EMOTION REGULATION AND INTERPERSONAL GROUP THERAPY FOR CHILDREN AND ADOLESCENTS WITNESSING DOMESTIC VIOLENCE: A PRELIMINARY UNCONTROLLED TRIAL

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Running head: Group therapy for witnesses to domestic violence

Emotion Regulation and Interpersonal Group Therapy for Children and Adolescents Witnessing Domestic Violence: A Preliminary Uncontrolled Trial

Abstract

Around 19% of the patients who turn to childhood mental health centers are witnesses to domestic violence. The aim of this study was to evaluate the efficacy of Emotion Regulation and Interpersonal Group Therapy (ERIGT) in a multidisciplinary community program addressing domestic violence in reducing post-traumatic and depressive symptoms in children and adolescents who are witnesses to domestic violence. ERIGT was used with 24 patients ranging from 7 to 16 years old. We evaluated at three time points: before treatment, after treatment, and at 3 months following the end of treatment. We observed a reduction in the post-traumatic and depressive symptoms. This was a pilot study carried out with a small sample, but it indicates that ERIGT has the potential to be effective in the treatment of these symptoms.

Keywords: domestic violence, group therapy, children and adolescents, post-traumatic stress, emotion regulation.

Emotion regulation and interpersonal group therapy for children and adolescents witnessing domestic violence: a preliminary uncontrolled trial

Around 19% of the patients who seek help from childhood mental health centers are witnesses to domestic violence (Olaya, Ezpeleta, de la Osa, Granero, & Doménech, 2010). Around 35% of children and adolescents exposed to domestic violence present internalization and externalization problems, and 45% are borderline. Posttraumatic stress disorder (PTSD) is the main clinical consequence of exposure to family violence, while, notably, depression and lowered self-esteem are also observed (Augustyn & McAlister, 2005; Evans, Davies, & DiLillo, 2008; Howell, Barnes, Miller, & Graham-Bermann, 2016; Kitzmann, Gaylord, Holt, & Kenny, 2003; Margolin & Vickerman, 2007; Olaya, 2010). Similar levels of symptoms are observed among those who witness violence and those who are physically abused themselves (Kitzmann, 2003). Despite this level of incidence, few studies have been carried out with children and adolescents who are witnesses to domestic violence, especially using treatments that are manualized (Foa, Keane, Friedman, & Cohen, 2009).

Emotion Regulation and Interpersonal Group Therapy (ERIGT) for children and adolescents witnessing domestic violence was designed to fill the need for evidence-based treatment models for this population (Foa, 2009). The intervention was based on 'Skills Training in Affective and Interpersonal Regulation' (STAIR), developed by Cloitre, Cohen and Koenen (2006) for the treatment of adult patients who are victims of abuse in childhood. ERIGT is an adaptation of the first phase of STAIR, reworked for treatment in an out-patient clinical context of Spanish children and adolescents who have been witnesses to domestic violence. Like STAIR, it is based on the idea that exposure to violence affects the development of emotional regulation and interpersonal skills. The goal of the treatment is to

improve these skills in the patient. ERIGT is made up of three treatment modules addressing three main topics: emotional regulation, coping, and interpersonal skills.

Among behavioral cognitive therapies, Cloitre (2009) distinguishes those that are cognitive from those that are exposure-based. The difference is that cognitive therapy does not require the direct systematic review of the trauma, while this review is the central intervention in exposure therapy. For Cloitre, exposure therapy is focused on the emotion of fear, which is an automatic response to trauma, while cognitive therapy is focused on feelings that emerge from the meaning of the trauma for the subject (shame, guilt, and anger) and the idiosyncratic processes of self-evaluation. According to Cloitre (2009), the effectiveness of the two therapies in PTSD is similar.

Therapies focused on trauma, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), have demonstrated their efficacy in the treatment of PTSD in young children and adolescents (Cohen, Mannarino, & Deblinger, 2006; Cohen, Mannarino, & Iyengar, 2011). But in a recent study of therapeutic and mediating factors in an intervention program that included group therapy for children aged 6-12 and their parents, Overbeek, De Schipper, Willemen, Lamers-Winkelman, and Schuengel (2015) concluded that the benefits of applying therapy focused on trauma for child and adolescent witnesses to domestic violence, such as TF-CBT, were not clear. While they recognized that specific therapeutic factors, such as gradual exposure to traumatic memories, did reduce the clinical levels of post-traumatic stress, other factors that were not specific to the trauma also showed reduced symptomatology. Concretely, the non-specific factor that was related with the improvement in the symptoms of post-traumatic stress was the differentiation and expression of emotions. Graham-Bermann, Lynch, Banyard, De Voe, and Halabu (2007) also observed, in a randomized control efficacy trial, that children 6-12 years old who were witnesses to violence

showed reduced internalization of symptoms in group therapy focused on increasing vocabulary about emotions, feelings of security, and therapeutic alliance.

Furthermore, in the study by Overbeek et al. (2015), it was seen that, despite what was expected, greater exposure to traumatic emotions was associated with a reduction in the ability of emotional differentiation over time, which suggests a possible suppressing effect of exposure to trauma on the subsequent ability to differentiate emotions. The authors suggest that the two mighty be mutually dependent. Thus, children who successfully differentiate their emotions more readily share their traumatic emotions with their therapist, while those who had greater trouble in sharing emotions had greater trouble in differentiating them. ERIGT group therapy includes differentiation and emotional expression, which may have a positive effect on the reduction in post-traumatic symptomatology. In addition, if needed, the tasks of group emotional differentiation and regulation would facilitate subsequent direct confrontation with trauma in individual therapy.

ERIGT therapy does not include *in vivo* mastery reminders as do exposure therapies. Children and adolescents are not encouraged to speak in the group about their traumatic experiences. By not employing exposure techniques for traumatic memories the risk of abandonment of the treatment is reduced. This has been demonstrated by a recent meta-analysis that found that 36% of patients dropped out of specific treatments for PTSD that centered on trauma, in comparison to a 22% dropout rate for patients undergoing therapy centered on the present (Imel, Laska, Jakupcak, & Simpson, 2013).

In therapies for exposure to trauma the risk of re-traumatization may be greater. As a consequence, in these treatments the clinician must carefully guide the intervention so that the child maintains control and dominance over the experience (Judith A. Cohen et al., 2006). Therefore, although cognitive and exposure therapies are similarly effective in reducing

PTSD, the former show less dropping out from treatment, in that the children are not subjected to high levels of traumatic anxiety, thereby reducing the risk of retraumatization.

ERIGT therapy is part of a multidisciplinary program called TEVI (Testigos de Violencia Doméstica) that includes a team of psychologists, psychiatrists, and social workers in coordination with other community services (educational, social, and medical, and adult programs for domestic violence). It offers dyadic treatment with the non-offending parent, group therapy, and individual therapy. An essential component of intervention with all children is the priority of supporting and strengthening the relationship between the non-offending parent and the child while the child is recovering from the post-traumatic symptoms. The purpose of including the therapy group in the broad program is to improve emotional regulation and coping skills before addressing the reminders of trauma in individual therapy.

There are four group psychotherapy sessions in each module. Taken together, the 12 sessions have a coherent structure, and the contents follow a sequence determined by priorities and objectives. Table 1 summarizes the contents of the sessions. The research team prepared an ERIGT treatment manual for use by professionals (Lacasa, Alvarez, Navarro, Ortiz, & Richart, 2014).

-Table 1 here-

Group therapy is a therapeutic procedure applied frequently in the treatment of mental disorders because of its therapeutic effectiveness and cost-benefit efficiency. In the case of patients who are victims of trauma, group therapy, with its interpersonal nature, offers an environment that is secure enough to provide the opportunity for the development of relations based on trust and the experiencing of interpersonal security, thereby helping to remedy the sense of isolation that often accompanies PTSD (Shea, McDevit-Murphy, Ready, & Schnurr,

2009). The ERIGT treatment contains elements in common with STAIR, including a shared general view of trauma, deep-breathing exercises as a strategy for emotional regulation, and the development of an individualized security plan for each patient.

The preliminary results of an application of a version of STAIR, designated STAIR-A, were recently presented. This study involved the treatment of adolescents 12-17 years old hospitalized in a psychiatric unit and suffering from several types of trauma (Gudiño et al., 2014). Post-treatment evaluations were made, but there was no follow-up evaluation. Furthermore, 92% of the patients were receiving psychopharmacological treatment at the end of their stay, so it is not clear whether the improvement they showed was attributable to the psychological therapy or the medication the patients were taking.

Unlike the study by Gudiño et al. (2014), in the present study evaluations were carried out before treatment, after treatment, and at three months following the end of treatment; none of the patients required psychopharmacological treatment at any time. Another difference between the present study and that of Gudiño is that the subjects in our study were out-patients who had been exposed to domestic violence and abuse.

Unlike other studies in which only the mothers were questioned, in the present study exposure to violence was evaluated by direct contact with the children and adolescents through an open interview (Sudermann & Jaffe, 1999), and not merely with a questionnaire.

The aim of this study was to evaluate the effectiveness of the ERIGT treatment in reducing the symptoms of depression and PTSD in child and adolescent witnesses to domestic violence. To this end we compared changes in the evolution of the post-traumatic stress and depression symptoms before the ERIGT treatment, at its conclusion, and three months later.

Method

Participants

The participants were 24 children and adolescents ranging in age from 7 to 16 years old (*M*=11.2; *SD*=2.5); 54% were male. The majority of the sample, 75%, identified as Caucasian, 17% as Latino, and 17% as Muslim.

Procedure

The participants were drawn from the program 'Testigos de Violencia Doméstica (TEVI), Centro de Salud Mental Infanto-Juvenil (CSMIJ)' [Witnesses to Domestic Violence from the Child Mental Health Center] in Cornellá, Barcelona. Group treatment begins once the child is in a safe situation in terms of domestic violence. In a preliminary phase, therapeutic consultations are carried out with the mother in order to help her deal with difficulties in relation to the child. In addition, the mothers are put in touch with social and legal services in the community and are also offered psychological support at an adult mental health center. The TEVI program offers the family a support network designed to help create an atmosphere of security and trust in which therapy can then begin.

There was no abandonment of group treatment; all the children and adolescents who began the treatment completed the twelve treatment sessions and the first two evaluations (baseline and post-treatment). Twenty patients completed all three evaluations (baseline, post-treatment, and follow-up); that is, 4 patients underwent the treatment but did not complete the final follow-up evaluation. Children and adolescents who directly confirmed exposure to domestic violence in a clinical interview were included in the study. Excluded were those for whom violence has not stopped and those with a diagnosis of general developmental disorder, psychotic disorder, or serious eating behavior disorder.

The study received the approval of the Clinical Investigation Ethics Committee of the Sant Joan de Déu Barcelona Hospital Foundation. Informed consent was obtained from the legal guardians of the participants.

Professionals from the CSMIJ, using the Diagnostic and Statistical Manual of Mental Disorders classification system DSM-IV R (4th ed., text rev.; American Psychiatric Association, 2000), established the clinical diagnoses of the participants. The diagnoses were as follows: 25% behavioral disorder, 25% post-traumatic stress disorder (PTSD), 17% depression, 13% attention deficit hyperactivity disorder (ADHD), and 17% sleep disorder. Four separate therapy groups were put together, two with children aged 8 to 11 and two with adolescents aged 12 to 17.

The ERIGT treatment was applied for 12 consecutive weeks with weekly sessions lasting 75 minutes. The sessions were led by two clinical psychologists specialized in child mental health; an observer was also present. The sessions were carried out in line with the treatment manual prepared by the team at the center (Lacasa, 2014). Between the conclusion of the sessions and the evaluation at three months, 21 of the 24 patients received a follow-up visit, and 3 of them received more than one visit.

Post-traumatic stress and symptoms of depression were evaluated in the baseline visit, at the conclusion of treatment, and at three months following.

Instruments

Domestic violence. A social worker evaluated the incidents of domestic violence in the baseline visit. The interview by Sudermann and Jaffe (1999) for intra-family violence witnessed by minors was used. The violence suffered by the mothers was evaluated with the Questionnaire for Systematically Detecting Situations of Violence against Women in Clinical Consultation (Majdalani et al., 2005).

Post-traumatic stress. Participants took the PTSD Reaction Index—Child Form, adapted by Rossman and Jo (2000) for the population of witnesses to violence. This is a self-administered questionnaire with 24 items designed to detect the presence of symptoms of post-traumatic stress experienced by children, in accordance with the criteria of the DSM-IV R. It is made up of three scales: Intrusion/re-experience, with 6 items (for example, "Images or sounds appear suddenly in your head"); Avoidance, with 5 items (for example, "You try to keep a distance from the things that remind you of your parents' fighting"); and Hyperarousal, with 5 items (for example, "You feel more nervous now than you used to").

Depression symptoms. Participants took the Spanish version of the Children's Depression Inventory (CDI) of Kovacs (Del Barrio & Carrasco, 2004). This questionnaire is widely used in the clinical treatment of children aged 7 to 16 years old. It has been shown to have good internal consistency, test-retest reliability, and construct validity.

Statistical analysis

Given the small sample size, the effectiveness of the ERIGT treatment was evaluated by means of repeated measurement with non-parametric tests (Wilcoxon signed-rank test). Changes in the averages for the PTSD symptoms, anxiety, and depression were analyzed throughout the period of evaluation at the chosen time points: baseline, post-treatment, and at three months' follow-up. The McNemar test was also used to analyze the number of patients with a possible diagnosis of PTSD at baseline, post-treatment, and at three months' follow-up.

Results

Between baseline and post-treatment there was observed to be a significant decrease in the symptoms of re-experiencing post-traumatic stress and also of symptoms of depression (Table 2).

The participants showed a decrease in the overall post-traumatic stress symptoms and on the scales for re-experience and hyperarousal, when baseline and three months' follow-up were compared (Table 2). The magnitude of the effect of overall post-traumatic symptom reduction between the beginning of treatment and at three months' follow-up was large (Hedges g = 0.94) (See Table 2).

From the conclusion of the group treatment to the evaluation at three months following only three patients received more than one follow-up visit. In order to control for any possible bias, once the group treatment was finished these patients were excluded from the analysis. In the analysis without these three patients the same improvement was seen as was observed with the total sample (Table 2).

- Table 2 here -

It is of some importance to note the decrease in the number of patients selecting the item designed to identify suicidal thoughts in the CDI scale ("I think about taking my life but I wouldn't do so."). Those selecting this item fell from 29% at baseline evaluation to 10% at three months' follow-up (P=0.05).

In examining the number of patients with a possible diagnosis of PTSD, there was observed to be a progressive decrease in the number of patients meeting the PTSD criteria. Prior to group treatment, 9 patients (38%) met the criteria; at post-treatment the number was 7 patients (29%), while at three months' follow-up it was down to 1 patient (4%). The reduction achieved statistical significance at three months' follow-up (p=0.021).

Discussion

The pilot study on the effectiveness of ERIGT group therapy, based on emotion regulation and the development of social skills, yielded good results. The overall total load of post-traumatic stress and re-experience symptoms of the patients was reduced with treatment,

and this trend continued after the conclusion of the treatment, even with symptoms of hyperarousal at three months following conclusion. These results build upon those of Gudiño et al. (2014) with STAIR-A, who also observed that post-traumatic stress symptoms had improved at the conclusion of treatment. Their study, however, did not include a follow-up evaluation.

The patients in our sample did not receive any other treatment concurrent with the ERIGT, either psychotherapeutic (individual or family) or pharmacological; this is in contrast to the Gudiño study (2014) in which the patients received psychopharmacological treatment. During the follow-up period, patients received only one control visit, which means that the observed improvement may be attributed to the ERIGT.

There was no abandonment of group treatment; all the children and adolescents who began the treatment completed it. This represents an important advantage in comparison to other therapies, for which abandonment rates reach levels as high as 36% (Imel et al., 2013). We attribute this high rate of adherence to not using exposure techniques, but this needs to be confirmed in comparative studies.

The fact that there was an improvement in the post-traumatic avoidance symptoms, albeit shy of statistical significance, alerts us to the need for a larger sample size in future studies.

Regarding the symptoms of depression, these were found to have improved by the end of the treatment, as was also the case in the study of Gudiño et al. (2014), although it could not be demonstrated that this improvement was maintained during the follow-up period. In addition, suicidal thoughts also decreased. During the group treatment, the negative images that the children held of themselves were often given voice (for example, the children often spoke of themselves as stupid or useless because they were unable to carry out tasks put to

them), which then afforded the opportunity to discuss these perceptions and respond to them. Furthermore, the therapeutic relation proposed for the ERIGT group contributed to a reduction in the sense of guilt and the impulse for punishment—impulses that reinforce these negative perceptions and symptoms of depression. Our findings highlight the importance of focusing on emotion regulation and social skills in order to lower the PTSD symptoms. These results suggest a direct relation among emotional regulation, social skills, and PTSD symptoms. These findings are in accordance with those from a study by Tull, Barrett, McMillan, and Roemer (2007), who found that the severity of the PTSD symptoms in young university students was related with the difficulty they had in emotional regulation. Our results also confirm the study of Overbeek et al. (2015), who observed that, in young children and adolescents, the increase in the ability to differentiate emotions was related to the reduction in post-traumatic symptoms. ERIGT enhances positive strategies for emotion regulation, such as emotional differentiation and emotional resignification of traumatic situations and the search for emotional alternatives, leading to symptomatic improvement (Aldao, Nolen-Hoeksema, & Schweizer, 2010).

These preliminary data suggest that victims who are witnesses to violence may benefit from a reduction in clinical symptoms as well as from an improvement in their self-esteem by participating in a 12-session ERIGT therapy. This format may prove to be highly useful and easily applied in out-patient centers such as the one where the study was carried out, as well as in other therapeutic environments. As noted by Overbeek (2015), it is easier for therapists to treat trauma in children with a greater ability to differentiate among their emotions. In light of this we may say that improvement in emotional regulation and interpersonal skills is helpful in subsequent individual treatment (See Table 1).

This pilot study has limitations in terms of the generalizability of its results, although it also is of undeniable value in pointing the way to future studies. The first limitation is that it was not randomized with a control group, so that other variables that might have come into play, such as the passing of time, could not be taken into account. The second limitation is the size of the sample, which limits the applicability of more powerful statistical tests to the results. Thirdly, there is the question of age: young children and adolescents, with differing developmental levels, were lumped together. It would be helpful to consider the two age groups separately in future studies. The fourth limitation is our not having recorded the psychological treatment of the abused mothers, given that the balance and availability of the mothers is an intermediate variable in the improvement of the children (Visser, et al., 2015). And finally, no diagnostic scale was used for PTSD, which meant that we were only able to speak of post-traumatic stress symptoms and possible PTSD.

As to the variables, in future studies it would be advisable to use validated instruments to directly evaluate emotional regulation and coping strategies. The study of emotion regulation should allow for examination of the causality of therapeutic change to be approached in a more objective manner. In this way, it would be possible to verify the theory that the measurement of the improvement in emotional regulation modifies the symptoms of post-traumatic stress, through a group framework geared to the acquiring of a series of characteristics of ‘secure attachment'.’

In spite of the limitations in the study’s design, the results suggest that ERIGT can reduce post-traumatic stress symptoms in witnesses to domestic violence. Appropriate interventional means are needed to prevent the negative consequences of domestic violence in the pediatric population and thereby improve the prognosis for these patients.

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Table1.

General content of the group treatment sessions.

Content	Treatment session
	Session 1: Presentation, outline, and identifying and naming of emotions.
First block: Focus on emotions: identifying, naming and differentiating. The importance of recognizing unpleasant emotion—those appear when trauma is experienced.	Session 2: Recognizing and differentiating emotions. Explanation of the function of negative emotions. Session 3: Psychoeducation about effects of traumatic experiences part I. Explanation of the function of negative emotions: re-experiencing symptoms, avoidance, negative changes in beliefs and feelings, and hyperarousal. Session 4: Psychoeducation about effects of traumatic experiences part II: problems in regulating emotions.
Second block: Focus on learning to manage unpleasant emotions. Practice in skills for regulating emotion by means of strategies based on body, behavior, and mind. Psychoeducation about domestic violence. Basis for clear communication.	Session 5: Managing unpleasant emotions, and skills in coping focused on body, mind, and behavior. Building a new outlook with strategies for improvement. Session 6: New coping skills: Emphasizing the capacity to moderate emotions and improve self-esteem. Session 7: new coping skills: taking care of oneself. Psychoeducation about domestic violence. Session 8: Abilities for clear communication.
Third block: Training in social skills, effective communication, assertiveness, and self-confidence. Distinguishing between people who are worthy of trust and those who are not, and on promoting security.	Session 9: Assertiveness skills training. Session 10: Social skills and recovering self-confidence. Learning whom to trust. Session 11: Negotiating skills. Completing the new strategic outlook. Session 12: Wrap-up and farewell. Several sessions conclude with relaxation techniques.

Table 2.

Analysis of the repeated measurement of the response variables.

	Pre-treatment	Post-treatment	Follow-up	Pre-/Post-treatment		Pre-treatment/ Follow-up		Effect size
	n=24	n=24	n=19					
Measurements	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	Wilcoxon *Z*	Sig. (two-tailed)	Wilcoxon *Z*	Sig. (two-tailed)	Hedges *g*
Total PTSD	11.3 (5.2)	9.8 (5.6)	6.8 (4.2)	1.92	†	2.98	**	0.94
Re-experience PTSD	3.3 (1.8)	2.4 (1.7)	1.8 (1.5)	2.47	*	2.81	**	0.90
Hyperarousal PTSD	2.5 (1.5)	2.1 (1.4)	1.2 (1.2)	1.57		3.14	**	0.95
Avoidance PTSD	2.4 (1.3)	2.1 (1.6)	1.6 (0.8)	0.99		1.90	†	0.73
Total CDI	11.0 (8.1)	10.1 (7.7)	10.3 (6.8)	2.22	*	1.87		
Dysphoria CDI	5.0 (4.6)	4.5 (4.3)	4.5 (4.1)	1.33		0.02		
Self-esteem CDI	7.4 (3.8)	6.0 (3.2)	6.1 (3.1)	2.42	*	0.50		

*Wilcoxon signed-rank test. Two-tailed significance: † p< .1; * p< .05; ** p< .01*