However, in the alcohol field, traditionally, problems like partner violence have been largely ignored or not directly addressed in most treatments. We have found that even if IPV is not addressed directly in the substance abuse treatment, there is still a substantial reduction in violence associated with successful substance abuse treatment. The philosophy there has typically been that you treat the substance abuse problem and then other life issues like family difficulties, relationship difficulties, and employment problems stabilize. There is a lot of evidence that this is actually a reasonable model. Although improvements are not inevitable in all areas of life, with the resolution of substance dependence, other aspects of life start normalizing over time and substantial improvements in life functioning and resolution of difficulties are very common.

In our IPV group we discuss substance abuse. Everybody gets some education and basic information, but we do not think that that is a sufficient intervention or treatment for those with substance use problems. We want someone to get additional help with that. We have also experimented with brief alcohol interventions which we deliver before someone goes into the domestic violence treatment program. We have found that we can get some substantial reductions in alcohol consumption from those brief interventions either based on motivational interviewing or based on an education model.

**Dr. McCarroll: How is the alcohol treatment structured?**

Dr. Murphy: Typically, we would have it start either before the person starts the domestic violence program or at the same time. Part of what we have been working on is addressing alcohol problems for people who have partner violence, but who do not fit well into traditional addiction programs

because the level of substance abuse and dependence is not as high as what they are used to treating. These individuals may not meet all the criteria for diagnosis, but yet they might binge drink on occasion and get into fights with their partner when they are drinking. So, one question of our ongoing research is whether these individuals can benefit from less intensive interventions than are normally provided in substance treatment facilities, and whether they can exercise better control over their drinking and reduce the risk of alcohol-related violence. These are things we are studying right now, but we do not have answers yet.

*Dr. McCarroll: Is there a particular time period for the alcohol treatment?*

Dr. Murphy: That varies a lot depending on the program and the expectations for the treatment. It also varies with the severity of their problem.

*Dr. McCarroll: How should IPV and alcohol counselors communicate?*

Dr. Murphy: The more that those efforts can be integrated, the better. It is good for people to work closely together and to share perspectives with one another. That is especially true in this work because there is such a big disparity between the two fields as to how these problems tend to be viewed.

*Dr. McCarroll: Do you have outcome criteria for the alcohol counselor before a client can go into IPV counseling?*

Dr. Murphy: No. Not typically. We do not expect that any treatment is going to work all the time. The issue for me is always whether clients are in a state of mind or have problems that make it very unlikely that they will benefit from the IPV treatment program. If they have co-occurring problems like drug or alcohol dependence, we have found that they are unlikely to complete our program, unlikely to be compliant with program activities, and less likely to benefit from it. Their outcomes are likely to involve continued violence if those other problems are not addressed. So, for us the criterion for being in our program is that we want the person to have some chance that the program will be successful in helping them to end their violence and abuse. Therefore, we require them, as a condition of treatment, to address problems that are likely to impede progress. That is true for major psychiatric conditions as well as substance dependence. But, it is not true for more minor problems. For example, if they have social anxiety or mild reactive depression we are not going to say, "You have to have that treated to be in our program." because we do not think those problems will necessarily impede their ability to benefit from our treatment. We may recommend other services, but not require them.

*Dr. McCarroll: I can see how the motivational interviewing and motivation-*

*al therapy would fit into determining how you evaluate and treat clients.*

Dr. Murphy: The real key there is to see if you can help people identify intrinsic motivations that they have to want to work on these problems and change their behavior. This is true both in the partner violence and substance abuse areas. The more you can get someone to really take a serious look at those issues and start developing some motivation to change and to have good compliance with treatment, the better the outcome.

**Dr. McCarroll: Are your counselors trained in motivational interviewing? How long do you think it takes for people to acquire that skill?**

Dr. Murphy: A training plus consultation model seems to be the most successful in imparting the motivational interviewing skills. That model is actually true for a lot of skill training. If you just do a one-shot workshop I do not think that people necessarily acquire the clinical skills. They might acquire some knowledge and information, but the how-to piece also needs ongoing support and training over time. The other piece that I would just mention is that there are individual differences among therapists in terms of how easy it is for them not to be directive. Motivational interviewing is not as overly directive as a lot of other types of therapies such as cognitive-behavior therapy, for example. Some folks have a hard time getting over the initial hump of shifting their habitual reactions in the counseling session. The biggest problem for many people is to learn to have high levels of empathic reflection. As you know, that is the first thing that you learn in any counseling or helping skills class or program, but it is the hardest skill for many professionals to practice consistently.

You also have to be clear that motivational interviewing is mostly geared to helping people to become prepared to change. It is not necessarily the clinical technique that is necessary to actually help people to accomplish change in a longer term treatment.

**Dr. McCarroll: Then you have to know when to switch models.**

Dr. Murphy: Yes. That is an area where we really do not have much knowledge about how to integrate motivational interviewing with other therapies, like cognitive behavior therapy, and how to help therapists learn to know when to switch modes. That is a very interesting and challenging topic for those of us who are training therapists. This is particularly true when working with difficult, resistant clients. But, my sense from our research is that the big thing that motivational interviewing does for domestic violence offenders is to diffuse their hostility toward coming into treatment. It really takes the wind out of their sails and helps them leave in a state where they are not angry and frustrated and they feel understood. Once you get

over that initial hump you often have an opportunity for some openness and they stand a better chance of benefiting from the treatment program. If you do not get over that hump then you often get stuck in their rejection of whatever the treatment program has to offer.

**Dr. McCarroll: What differences have you seen between relapsed and remitted patients alcoholic clients?**

Dr. Murphy: From the results across a whole series of studies, we know that that those who relapse to their substance abuse after treatment have considerably higher rates of partner violence than those whose substance abuse problems remit stably. That is a very consistent finding. There is a big difference between those two groups over time. For example, in studying just domestic violence treatment programs, ongoing abuse of alcohol is a major predictor of recidivism of violence. Ongoing abuse of alcohol appears to be a major risk factor for partner violence recidivism whether the individual is initially referred for treatment of substance abuse problems or partner violence.

**Dr. McCarroll: How you determine if clients will nor will not be successful in treatment?**

Dr. Murphy: We have not found anything that is particularly useful in that regard. That is a good news story in some ways because I do not think there are any factors that would say that you should not try to treat someone. The severity of problems tends to be the best predictor of ongoing issues. We look at the extensiveness and severity of the substance abuse problem, how long that person has had it, how severe it is, and how many different drugs they abuse. Those sorts of issues are generally predictive of poor outcome or at least more of a challenge to treatment. The same goes on the domestic violence side. The more severe and the more frequent the violence has been the more likely they are to keep doing it. But, that having been said, there is a lot of variation and some people with severe problems appear to respond to treatment and some with less severe problems do not.

**Dr. McCarroll: What are the gaps in either your research or practice that you would explore if you could do that?**

Dr. Murphy: One big gap is in the need for combined treatments for substance abuse and partner violence. Behavioral couples therapy seems helpful, but that is only relevant to people who have a stable relationship partner. A lot of people are not in stable relationships or their partner also has their own severe problems with substance abuse. We do not have good combined treatment models that address both substance abuse and partner violence.

That is an area where there is not a lot of research. We need to know how these problems go together. Why do they go together? What makes somebody who is abusing substances prone to be abusive toward their partner? What are the different factors involved? Is it more of a personality factor? Is it more of a relationship and stress-based process? To what extent is it a function of acute intoxication and poor impulse control while intoxicated or are broader, more general factors involved? Some answers to those questions might influence our treatment models.

We also need a longer term perspective on treatment in all these areas. We do not have the dental model with checkups over time or following people over time because they may have good initial response to treatment, but may relapse down the road and end up with the same old problems. So, we really need to develop models that help us be more involved, even if contact is not as frequent, but occurs over an extended period of time, a model that would help people maintain changes in their own life contexts.

*Dr. McCarroll: We very much appreciate the opportunity to talk with you.*
Dr. Murphy: Thank you.

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**Key Points**

Psychological aggression is a very common part of almost all treatment programs for partner violence. We have to realize that physical assault is just the tip of the iceberg.

If you interview formerly battered women and ask them what was the most hurtful or damaging part of what they experienced, over three quarters of them say it was the psychological and emotional abuse more than the physical violence.

Those who relapse to their substance abuse after treatment have considerably higher rates of partner violence than those whose substance abuse problems remit stably.

We need a longer term perspective on treatment. We do not have the dental model with checkups over time. They may have a good initial response to treatment, but may relapse down the road and end up with the same old problems.

## Reference

Schumm JA, O'Farrell TJ, Murphy CM, & Fals–Stewart W. (2009). Partner violence before and after couples–based alcoholism treatment for female alcoholic patients. *Journal of Consulting and Clinical Psychology; 77*:1136–1146.