

**Innovating Services for Children Exposed to Domestic Violence:  
A Child-Focused Evaluation of the MOVE Program**

**Rebecca J. Macy<sup>1</sup>, PhD, ACSW, LCSW**

**L. Richardson Preyer Distinguished Chair for Strengthening Families**

**Jennifer O'Brien<sup>1</sup>, MSW, LCSW**

**Doctoral Student**

**Cynthia Fraga Rizo<sup>1</sup>, PhD**

**Assistant Professor**

**Dania M. Ermentrout<sup>1</sup>, MPH, MSW**

**Clinical Instructor**

**<sup>1</sup>University of North Carolina at Chapel Hill, School of Social Work**

**Acknowledgements:** We acknowledge Kanisha Coleman, Ariel Reynolds and Natalie Ziemba for their help with this research. We acknowledge all of the staff of SAFEchild and InterAct for their development and delivery of the MOVE program. In particular, we acknowledge Leah Duque, David Farrell, and Kathy Johnson at InterAct, as well as Marjorie Menestres and Stacey Sullivan at SAFEchild. We acknowledge all of our research participants for their individual contributions and their dedication to making MOVE a better program for future participants.

**Correspondence:** Correspondence regarding this report should be addressed to Rebecca J. Macy, School of Social Work, Tate-Turner-Kuralt Building, 325 Pittsboro Street CB #3550, Chapel Hill, North Carolina 27599; 919-843-2435 (telephone); 919-962-0890 (fax); or via e-mail to [rjmacy@email.unc.edu](mailto:rjmacy@email.unc.edu).

**Funding:** The Duke Endowment provided funding for this research and report.

**Recommended report citation:**

Macy, R. J., O'Brien, J., Rizo, C. F., & Ermentrout, D. M. (2015). *Innovating services for children exposed to domestic violence: A child-focused evaluation of the MOVE program*.

Chapel Hill, North Carolina: School of Social Work, University of North Carolina.

## REPORT SUMMARY

Women who experience intimate partner violence (IPV) and who are the primary caregivers (i.e., parents) of children may find themselves required to attend programs for parenting and safety by either child protective services and/or the court system. Best practice recommendations urge that such services should account for these women's status as IPV survivors as well as address the needs of these women's children. However, many communities do not offer services based on these best practice recommendations. Nonetheless, the authorities within the systems that are referring women to community-based parenting and safety services typically assume that such services improve women's parenting and reduce children's exposure to IPV and maltreatment risk. However, little empirical evidence is available to support the effectiveness of such parenting and safety interventions. Thus, research investigating the helpfulness of these programs is urgently needed.

Two community-based agencies located in Wake County, North Carolina—**InterAct** (a domestic violence and sexual assault services agency) and **SAFEchild** (a child abuse prevention agency)—found themselves serving increasing numbers of female IPV survivors who were the primary caregivers of children and mandated to attend parenting and safety services. In response, the two agencies began collaborating to create and implement the *Mothers Overcoming Violence through Education and Empowerment* (MOVE) program. Based on recommended best practices, MOVE used a dual-pronged approach to provide services for IPV survivors and their children. Since 2007, our research team has worked with the two community-based agencies delivering MOVE to: (a) document the program; (b) examine the program's acceptability and feasibility; and (c) investigate program outcomes. This report presents pilot findings from the data collected as part of the child-focused evaluation of the MOVE Program.

This report presents findings concerning: (a) the acceptability and feasibility of collecting data from these children and their mothers; (b) the acceptability and feasibility of data collection methods and instruments for children of varying age and developmental groups; (c) the characteristics, needs, and strengths of the children who were involved with the MOVE program; and (d) initial outcomes among the IPV survivors and children who participated in MOVE by comparing data collected at program entry and program completion. To the best of our knowledge, this is one of the first efforts to conduct research with the children of IPV survivors receiving community-based parenting and safety services at the behest of CPS and/or the court system. Accordingly, the data gathered from this study provides valuable information on system-involved IPV survivors and their children.

Although preliminary and tentative, the study findings suggest that the MOVE children's program may provide critically needed support to children exposed to IPV. The promising, albeit initial, outcome trends from this evaluation suggest that when school-aged children are able to participate in the MOVE program, they experience benefits. Accordingly, the MOVE children's program warrants future research with a larger sample of children from which a more rigorous and robust study may be conducted. Given the study design and the small sample size, our research team also cannot make any meaningful statements regarding the specific and unique

effects of either the MOVE Parenting Program or the MOVE Children's Program on older child participant outcomes. Without studying both programs separately and in distinct ways, it is impossible to know if the older children's improvements were due to their own participation in their program, their mothers' participation in their program, or some combinations of effects between both programs. Future research will need to carefully consider how to rigorously evaluate the potential unique effects of the children's program. In addition, given the participating families' complex needs unearthed by this research, children from these families most likely need specialized services and outreach as well. Such outreach and services may be especially important for children who live in families where IPV is current and ongoing. Despite these limitations, we hope that future research can build from the successes and lessons-learned from this study to extend and strengthen this line of research and determine what services are most beneficial for system-involved IPV survivors and their children.

## **Introduction**

Women who experience intimate partner violence (IPV) may find themselves required by authorities to attend programs on parenting and safety. Such service requirements might happen in two ways. First, as an unanticipated result of the pro-arrest domestic violence policies introduced in the late 1980s, an increasing number of female IPV survivors are becoming involved with the court system. Under pro-arrest domestic violence policies, law enforcement officers are more likely to make arrests in IPV situations. With little guidance regarding how to determine the primary perpetrator in IPV situations, responding officers may arrest survivors as well as their perpetrators. IPV survivors who are arrested and involved with the courts are often mandated to community-based parenting and/or safety services in lieu of jail time (Simmons, Lehmann, & Dia, 2010).

Service requirements may also result from the increasingly emphasized need for child protection service (CPS) workers to address IPV in their plans with families reported for child maltreatment. This emphasis has led to large numbers of CPS referrals to attend IPV-related services (Moles, 2008). Nationwide, 28.5% of CPS- involved children presented with IPV as a caregiver risk factor (US Department of Health and Human Services, 2013). Likewise, research suggests that children who are living in families with IPV are more likely to experience other forms of child maltreatment, including neglect and physical abuse (Edleson, 1999; Hamby, Finkelhor, Turner, & Ormrod, 2010). For these reasons, the child welfare policies of many states consider IPV exposure to be a form of child maltreatment (Moles, 2008). Thus, IPV survivors with children may find themselves attending community-based parenting and safety services as part of their CPS plan.

Regardless of why women are referred to parenting and safety services and regardless of

whether they were referred by the court system and/or CPS, best practice recommendations urge for such services to account for their status as IPV survivors (e.g., Hamberger & Potente, 1994). Acknowledgement of their experiences with IPV is important because system-involved IPV survivors have unique needs that must be addressed for services to contribute to ending IPV and ensuring the well-being of these women and their children. In particular, parenting and safety services for these women and their children should speak to their experience of victimization as well as to the unique needs and characteristics of IPV survivors (Feder & Henning, 2005; Simmons, Lehmann, & Collier-Tenison, 2008; Stuart, Moore, Hellmuth, Ramsey, & Kahler, 2006). Note that we use the phrase “system-involved” IPV survivors throughout this report to describe women who have been required to attend community-based IPV services at the direction of the courts, CPS, and/or both systems.

Ideally, services for system-involved IPV survivors should also include addressing the needs of these women’s children. Although not always the intended target of IPV victimization, children exposed to IPV suffer numerous negative consequences including poor psychosocial outcomes, as well as cognitive and academic problems (Bedi & Goddard, 2007; Black & Newmann, 1996; Kitzmann, Gaylord, Holt, & Kenny, 2003). Longer-term consequences of IPV exposure during childhood include adult mood disorders and difficulty developing positive adult relationships (Lupien, McEwen, Gunnar, & Heim, 2009). Although children are rarely mandated to attend services, children often accompany their mothers to the service delivery settings. Accordingly, developing, providing, and evaluating services for accompanying children provides a fortuitous opportunity to help address many of the negative consequences associated with children’s IPV exposure.

Frequently, the authorities within the systems that are referring women to community-based

parenting and safety services assume that such services improve women's parenting and reduce children's exposure to IPV and maltreatment risk. However, little empirical evidence is available to support the effectiveness of such parenting and safety interventions (Rizo, Macy, Ermentrout, & Johns, 2011). This lack of research on the outcomes of parenting and safety programs for families struggling with IPV is of particular concern when the court and/or CPS systems require IPV survivors' participation. Although women are mandated to attend these parenting and safety programs, the limited available evidence cannot assure that such services are helpful to women and their children. Therefore, research investigating the helpfulness of these programs is urgently and ethically needed.

### **The MOVE Program**

Two community-based agencies located in Wake County, North Carolina—**InterAct** (a domestic violence and sexual assault service agency) and **SAFEchild** (a child abuse prevention agency)—found themselves serving increasing numbers of women who were system-involved IPV survivors, primary caregivers of children, and mandated participants of parenting and safety services. In response, the two agencies began collaborating to create and implement the *Mothers Overcoming Violence through Education and Empowerment* (MOVE) program. Given the scant research available to guide this effort, MOVE was based on the professional expertise and experience of the providers working in the two agencies, as well as informed by curricula developed for families experiencing IPV (e.g., Turner, Gilbert, Hendricks, & Demaree, 2006; Turner, Weitz, Peterson, & Demaree, 2006).

We note here that service providers at InterAct and SAFEchild took the lead on (a) identifying the need for the program, (b) conceptualizing the program philosophy, (c) developing the program, and (d) creating the specific service delivery strategies for the program. Over the

past several years our research team has worked with InterAct and SAFEchild to develop a comprehensive program manual for MOVE that includes descriptions of weekly session content, service delivery strategies, and fidelity assessment instruments.

MOVE uses a dual-pronged approach to provide services for IPV survivors and their children. For adult IPV survivors, MOVE is a 13-week parenting program intended for IPV survivors who are either mandated by the courts to treatment for alleged violence against their abusive male partners or mandated by CPS to attend a parenting program. The MOVE mothers' program consists of a psychoeducational, therapeutic parenting group for mothers that delivers content on IPV, parenting, and safety. For the children of IPV survivors, the MOVE program offers therapeutic support group services for children ages five and older concurrent with the mothers' group. In addition, MOVE provides comprehensive childcare for children from birth to four years old.

**MOVE Mothers' Program.** MOVE program providers use a group treatment modality, in which seven to ten participants meet together one evening per week. Two staff members with experience in family violence and group treatment co-facilitate the meetings. The group treatment modality was selected for intervention delivery for the following reasons: (a) to provide opportunities for peer learning and support; (b) to provide opportunities for participants to practice new knowledge and skills; (c) to normalize participants' experiences with IPV, CPS, and the court system; and (d) to diminish social isolation. Over the 13 meetings, the group leaders deliver content on parenting, IPV, and safety. All program activities are guided by the program's positive and empowerment-focused service approach, with the aim of enhancing participants' self-esteem and self-efficacy. In addition to child care for young children and therapeutic support group services for older children, program amenities include (a) dinner for

mothers and children, (b) transportation to and from the program meetings as needed, and (c) security services (i.e., an off-duty female police officer) for staff, mothers, and children. Further, the program is provided to mothers and their children at no cost. By offering the program free of charge and including a number of amenities, the providers aim to model a positive, safe environment for families and to encourage program participation.

**MOVE Children's Program.** For the MOVE children groups, children are assigned to one of two groups on the basis of age and developmental level. One group serves younger children (5-9 year olds) and a second group serves older children (10-14+ year olds). Group size varies across cohorts of MOVE mothers, but groups ideally consist of six to nine children. The manualized program consists of 13 weekly group sessions held one evening per week in coordination with the mothers' program. Each session lasts two and a half hours and follows a specific format: (a) free play and dinner (75 minutes), (b) check-in (10 minutes), (c) curriculum-based activities (60 minutes), and (d) closure (5 minutes). The groups are co-facilitated by a clinician with a Master's level education (e.g., social work, counseling) and a social work student intern or volunteer with IPV and group facilitation training. The group modality was selected to provide opportunities for peer learning, mentoring, and support, as well as opportunities for participants to share and practice knowledge and skills. Co-facilitation was selected to manage group dynamics, provide individual attention when needed, and handle disciplinary issues. The program topics include (a) self-esteem, (b) IPV and safety planning, (c) anger management, (d) conflict resolution, (e) communication, and (f) goal formation and attainment. All activities are guided by the program's positive service approach.

### **The MOVE Program's Child-Focused Evaluation**

Since 2007, our research team has worked with the two community-based agencies

delivering MOVE to document the program (i.e., develop detailed program manuals and fidelity instruments), to examine the program's feasibility and acceptability among system-involved IPV survivors and their children, and to investigate program outcomes. This current report presents preliminary findings from the data collected as part of the child-focused evaluation of the MOVE program.

Before participant recruitment and data collection, all study methods were reviewed by the following groups to ensure that the research would be acceptable, feasible, and beneficial: staff at InterAct and SAFEchild; the study's community advisory board which was comprised of service providers and professionals working in the areas of child protection and domestic violence; and a group of MOVE graduates who had previously completed the program. Feedback from these groups was used to finalize study methods. Subsequently, all study methods were reviewed and approved by the University of North Carolina (UNC) at Chapel Hill's Office of Human Research Ethics. In light of the research participants' unique safety issues and vulnerabilities, a National Institute of Health Certification of Confidentiality was also obtained before beginning the research.

**Participant recruitment.** To invite potential participants into the study, the research team used both a standardized recruitment script and a brochure. At the time of the initial intake interview for the MOVE program, MOVE group facilitators informed MOVE participants about the study and asked the women to consider participating in the evaluation. In addition, the UNC research team also provided a brief oral prospectus of the project. When women expressed initial interest in research participation, a research team member arranged a study intake interview to provide in-depth information about the research risks and benefits, as well as to obtain informed consent. Each woman who expressed interest in participating in the evaluation was offered a

reminder contact for this first meeting using a self-designated safe method of contact.

**Evaluation approach.** For the child-focused evaluation, the research was divided into two parts. In one part, mothers were required to have at least one child 4 years old or younger. In the second part, mothers were required to have a child who was 5-17 years of age and participating in the MOVE children's program. For the part of the study focused on younger children, mothers with more than one child four years old and younger were asked to choose one child for study participation and to consent to being videotaped playing with the selected child for two separate 15-minute sessions. For this part of the research, study participation was contingent upon consent to be videotaped. For the part of the study focused on older children, children aged 5-17 years had to participate in one or more sessions of the MOVE children's program to qualify for the research. Mothers with more than one child aged 5-17 years could have all children participate in the study. Mothers who had children in both age ranges (i.e., 0-4 years and 5-17 years) were eligible to have children in both parts of the study. Once mothers were determined to be both eligible and interested in study participation, mothers were invited to provide informed consent for their participation and parental assent for their child(ren)'s participation.

**Data collection instruments and evaluation measures.** Following informed consent, a research team member administered psychometrically validated questionnaires to participating mothers. The questionnaire packet was composed of measures on IPV victimization and perpetration (i.e., the Conflict Tactics Scale [CTS], Women's Experiences of Battering [WEB]), mental health (e.g., Center for Epidemiologic Studies Depression Scale [CES-D], PTSD Checklist-Civilian Version [PCL-C]), parenting (i.e., Healthy Families Parenting Inventory [HFPI], Adult-Adolescent Parenting Inventory [AAPI], Corporal Punishment Scale [CTS-parent], Parent Strengths and Difficulties [SDS], Parenting Stress Index [PSI]), drug/alcohol use

(i.e., Alcohol/Drug Use Identification Test [AUDIT/DUDIT]), and demographic information. A similar packet, with the addition of a brief program satisfaction survey and the Caregiver Self Assessment [CSA] instrument, was provided near program completion.

To promote candid responses, participants were presented the option of self-administering their questionnaire packets. Nonetheless, research team members were trained to be aware of and to inquire sensitively about participants who may have limited literacy. With those participants in mind, research team members also offered to individually administer the questionnaires and read the survey questions aloud in a private setting to help facilitate all of the women's participation in the research.

To help ensure that the data collection instruments would be valid, reliable, and feasible for the study population, the research team included all the instruments used in this study based on the results of a systematic review of the literature on IPV program evaluations with mothers and children. In addition and as noted above, the instruments were reviewed and approved by an expert advisory group comprised of child abuse prevention and domestic violence prevention advocates, service providers, and researchers before their implementation in this study. Based on recommendations from these groups, the research team eliminated some instrument questions that might lead to child maltreatment reports to CPS authorities by the research team. Based on feedback from the group of MOVE graduates who had previously completed the program, the research team also eliminated some questions about sexual intimate partner violence that the graduates deemed to be objectionable.

Once mothers had filled out their questionnaires, a date and time for data collection with their children was scheduled. Mothers were encouraged to choose a date and time for data collection that would be convenient for themselves and their children. A number of supports, including

transportation, child/participant snacks, and age-appropriate incentives for children (e.g., Play-Doh packs, basketballs) and mothers (e.g., \$50 gift card to a discount store), were offered to participants to ease the burden of participation.

In advance of any data collection with individual children, mothers were given the opportunity to examine the questionnaire packet that would be administered to their children. Mothers were invited to mark out any questions that they did not feel would be appropriate for their children. Subsequently, any questions marked out were skipped by researchers administering the questionnaires or taken out of the packet altogether.

Packets for children ages 0-4 years were composed of measures on violence exposure (i.e., Violence Exposure Scale for Children-Revise [VEX]) and mood (i.e., Child Outcome Rating Scale [CORS]). Packets for children ages 5-17 years included measures on safety planning (i.e., Domestic Violence and Safety Planning Knowledge Survey), mood (i.e., Child Outcome Rating Scale [CORS], Beck Anger Inventory for Youth [BAI], Beck Self Concept Inventory for Youth [BSCI]), and violence exposure (i.e., Violence Exposure Scale for Children-Revise [VEX], Child Exposure to Domestic Violence [CEDV]). Due to the significant age range of participating children, packets for individual children ages 5-17 years varied on the exact measures included. As a result, children were only given the questionnaires that had been psychometrically validated for their respective ages. Protocols for data collection with children were the same at both data collection points, program entry and program completion.

**Child assent to participate in research.** Before any data collection activities with children began, parental permission to approach each individual child was sought. If parental permission for recruitment and participation was obtained, the research team carefully followed procedures to ensure that all children permitted to participate also actively and positively assented to

participate in this research.

For children younger than age seven who had received parental permission to participate, research team members individually and orally administered a behavioral assent to research participation protocol to the children in the presence of their mothers. The children's research participant rights were individually reviewed in very plain language. The research team members explained to each child that he or she could decide not to answer any question or stop participating at any time. The researchers also explained that each child's decision about participation would be accepted by all of the adults and that choosing not to participate would not affect how the program staff or the researchers would treat him or her (or his or her mother). Child participants in the dyads were shown the digital video recorder, and researchers described how their interactions would be taped.

Consistent with our team's IRB-approved behavioral assent protocol for these young children, children had to actively assent to participate in the research. In other words, the actions of the child signaled his or her decision. Specifically, a research team member explained, in an age-appropriate manner, the purpose of the research. The research team member also explained that everyone would have a choice to do what he or she wanted to do. Then the research team member asked the child to indicate his or her choice (demonstrating if necessary): "If you want to be a part of this research with your mom, say "yes." If you would rather go to the childcare room, say "no." Moreover, during data collection, when children wandered away from their mothers, refused to answer questions, or became otherwise distracted, the research team members viewed such behaviors as implied retraction of assent, and data collection was discontinued.

For children between the ages of seven and 17 who had parental permission to participate in

the outcome evaluation, research team members individually administered an age-appropriate child assent form (i.e., there were two, developmentally appropriate child assents forms: an assent form for children aged 7-14 and an assent form for children aged 15-17). Prior to commencing any data collection with these older children, research team members explained research participant rights individually to each child in very plain language, including the rights that each child could decide not to answer any question or stop participating at any time. Like the assent protocols with the younger children, researchers clarified that each child's decision about participation would be accepted by all of the adults and that choosing not to participate would not affect how the program staff or the researchers would treat him or her (or his or her mother).

**Ensuring participant confidentiality and comfort.** Due to the vulnerability of the women and children in this study, a number of additional methods to ensure participant confidentiality were used. All research team members signed a confidentiality agreement. When contacting MOVE mothers' group participants, research team members followed agency safety protocols. Specifically, this meant that when someone other than the study participant (e.g., a spouse or partner) answered the contact phone, research team members did not release any information about the study participant, the study evaluation, or participation in the MOVE program. All research team members who were directly involved in data collection were trained to handle emotional distress brought about by study questions or study participation. In the event that a mother or child revealed information during data collection that necessitated filing a CPS report, a CPS report protocol was developed and followed by all research team members.

## **Findings**

This report presents preliminary findings from two parts of the overall MOVE program research. First, this report presents quantitative and qualitative findings collected from the older,

school-age children and their mothers as part of the *MOVE Children's Program Pilot Test (Children ages 5-17)*. The purpose of this part of the evaluation research was to gather preliminary pilot data on children's outcomes for those children who participated in the MOVE Children's Program, regardless of their level of program exposure. By collecting data from MOVE cohorts beginning in the fall of 2012 through the fall of 2013, the UNC research team was able to accomplish the following aims: (1) investigate preliminary outcomes for children, (2) assess the feasibility of collecting data from children, and (3) evaluate the feasibility of our data collection methods and instruments. Over the course of the 13-week program, the research team collected data from mothers and their children on child participant outcomes using standardized and developed measures on topics such as mothers' mental health, mothers' parenting practices, family violence, and children's functioning both at program entry and program completion.

Second, this report presents quantitative findings collected from the very young children and their mothers as part of the *Infants and Young Children: Mother-Child Dyad Observation and Evaluation (Children ages 0-4)*. The purpose of this part of the evaluation was to: (1) investigate the characteristics, needs, and strengths of the infants and young children of adult MOVE participants; (2) demonstrate the feasibility of data collection methods with infants and young children; and (3) explore whether there are promising trends in mother-child outcomes. By collecting such data from spring of 2012 through the fall of 2013, the UNC research team investigated the following questions in a preliminary way: (1) What are the characteristics, needs, and strengths of the young children of adult MOVE participants?; (2) What is the nature and quality of the relationships between the adult MOVE participants and their young children?; and (3) Does the nature and quality of the relationships between the adult MOVE participants and their young children change because of their caregivers'/mothers' MOVE participation?

Data was collected from mother (or primary caregiver)-child dyads at two time points: (1) program entry and (2) program completion. One child from each family between the ages of 0 and 4 was selected by the mother to participate in the dyad. In addition to behavioral observations of attachment, parenting practices, and discipline using a standardized dyad interaction observation system, the research team collected demographics, information on family/individual needs and strengths, out-of-home placement data, and outcome data on mothers' social support, mental health, and parenting practices/beliefs.

Note that this report only presents the survey data and findings collected as part of the Mother-Child Dyad Observation and Evaluation research. The video data and findings are presented elsewhere; contact the first author of this report for additional information on these findings. This report presents data and findings in the following four sections:

**1. RESEARCH PARTICIPATION OVERALL**

This section presents the participation rates of mothers and children in the evaluation research overall, as well as the specific aspects of the study.

**2. MOVE MOTHER AGGREGATED DATA, INCLUDING BOTH THE CHILDREN'S PROGRAM AND DYAD PILOT TESTS**

This section presents data and findings from all of the mothers across all aspects of the evaluation research in a combined manner.

**3. MOVE CHILDREN'S PROGRAM PILOT TEST (CHILDREN AGES 5-17)**

This section presents data and findings collected as part of the MOVE Children's Program Pilot Test (Children ages 5-17).

**4. INFANTS AND YOUNG CHILDREN: MOTHER-CHILD DYAD OBSERVATION AND EVALUATION (CHILDREN AGES 0-4)**

This section presents data and findings collected as part of the Mother-Child Dyad Observation and Evaluation (Children ages 0-4).

### **1. Research Participation Overall.**

Tables 1 and 2 on the following pages provide detailed data regarding research participation. A total of 35 women and 50 children participated in this study. Specifically, slightly less than half (49%,  $n=25$ ) of MOVE mothers with children aged 0-4 years participated in the Mother-Child Dyad Observation and Evaluation study. Therefore, there were 25 mother/child dyads that participated in the study. As noted earlier, mothers could only have one child four years old and younger participate in the study. In the case of at least 10 of the women who were eligible for the study but did not participate (i.e., had at least one child from birth to four years old, but chose not to participate), there were custody issues (e.g., mother did not have custody of her child, mother had partial custody, or child was in foster care/state custody), timing issues related to eligibility (e.g., child began coming halfway through the group), or concerns about how a child's development might hinder study involvement (e.g., Autism diagnosis).

A total of 74% ( $n=17$ ) of eligible mothers with children 5-17 participated in the MOVE Children's Program Pilot Test study, and many of the participating mothers had more than one child between these ages. Thus, 25 children ages 5-17 from 17 mothers participated in this study. Notably, seven mothers had children in both age ranges (i.e., 0-4 and 5-17), and therefore they and their children participated in both aspects of the study. Almost all of the mothers and children that participated in initial data collection activities participated in follow-up data collection. Additional results regarding research participation overall may be found in Appendix A.

**Table 1: Number of Child and Adult Participants by Cohort and Study Section**

<b>Cohort</b>	<b>Total Number of Mom Participants*</b>	<b>Total Number of Children Participants</b>	<b>Number of Children in Outcome Study</b>	<b>Number of Children in Dyad Study</b>
<b>Cohort 1</b>	<b>3</b>	<b>3</b>	<b>0**</b>	<b>3</b>
<b>Cohort 2</b>	<b>4</b>	<b>9</b>	<b>6</b>	<b>3</b>
<b>Cohort 3</b>	<b>7</b>	<b>8</b>	<b>3</b>	<b>5</b>
<b>Cohort 4</b>	<b>6</b>	<b>8</b>	<b>5</b>	<b>3</b>
<b>Cohort 5</b>	<b>5</b>	<b>8</b>	<b>4</b>	<b>4</b>
<b>Cohort 6</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>2</b>
<b>Cohort 7</b>	<b>4</b>	<b>8</b>	<b>5</b>	<b>3</b>
<b>Cohort 8</b>	<b>4</b>	<b>4</b>	<b>2</b>	<b>2</b>
<b>TOTAL</b>	<b>35</b>	<b>50</b>	<b>25</b>	<b>25</b>

**NOTES:**

\* Differences in the number of mom participants compared to the number of child participants reflect the fact that many mothers had multiple children participating in various components of the study.

\*\*The research team had not yet started the outcome study.

**Table 2: Eligibility and Participation Rates by Study Section**

<b>Group</b>	<b>Eligibility/ Participation</b>	<b>Participation Rate (%)</b>
<b>Dyad</b>		
<b>Eligible</b>	<b>51/71</b>	<b>.7285 (73%)</b>
<b>Participated</b>	<b>25/51</b>	<b>.4902 (49%)</b>
<b>Participation removing Custody</b>	<b>25/41</b>	<b>.6098 (61%)</b>
<b>Retention at Program Completion</b>	<b>24/25</b>	<b>.9600 (96%)</b>
<b>Outcome Moms</b>		
<b>Eligible Moms</b>	<b>23/61</b>	<b>.3770 (38%)</b>
<b>Participating Moms</b>	<b>17/23</b>	<b>.7391 (74%)</b>
<b>Retention at Program Completion</b>	<b>15/17</b>	<b>.8824 (88%)</b>
<b>Outcome Children</b>		
<b>Eligible Children</b>	<b>39</b>	
<b>Participating Children</b>	<b>25/39</b>	<b>.6410 (64%)</b>
<b>Retention at Program Completion</b>	<b>23/25</b>	<b>.9200 (92%)</b>

\* In the case of at least 10 of the women who did not participate, there were custody issues (i.e. mother did not have custody, mother had partial custody, children were in foster care, etc.), eligibility timing (i.e., participants who were coming halfway through group), concerns about developmental disabilities such as Autism.

## **2. MOVE Mother Aggregated Data, Including Both Children's Program and Dyad Pilot Tests**

Detailed and comprehensive findings from the results of the MOVE Mother's Aggregated Data may be found in Appendix B. When considering all of the mothers who participated in the current study ( $N=35$ ), a number of mental health and IPV variables showed significant improvement between starting the MOVE program and program completion. Specifically, MOVE mothers experienced statistically significant reductions in depression ( $t(59)=3.06, p<.01$ ), and posttraumatic stress symptoms ( $t(54)=4.90, p<.001$ ). Reflective of these overall trends for example, the number of participants who moved from scores indicating clinical concern with depressive symptoms decreased from 53% at program entry to nearly 20% at program completion. In addition to these largely positive findings regarding women's mental health symptoms, we also note that there were positive data trends regarding women's reported use of alcohol as well as illegal drugs and other substances (e.g., abuse or misuse of prescription medications).

Regarding the mothers' self-perceptions of their parenting practices and feelings, MOVE participants reported statistically significant increases in their ability to recognize abuse ( $t(56)=5.00, p<.001$ ), protect their children from IPV ( $t(56)=4.75, p<.001$ ), understand the effects of IPV on children ( $t(56)=5.62, p<.001$ ), problem solve ( $t(64)=-4.35, p<.001$ ), and mobilize helpful resources ( $t(56)=-3.52, p<.01$ ). Mothers also reported greater overall satisfaction in their role as parents ( $t(62)=-3.68, p<.001$ ). Moreover, mothers had statistically significant improvements in parenting role reversal (e.g., parentified child;  $t(62)=-2.89, p<.01$ ). Related to parenting stress overall, findings also showed that mothers reported significant improvements in their parental distress ( $t(58)=-3.67, p<.001$ ).

The research team also investigated differences in IPV perpetration and victimization prevalence from program entry to program completion. The Women's Experience of Battering (WEB) scale indicated a significant reduction in types of experiences of IPV victimization among the participants (e.g., feeling unsafe in her own home, feeling powerless and trapped). At program entry, 79% of participants endorsed enough WEB items to indicate a strong likelihood of battering. By program completion, these numbers had fallen to 58%. Findings from the Conflict Tactics Scales (CTS), which is frequently used in research to assess IPV, also showed that MOVE mothers experienced statistically significant reductions in IPV victimization (particularly minor and severe psychological victimization [ $\chi^2(1, N=53) = 6.97, p < .01$  and  $\chi^2(1, N=55) = 18.55, p < .001$  respectively]) and minor and severe injurious victimization ( $\chi^2(1, N=56) = 4.11, p < .05$  and  $\chi^2(1, N=56) = 6.66, p < .01$  respectively) and IPV perpetration (particularly minor and severe psychological perpetration [ $\chi^2(1, N=57) = 10.98, p < .01$  and  $\chi^2(1, N=56) = 9.90, p < .01$  respectively]) and minor physical perpetration ( $\chi^2(1, N=57) = 8.56, p < .01$ ). Taken together, all these findings demonstrate that mother participants were reporting strongly positive improvements in their experiences of IPV.

### **3. MOVE Children's Program Pilot Test (Children ages 5-17)**

Children in this part of the research evaluation ( $n=25$ ) varied widely in their ages (i.e., children ranged in age from 5 to 17). Detailed findings and additional information on the results of the MOVE Children's Program Pilot Test may be found in Appendix C.

Unfortunately, there are a limited number of valid, reliable, and relevant questionnaires and instruments that capture an age range as wide and varied as the one found among the children who typically participate in the MOVE Children's Program. In other words, a standardized research data collection instrument or survey item that is appropriate for a child aged 14 years

might not be understood and/or appropriate for a child aged 5. Therefore, the research team tailored the questionnaire packet provided to each child research participant so that each child received measures that were valid, reliable, and appropriate for his or her age. As a result, at the end of data collection, not enough of any one instrument had been completed to conduct meaningful statistical tests.

Another factor complicating the research team's analysis of this portion of the data was that many evaluation instruments, although attempted, were not completed in their entirety. In accordance with advice from previous MOVE mothers (Rizo et al., 2015), the research team invited mothers to scan each survey in the questionnaire packet meant for their respective children prior to survey administration. Mothers were able to cross out questions, entire survey scales, or any other material they felt was inappropriate for their children. Accordingly, the lack of complete measures for some of the instruments limited the interpretability of the data because many of the surveys and questionnaires must be scored cumulatively and a blank response renders the entire instrument unusable for meaningful data analysis.

A few of the measures that were unsuccessfully used in the current study for children aged 5-17 years included the Beck Anger Inventory (BAI), the Beck Self Concept Inventory (BSCI), and the Children's Exposure to Domestic Violence Scale (CEDV). These measures were either not completed in their entirety due to child or parent omission and/or were validated for children in an age range that did not encompass the majority of child participants. For example, the CEDV is validated for children aged 11-17, an age range that fit only five study participants (20%). The BAI and BSCI were intended for children aged 7 and older, an age range which comprised just under 50% of the overall sample (48%,  $n=12$ ). However, in addition to the limited number of children eligible to complete the BAI and BSCI, several children reported that

they were unable to comprehend specific questions and/or became confused by question wording. When they did not understand questions, children often opted not to answer them.

Despite these limitations, there were a few noteworthy, albeit preliminary, findings in the data gleaned from this age group. Overall, children ages 5-17 noted a decreased incidence of witnessing violence ( $t(24)=1.96, p<.05$ ). This data lend support to mothers' reports of decreased IPV perpetration and victimization and strengthens the assertion that at MOVE program completion, families were experiencing less IPV in the home. In addition, mothers reported an increase in their children's internalizing behaviors ( $t(38)=-6.64, p<.001$ ), a decrease in their children's externalizing behaviors ( $t(38)=2.75, p<.05$ ), and an increase in their children's emotional problems ( $t(38)=-5.90, p<.001$ ).

Survey findings also indicated noteworthy trends that were not statistically significant but showed positive change. For the BAI, the children who were eligible and able to respond to this instrument ( $n=11$ ) reported improvements in their fears, worrying, and physical anxiety symptoms at program completion relative to program entry. Likewise, on the BSCI, the children who responded ( $n=9$ ) reported improvements in their self-beliefs regarding their abilities and their competencies. Although these findings were not statistically significant, these trends are notable given their positive direction.

In addition to the quantitative measures used among this age group, three qualitative questions were developed to explore children's understanding of the concepts included in the MOVE children's group curriculum. The research team investigated the following concepts from the MOVE children's group: safety-planning, communication, feeling identification, as well as self-soothing and coping skills. Examples from the qualitative questions concerning these program concepts included "When you feel scared, what are some things you can do to help

yourself feel better?;" "What are three things you can do to keep yourself safe?;" and "What is the difference between feeling safe and feeling unsafe?"

At program entry data collection, child participants' answers to all questions were typically non-specific, and children seemed uncertain how to reply. Example responses from the child participants at program entry include "I'm not sure," and "I don't know." When asked about the difference between feeling safe and unsafe several children responded similarly, stating "When I'm safe, I am happy. When I'm unsafe, I am sad." Children also seemed uncertain about specific strategies they could use to keep themselves safe. For example, when asked about actions one can do to promote individual safety, one child participant noted, "I just close my eyes and wait."

At program completion data collection, child responses were concrete and specific. Most of the participating children were able to name several strategies for keeping themselves safe from IPV and other dangerous situations. In the words of one child, "If I feel unsafe, I can call the police, get out of the area, or go to my safe place (my closet)." When discussing the difference between feeling safe and unsafe at program completion, many child participants related their feeling of discomfort to safety concerns. As one child noted, "When you feel safe, you are calm and content. You know that nothing can harm you. When you feel unsafe, you are uneasy and could be hurt. Also usually when you are unsafe, people around you act differently, so you need to try and make yourself safe." At program completion, it was also rare for a child to skip a qualitative question.

#### **4. Infants and Young Children: Mother-Child Dyad Pilot Test (Children 0-4)**

Children in this age range ( $n=25$ ) completed all questionnaires with their mothers present, and there were a few questions in the battery that were geared towards parents and parenting behaviors. Parental questions were given in this part of the research because many children in

this age range have limited verbal capacity, and therefore measurement tools must rely on parental impressions. Similar to the procedure outlined above, mothers were able to examine all materials that would be shown to their children and cross out any questions that they felt were inappropriate. Despite the limitations such deletion may cause (such as issues with scoring), most measurement tools used were appropriate for the entire range of ages in this sample. Consequently, these data were typically more complete than the older child data discussed above.

Overall, these younger children had statistically significant improvements in prosocial behaviors ( $t(42)=-4.10$ ,  $p<.001$ ), hyperactivity (e.g., a decrease in hyperactivity;  $t(42)=5.61$ ,  $p<.001$ ), and adaptability (e.g., a decrease in being inadaptability;  $t(16)=4.36$ ,  $p<.01$ ). Similar to mothers' reports of their children overall, children in this study demonstrated an increase in internalizing behaviors ( $t(38)=-6.64$ ,  $p<.001$ ), a decrease in externalizing behaviors ( $t(38)=2.75$ ,  $p<.05$ ), and an increase in emotional problems ( $t(40)=-5.90$ ,  $p<.001$ ). Detailed findings and additional information on the results from the Mother-Child Dyad Pilot Test may be found in Appendix D.

## **Discussion**

This report presents preliminary findings from the data collected as part of the child-focused evaluation of the MOVE Program. To the best of our knowledge, this is among one of the first efforts to conduct research with the children of system-involved IPV survivors who are receiving community-based parenting and safety services. Accordingly, the preliminary pilot data gathered from this study provides valuable information on system-involved IPV survivors and their children.

In light of the dearth of program evaluation and intervention research on system-involved IPV survivors and their children, our research team was uncertain about the feasibility and

potential success of any of our planned data collection efforts. Thus, first and foremost, our research team aimed to assess the acceptability and feasibility of collecting data from these children and their mothers, as well as evaluate the acceptability and feasibility of our data collection methods and instruments across children from a range of ages. In addition, we sought to investigate the characteristics, needs, and strengths of the children who were involved with the MOVE program. Last, the research team sought to investigate preliminary outcomes among the system-involved IPV survivors and children who had participated in MOVE by collecting data at program entry and program completion, and by comparing differences between the two time points. We discuss specific successes, challenges, and findings below.

### **Research Participation and Feasibility**

*Research participation.* One of the most important questions addressed in the current study was the feasibility of collecting sensitive data from this vulnerable group of mothers and children. Overall, many mothers who participated in MOVE were willing to participate in this research and willing to allow the research team to ask both them and their children in-depth questions about parenting, mental health, and IPV. That said, research participation rates were less than optimal, that is, not 70%+ overall. Thus, there may be room for improvement in research participant recruitment, despite the extraordinary efforts our research team employed to ensure high research participation (e.g., multiple invitations, confidentiality assurances, participation amenities).

We note that, among the mothers who did not participate in the research at all, many reported significant barriers (e.g., custody issues, children with disabilities) that precluded their families' participation in the research. Accordingly, future researchers should learn from this finding to account for such complexities in participant recruitment. We recommend that future researchers

replicate our study methods that emphasized significant research participant amenities (e.g., childcare, transportation). Our research team also made special efforts to conduct data collection in convenient locations (e.g., CPS offices) to increase research participation whenever possible. In addition to these research recruitment strategies, we encourage future researchers (a) to be present and available during program intake procedures to meet with potential participants; (b) to be available nearby in a confidential, but known, location before, after, and during service delivery to be accessible to research participants with questions; and (c) to be candid about any university affiliation (when applicable). The familiarity of research team staff, rapport between group facilitators and research team members, as well as the research team's clear affiliation with a well-known university appeared to help many participants feel confident in participating and to promote participant candor. We also acknowledge here that given the challenging life circumstances faced by families while participating in MOVE, the research participation rates determined in this investigation may be realistic for these vulnerable families.

Despite the challenges to research participant recruitment, we note high rates of research participant retention for both mothers and their children. These findings suggest that the participant retention strategies used in this study were successful. Retention strategies used in this study included (a) making follow-up contacts using self-designated safe telephone numbers; (b) allowing considerable flexibility in the timing and location of follow-up data contacts; and (c) offering participant amenities to help reduce the burden of participation (e.g., child care, transportation assistance, gift cards to recognize participants' time and efforts). Accordingly, we encourage future research with system-involved, female IPV survivors and their children to replicate our participant retention strategies to ensure similar high rates.

*Data collection instruments and measures.* When choosing measurements for this study, our research team diligently researched and found recommended measures for our populations of interest. As a result of these efforts, the measurement instruments that were used in this study demonstrated high validity and reliability in past studies. However, some of these instruments seemed to be less valid and reliable in the current population. For example, some children did not appear to understand the questions that were asked of them even though the questions were from age-appropriate measures used previously with children of a similar age. In contrast to prior research, the data collectors for this study reported that some children responded with the same answer to multiple questions, regardless of the question. Other children responded by telling stories that may or may not have had a relationship to the initial question asked. Such responses from participants indicated to our research team a lack of understanding of the study questions.

Although it is difficult to be certain about the reasons why the child participants in this study responded poorly to these well-respected measures, our team has speculated that the reason may be related to the detrimental psychological and psychosocial effects of family violence on child cognitive and emotional development. In particular, our research team has posited that the difficulty many of the children had in answering questions on measures validated among children of a similar age may reflect cognitive delays common in children who have been exposed to trauma (e.g., Lupien et al., 2009).

Furthermore, given the limited research on system-involved IPV survivors and their children, we also speculate that the general population of children exposed to IPV might be different from children who are both exposed to IPV and who live in families that are involved in the court and/or CPS systems. Children who live in families that are involved in the court and/or CPS

systems may be an especially vulnerable, stressed, and traumatized group of IPV-exposed children.

Anecdotally, we understood that several mothers who were participating in this study had children suffering from disorders such as autism, attention-deficit/hyperactivity disorder, depression, posttraumatic stress disorder, anxiety, as well as academic failure. Moreover, many of the children in this study had suffered early disruptions in attachment due to changing custody arrangements and CPS involvement. Such stressors can hinder cognitive and emotional development and may make it difficult for children to adequately focus on tasks such as answering a battery of survey questions.

For all these reasons, research instruments and measures that are valid and reliable with children exposed to IPV generally may be less optimal among this sub-group of unique IPV-exposed children. Thus, to investigate the value of IPV services among these children successfully, studies focused on children who live in families that are involved in the court and/or CPS systems may need to develop tailored measures and instruments, as well as specialized data collection methods.

In addition to measurement issues concerning child comprehension, there were also challenges associated with intentionally missing data. Mothers often picked similar questions to remove from their children's packets, making it difficult to analyze data without an adequate sample size. Mothers who eliminated questions from their children's questionnaires often did not want their children answering questions regarding drug sales (e.g., "Have you ever seen a person dealing drugs?"), severe violence (e.g., "Have you ever seen a person get shot?" and "Has anyone ever tried to stab you?"), and corporal punishment (e.g., "Have you ever been spanked?" and "Have you ever seen someone else be spanked?").

In the case of the older children, many mothers either crossed-out or questioned the utility of questions related to sexual abuse (e.g., “Has anyone ever forced you to have sex with them? If so, who and how often?”), stating that they felt the question would create unnecessary discomfort for their child or that their child would not understand what was meant by the word “sex.” Given how often mothers eliminated these specific question types, we encourage future research to validate measures without these sensitive questions so that measurement scoring may be completed regardless of survey completion.

By inviting mother participants to eliminate survey items, our research team undoubtedly invited complexities into our study. Nonetheless, the mother participants also seemed to appreciate the opportunity to examine and rule out specific child measures (Rizo et al., 2015). Thus, our research team postulates that mothers might not have allowed their children to participate in the research at all had the mothers not been able to review and eliminate survey items that they found concerning or inappropriate. Nonetheless, we encourage future researchers to be mindful of this trade-off. Research participation overall may increase as mothers are invited to review research questions for their children. However, researchers may also find that many sensitive, although important, research questions go unanswered.

*Characteristics, needs, strengths, and outcomes.* The data gathered suggests that mothers of children of all ages participating in the MOVE program had significant reductions in depression and PTSD symptoms, and increases in their overall satisfaction in their role as a parent. Similarly, mothers overall experienced significant reductions in both IPV victimization and perpetration. These results were corroborated by their children’s responses regarding witnessing violence, suggesting that participation in the MOVE program was associated with an overall decrease in violence in the home.

Younger children (aged 0-4 years) experienced a decrease in parent-reported levels of hyperactivity, an increase in adaptability, and an increase in prosocial behaviors. Both younger (aged 0-4 years) and older (aged 5-17 years) children demonstrated an increase in internalizing behaviors, a decrease in externalizing behaviors, and an increase in emotional problems. These findings regarding child participants' internalizing and externalizing behaviors are notable. Potential explanations for this finding included that the mothers felt better equipped to handle externalizing behaviors by program completion relative to program entry. We also posit that mothers may have been more aware of the complex emotional effects of IPV on children over the course of the program and research and thus were more attuned to their children's internalizing behaviors. Furthermore, children's externalizing behaviors may have decreased and their internalizing behaviors may have intensified as their home life became increasingly safe and less violent. As noted earlier, findings from both mothers and older children suggest that there was less IPV occurring on average among participating families at the second data collection point.

Taken altogether, the study findings point to the many and complex needs of children who live in families who are struggling with both IPV and system-involvement (i.e., court system and/or CPS). As discussed earlier in this report, children exposed to IPV suffer numerous negative short-term consequences (e.g., cognitive and academic problems), as well as long-term consequences of such exposure after childhood (e.g., adult mood disorders, difficulty developing healthy adult relationships). Thus, services for system-involved IPV survivors should ideally address the needs of their children.

Although preliminary and tentative, the findings from this research suggest that the MOVE children's program may provide such critically needed help and support to children exposed to

IPV. The promising, albeit initial, outcome trends from this evaluation suggest that when school-aged children are able to participate in the MOVE program, they experience benefits.

Accordingly, the MOVE children's program warrants future research with a larger sample of children in which a more rigorous and robust study may be conducted.

In addition, given the complex needs this research has discovered among participating families, children of system-involved IPV survivors likely also need specialized services and outreach. Although the MOVE children's program may produce benefits for children (again, this should be determined in rigorous future research), children with serious academic problems, complex custody arrangements, and disabilities likely need additional services beyond what the weekly, group-based MOVE children's program can currently provide. Such outreach and services may be especially important for children who live in families where IPV is current and ongoing. For children in families where IPV is diminishing and safety is increasing, such services may not be as critical. Accordingly, we encourage researchers to investigate the changing needs of children of system-involved IPV survivors over time.

***Limitations.*** We urge readers to consider all of these findings in light of their limitations. Given that the aims of this research were focused on research acceptability, feasibility, and preliminary outcomes, a small study sample was a planned part of this research. Nonetheless, the small sample size used in this research means that statistical significance and promising trends may change (e.g., increase, decrease, or disappear) if such a study were repeated with a larger sample. Similarly, the sample size was further reduced because participants inadvertently and purposefully skipped questions. As described previously, many of the instruments used in this research cannot be appropriately scored if all questions are not answered completely. Therefore, some of the measurement totals as well as significance and/or trend findings reflect only a

portion of the sample they are intending to represent (e.g., all mothers, [mothers of] children 5-17, [mothers of] children 0-4).

Further, we note here that although this research was purposely designed as a quasi-experimental, single group, pre- and post-test study, there is no way to know whether the positive trends shown in these findings were due to the MOVE Program or another explanation (e.g., change over time). We are encouraged that the significant and trend findings are in positive directions, indicating improvements for women and children. We are also reassured that these findings do not show harms or worsening over time. Given these positive preliminary findings that show no harm, a rigorous randomized control test of MOVE—both the mothers’ and the children’s program—is warranted.

Given the study design and the small sample size, our research team also cannot make any meaningful statements regarding the specific and unique effects of either the MOVE Parenting Program or the MOVE Children’s Program on older child participant outcomes. In other words, without studying both programs separately and in distinct ways, it is impossible to know if the older children’s improvements were due to their own participation in the program, their mothers’ participation in the program, or some combinations of effects between both programs. Future research will need to carefully consider how best to rigorously evaluate the potential unique effects of the children’s program, in light of these mothers’ service requirements. That is, since the mothers must attend services, the children’s program will typically always be delivered in conjunction with the mothers’ program. Accordingly, future research might explore the unique effects of the children’s program by implementing this intervention in a population of IPV-affected families who are not mandated to services (e.g., children in a shelter setting or children in a community-based program).

In addition to these overall limitations, we note here that the research team experienced two unexpected challenges while conducting this research. In turn, these challenges may have had an effect on the data collection efforts, the research participation rates and the overall study findings. The first unexpected challenge for our research team was the time-intensive nature of the data collection activities with the participating children. Individual data collection meetings with children, as well as dyad meetings with children and their mothers, took considerable time. Our team was able to accommodate all the children and mothers who wanted to participate in the research; however, to do so, we added additional team members to the study when possible. For example, when graduate student research assistant funding was available through our university, we recruited additional graduate student research assistants to help with the data collection efforts at no additional cost to the overall project. Even with this additional help however, our team was not always able to collect data as efficiently as we would have liked. In turn, our limited efficiency delayed some of the data collection meetings with children and mothers. As noted above, no prior research project (to the best of our knowledge) had invited children of mothers who were mandated into IPV services to participate in research. Moreover, this was our team's first effort to collect data with child participants in the ways that we did (e.g., video taping in a community-based service setting). For future studies with IPV-exposed children who are living in families that are involved with the court and/or CPS systems, it would be helpful to add additional, experienced data collectors to the study team. Additional data collectors available during key times of the study (e.g., at program entry, immediately after program completion) could significantly enhance the team's data collection capacity.

The second unexpected challenge for our research team was the ebb and flow in the numbers of families participating in MOVE over time. Our research team's initial plan was to end this

study in the summer of 2013. However, as the study progressed, our team noted that, due to some relatively low numbers of MOVE families participating in the program at various times, we had lower numbers of participating families in the research overall, even when the study participation rates were adequate. Thus, our team requested and obtained a no-cost extension for this project. This no-cost extension enabled our team to keep enrolling families in the study and collecting data into the late fall of 2013. Accordingly, we were able to enroll a greater number of families in our study relative to the number we would have enrolled if our team had not extended the project for those additional months. For future research on the MOVE program, it may be important to recruit additional MOVE delivery sites to expand program capacity. Undoubtedly, with a program such as MOVE, there will likely be fluctuations in program participation. To account for such fluctuations, increasing the sites delivering MOVE may enable a consistently high number of families to participate in the program as well as the research.

Despite these limitations, this research demonstrated initial success in conducting research with a unique group of women and children. Moreover, this was an ambitious data collection effort in that our research team aimed to collect data from an especially vulnerable group of women and children using different data collection methods (e.g., quantitative surveys, qualitative feedback, and parent-child video taping). Given the findings from this complex and ambitious study, we hope that future research can build from our successes and lessons-learned to extend and strengthen this line of research and determine what services are most beneficial for system-involved IPV survivors and their children.

In closing, our research team acknowledges the contributions of staff and leadership at InterAct and SAFEchild. The research team also acknowledges that the willingness of the mothers to participate along with their children in the current study speaks to the many strengths

of the MOVE program. The demonstrated feasibility of conducting this research with vulnerable IPV survivors and their children shows that, with strong collaboration between researchers and community agencies, future studies may be conducted to examine the complex and varied relationship between IPV and parenting.

## References

- Bedi, G., & Goddard, C. (2007). Intimate partner violence: What are the impacts on children? *Australian Psychologist, 42*(1), 66-77. doi:10.1080/00050060600726296
- Black, D., & Newman, M. (1996). Children and domestic violence: A review. *Clinical Psychology and Psychiatry, 1*, 79-88.
- Edleson, J. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women, 5*(2), 134-154. doi:10.1177/107780129952003
- Feder, L., & Henning, K. (2005). A comparison of male and female dually arrested domestic violence offenders. *Violence and Victims, 20*, 153–171. doi:10.1891/vivi.2005.20.2.153
- Hamberger, L. K., & Potente, T. (1994). Counseling heterosexual women arrested for domestic violence: Implications for theory and practice. *Violence and Victims, 9*, 125–137.  
Retrieved from <http://www.springerpub.com/product/08866708>
- Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse & Neglect, 34*, 734–741.  
doi:10.1016/j.chiabu.2010.03.001
- Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*, 339–352. doi:10.1037/0022-006X.71.2.339
- Lupien, S. J., McEwen, B. S., Gunnar, M. R., & Heim, C. (2009). Effects of stress throughout the lifespan on the brain, behaviour and cognition. *Nature Reviews Neuroscience, 10*(6), 434-445. doi:10.1038/nrn2639

- Moles, K. (2008). Bridging the divide between child welfare and domestic violence services: Deconstructing the change process. *Children and Youth Services Review, 30*(6), 674-688. National Institute of Child Health and Human Development (1996)
- Rizo, C. F., Macy, R. J., Dababnah, S., O'Brien, J., Ermentrout, D. M., & Pollock, M. D. (2015). Research with children exposed to partner violence: Perspectives of service-mandated, CPS- and court-involved survivors on research with their children. *Journal of Interpersonal Violence*. doi:10.1177/0886260515596534
- Rizo, C. F., Macy, R. J., Ermentrout, D. E., & Johns, N. B. (2011). A review of family interventions for intimate partner violence with a child focus or child component. *Aggression and Violent Behavior, 16*(2), 144-166. doi:10.1016/j.avb.2011.02.004
- Simmons, C. A., Lehmann, P., & Collier-Tenison, S. (2008). From victim to offender: The effects of male initiated violence on women arrested for using intimate partner violence. *Journal of Family Violence, 23*, 463–472. doi:10.1007/s10896-008-9173-8
- Simmons, C. A., Lehmann, P., & Dia, D. A. (2010). Parenting and women arrested for intimate partner violence. *Journal of Interpersonal Violence, 25*, 1429-1448. doi:10.1177/0886260509346064
- Stuart, G. L., Moore, T. M., Hellmuth, J. C., Ramsey, S. E., & Kahler, C. W. (2006). Reasons for intimate partner violence perpetration among arrested women. *Violence Against Women, 12*, 609–621. doi:10.1177/1077801206290173
- Turner, S., Gilbert, A., Hendricks, A., & Demaree, J. (Eds.). (2006). *Growing beyond conflict: The path to building safer families—Parent group curriculum*. San Diego, CA: Chadwick Center for Children & Families, Children's Hospital and Health Center.

Turner, S., Weitz, D, Peterson, L., & Demaree, J. (Eds.). (2006). *Growing beyond conflict: The path to Building Safer Families–Children’s group curriculum*. San Diego, CA: Chadwick Center for Children & Families, Children’s Hospital and Health Center.

U.S. Department of Health and Human Services (2013). *Child maltreatment 2012*. Retrieved from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>

**Appendix A: Research Participation**

Figure 1. MOVE Children's Program Evaluation: Ages 5-13+ Years

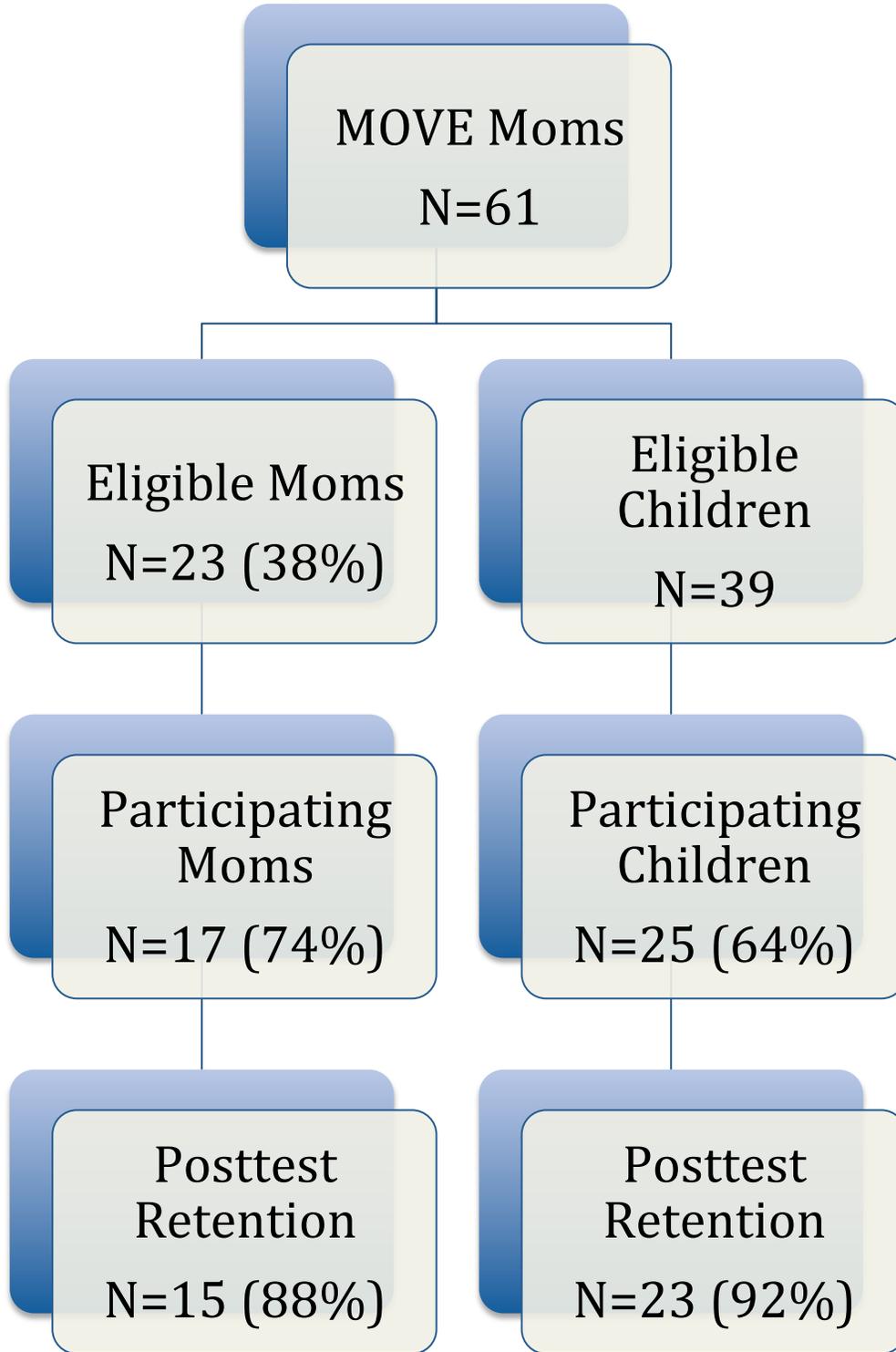
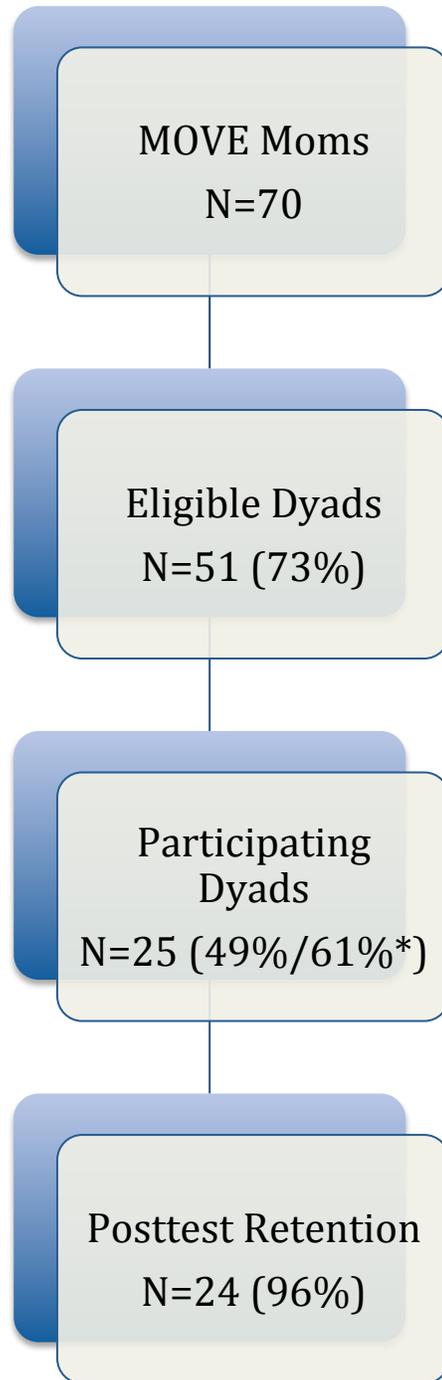


Figure 2. MOVE Mom & Child Dyad Research: Ages 1-4 Years



\* Higher percentage reflects participating Dyads out of eligible Moms without custody issues- out of the 51 eligible Moms, 10 Dyads that did not participate had issues with custody; however, another 2 Moms with custody issues did participate.

**Appendix B: Results from MOVE Mother’s Aggregated Data  
(Including Mother Participants from Both Children’s Program and Dyad Pilot Tests)**

**Caregiver Self-Assessment (CSA- Data Provided at Program Completion)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Self-Assessed Abilities to Recognize Abuse and Protect Their Children from Abuse

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>Ability to recognize child abuse</b>	28	3.46(1.20)	4.86 (0.59)	5.00***
<b>Understand effects of DV</b>	28	3.11 (1.26)	4.85 (0.76)	5.62***
<b>Ability to protect kids from DV</b>	28	3.07 (1.46)	4.71 (0.94)	4.75***
<b>Ability to get your kids help</b>	28	3.00 (1.52)	4.79 (0.69)	5.39***

\*\*\*p<.01, \*\*p<.001; Response items range from 1=“Low” to 4=“Very High”

NOTE: Delivered at program completion only, asked respondents to reflect back on their knowledge from before program start

Scaling information:

- 8 items; 4 regarding knowledge previous to MOVE, 4 regarding knowledge after MOVE (range 4-16)
- No Reverse coding
- Additive = exclude if any missing

Interpretation:

- Higher scores reflect great self-perceived agency

**Center for Epidemiologic Studies Depression Scale (CESD)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Depression and Depressive Symptoms

Survey Scale	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
<b>CESD</b>	28	16.21(8.92)	11.50(7.59)	3.06**

\*\*p<.01; Response items range from 0= “rarely or none of the time” to 3= “most or all of the time”

NOTE 1: Time frame for program entry and completion - past week

Scaling information:

- 20 items; sum all items (range 0-60)
- Reverse code the following items: 4, 8, 12, 16
  - Added “\_REV” to old variable name to create new reverse coded variable name (e.g., “precesd4” became “precesd4\_REV”)
- Additive = exclude if any missing

Interpretation:

- Higher scores indicate the presence of more symptomatology
- A score of 16 points or more is considered depressed

CESD Clinical	Program Entry (N =32 )	Program Completion (N = 29)
	Percentage (n)	Percentage (n)
<b>Area of Concern (16 or higher)</b>	53.13% (17)	20.69% (6)
<b>Other (15 or below)</b>	46.88% (15)	79.31% (23)

### **PTSD Checklist- Civilian Version (PCL-C)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Posttraumatic Stress Disorder and Posttraumatic Stress Symptoms

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>PCL-C</b>	27	41.37(13.51)	29.78(12.08)	4.90***

\*\*\*p<.001; Response items range from 1= "not at all" to 5= "extremely"

NOTE 1: Time frame for program entry data collection is past year; time frame for program completion data collection is last three months

#### Scaling information:

- 17 items; sum all items (range 17-85)
- Additive = exclude case if any item is missing

#### Interpretation:

- Higher scores indicate the presence of more symptomatology
- A score of 44 or above was found to be diagnostic among a predominantly female trauma sample with a sensitivity of 94% and a specificity of 86% (Blanchard, Jones-Alexander, Buckley, & Forneris, 1999)

### **Alcohol Use Disorders Identification Test (AUDIT)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Alcohol Use

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>AUDIT</b>	29	3.55(4.39)	3.28(4.91)	.30

Response items range from 0= "never" to 4= "almost daily"

NOTE 1: Time frame for program entry data collection is past year; time frame for program completion data collection is last month

#### Scaling information:

- 10 items; sum all items (range 0-40)
- Additive = exclude case if any item is missing

#### Interpretation:

- Higher scores indicate the presence of more severe alcohol use
- A cut-off value of 8 is typically used to identify alcohol dependence symptoms (Allen, Litten, Fertig, & Babor, 1997)
- Cut off score of 3 may be used with female populations to denote "at risk drinking" (Bradley et al., 2003)

### **Drug Use Disorders Identification Test (DUDIT)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Drug Use

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>DUDIT</b>	31	2.39(4.92)	1.10(2.27)	2.05*

\*\*\* $p < .05$  ( $p = .0242$ ); Response items range from 0= "never" to 6= "4 or more times a week"

NOTE 1: Time frame for program entry data collection is past year; time frame for program completion data collection is last month

#### Scaling information:

- 12 items; sum all items (range 0-72)
- Additive = exclude case if any item is missing

#### Interpretation:

- The following substance categories are explored: marijuana, cocaine, hallucinogens, stimulants, tranquilizers, opiates, and "other" substances (i.e., inhalants, steroids, diet pills)
- Higher scores indicate the presence of more severe drug use
- A cut-off value of 8 is typically used to identify drug-related problems (Voluse et al., 2012)
- A cut-off value of 2 has been recommended to identify drug-related problems in women (Berman et al., 2003)

## Healthy Families Parenting Inventory (HFPI)

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting

Survey Scales	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
Social Support	31	19.55 (5.61)	20.81 (4.30)	-1.65
Problem-Solving	32	22.19 (4.65)	24.88 (3.91)	-4.35***
Depression	31	38.10 (6.07)	39.23 (5.18)	-1.56
Personal Care	32	19.34 (4.26)	20.06 (4.46)	-1.86
Mobilizing Resources	30	20.07 (5.10)	24.57 (4.56)	-3.52**
Role Satisfaction	32	23.31 (4.60)	25.91 (3.58)	-3.68***
Parent/Child Behavior	31	43.68 (5.09)	45.71 (4.24)	-2.78**
Home Environment	32	42.47 (7.14)	43.47 (6.92)	-1.09
Parenting Efficacy	32	24.72 (4.97)	25.41 (4.20)	-0.98

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 1= "rarely or never" to 5= "always or most of the time"

NOTE 1: No time frame

### Scaling information:

- Nine Subscales
  - Social Support: 1, 2, 3, 4, 5 (5 items; range 5-25)
  - Problem-Solving: 6, 7, 8, 9, 10, 11 (6 items; range 6-30)
  - Depression: 12, 13, 14, 15, 16, 17, 18, 19, 20 (9 items; range 9-45)
  - Personal Care: 21, 22, 23, 24, 25 (5 items; range 5-25)
  - Mobilizing Resources: 26, 27, 28, 29, 30, 31 (6 items; range 6-30)
  - Role Satisfaction: 32, 33, 34, 35, 36, 37 (6 items; range 6-30)
  - Parent/Child Behavior: 38, 39, 40, 41, 42, 43, 44, 45, 46, 47 (10 items; range 10-50)
  - Home Environment: 48, 49, 50, 51, 52, 53, 54, 55, 56, 57 (10 items; range 10-50)
  - Parenting Efficacy: 58, 59, 60, 61, 62, 63 (6 items; range 6-30)
- Sum responses for all items within each subscale
- Reverse Coding: 12, 15, 16, 17, 18, 19, 31, 32, 33, 34, 35, 36, 37, 38, 42
- Additive = exclude if any missing

### Interpretation:

- Social Support: A score 14 or lower indicates area of concern
- Problem-Solving: A score 17 or lower indicates area of concern
- Depression: A score 23 or lower indicates area of concern
- Personal Care: A score 14 or lower indicates area of concern
- Mobilizing Resources: A score 17 or lower indicates area of concern
- Role Satisfaction: A score 17 or lower indicates area of concern
- Parent/Child Behavior: A score 29 or lower indicates area of concern
- Home Environment: A score 29 or lower indicates area of concern
- Parenting Efficacy: A score 17 or lower indicates are of concern

Program Entry Frequencies for HFPI Subscales by Interpretation

<b>Social Support</b>	<b>Program Entry (N = 33) Percentage (n)</b>	<b>Program Completion (N = 32) Percentage (n)</b>
Area of Concern (14 or lower)	15.15% (5)	9.38%(3)
Other (15 and above)	84.85% (28)	90.63% (29)
<b>Problem Solving</b>	<b>Program Entry (N = 34) Percentage (n)</b>	<b>Program Completion (N = 32) Percentage (n)</b>
Area of Concern (17 or lower)	20.59% (7)	6.25% (2)
Other (18 and above)	79.41% (27)	93.75% (30)
<b>Depression</b>	<b>Program Entry (N =34 ) Percentage (n)</b>	<b>Program Completion (N =31) Percentage (n)</b>
Area of Concern (23 or lower)	8.82% (3)	0.00% (0)
Other (24 and above)	91.18% (31)	100.00% (31)
<b>Personal Care</b>	<b>Program Entry (N =34 ) Percentage (n)</b>	<b>Program Completion (N = 32) Percentage (n)</b>
Area of Concern (14 or lower)	11.76% (4)	12.50% (4)
Other (15 and above)	88.24% (30)	87.50% (28)
<b>Mobilizing Resources</b>	<b>Program Entry (N = 32) Percentage (n)</b>	<b>Program Completion (N = 32) Percentage (n)</b>
Area of Concern (17 or lower)	15.63% (5)	12.50% (4)
Other (18 and above)	84.38% (27)	87.50% (28)
<b>Role Satisfaction</b>	<b>Program Entry (N = 34) Percentage (n)</b>	<b>Program Completion (N = 32) Percentage (n)</b>
Area of Concern (17 or lower)	11.76% (4)	3.13% (1)
Other (18 and above)	88.24% (30)	96.88% (31)

<b>Parent/Child Behavior</b>	<b>Program Entry (N =34 ) Percentage (n)</b>	<b>Program Completion (N = 31) Percentage (n)</b>
<b>Area of Concern (29 or lower)</b>	0.00% (0)	0.00% (0)
<b>Other (30 and above)</b>	100.00% (34)	100.00% (31)

<b>Home Environment</b>	<b>Program Entry (N = 33) Percentage (n)</b>	<b>Program Completion (N = 32) Percentage (n)</b>
<b>Area of Concern (29 or lower)</b>	6.06% (2)	6.25% (2)
<b>Other (30 and above)</b>	93.94% (31)	93.75% (30)

<b>Parenting Efficacy</b>	<b>Program Entry (N = 34) Percentage (n)</b>	<b>Program Completion (N = 32) Percentage (n)</b>
<b>Area of Concern (17 or lower)</b>	5.88% (2)	0.00% (0)
<b>Other (18 and above)</b>	94.12% (32)	100.00% (32)

### **Adult-Adolescent Parenting Inventory (AAPI)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting and Child-Rearing Attitudes

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>Inappropriate Expectations</b>	31	26.48 (3.18)	27.10 (3.14)	-1.13
<b>Empathy</b>	31	34.71 (4.72)	35.23 (4.83)	-0.91
<b>Corporal Punishment</b>	31	41.10 (6.39)	43.90 (5.41)	-3.65
<b>Role Reversal</b>	30	33.63 (6.18)	35.80 (5.70)	-2.89**

\*\*p<.01; Response items range from 1= "strongly agree" to 5= "strongly disagree"

NOTE 1: No time frame

#### Scaling information:

- Four Subscales
  - Inappropriate expectations: 6, 10, 16, 17, 20, 27 (6 items; range 6-30)
  - Empathy: 5, 18, 21, 23, 24, 26, 28, 31 (8 items; range 8-40)
  - Corporal Punishment: 2, 8, 9, 12, 13, 15, 19, 22, 25, 29 (10 items; 10-50)
  - Role Reversal: 1, 3, 4, 7, 11, 14, 30, 32 (8 items; 8-40)
- 32 items total; sum responses for all items within each subscale
- No reverse coding needed
- Additive = exclude if any missing

#### Interpretation:

<b>Inappropriate Expectations</b>	<b>Program Entry (N = 34) Percentage (n)</b>	<b>Program Completion (N = 23) Percentage (n)</b>
<b>High Risk (under 20)</b>	2.94% (1)	0.00% (0)
<b>Some Risk (20-22)</b>	5.88% (2)	9.68% (3)
<b>Average (23-24)</b>	23.53% (8)	16.13% (5)
<b>Positive (25-28)</b>	32.35% (11)	22.58% (7)
<b>Extremely Positive (29-30)</b>	35.29% (12)	51.61% (16)

<b>Empathy</b>	<b>Program Entry (N = 34) Percentage (n)</b>	<b>Program Completion (N = 31) Percentage (n)</b>
<b>High Risk (under 22)</b>	2.94% (1)	0.00% (0)
<b>Some Risk (22-27)</b>	2.94% (1)	12.90% (4)
<b>Average (28-30)</b>	20.59% (7)	3.23% (1)
<b>Positive (31-36)</b>	26.47% (9)	32.26% (10)
<b>Extremely Positive (37-40)</b>	47.06% (16)	51.61% (16)

<b>Corporal Punishment</b>	<b>Program Entry (N = 33) Percentage (n)</b>	<b>Program Completion (N = 32) Percentage (n)</b>
<b>High Risk (under 26)</b>	0.00% (0)	0.00% (0)
<b>Some Risk (26-31)</b>	6.06% (2)	0.00% (0)
<b>Average (32-37)</b>	21.21% (7)	12.50% (4)
<b>Positive (38-43)</b>	33.33% (11)	34.38% (11)
<b>Extremely Positive (44-50)</b>	39.39% (13)	53.13% (17)

<b>Role Reversal</b>	<b>Program Entry (N = 32) Percentage (n)</b>	<b>Program Completion (N = 31) Percentage (n)</b>
<b>High Risk (under 20)</b>	6.25% (2)	3.23% (1)
<b>Some Risk (20-24)</b>	6.25% (2)	3.23% (1)
<b>Average (25-28)</b>	3.13% (1)	0.00% (0)
<b>Positive (29-34)</b>	34.38% (11)	25.81% (8)
<b>Extremely Positive (35-40)</b>	50.00% (16)	67.74% (21)

**Women’s Experience with Battering (WEB)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Battering

Survey Scale	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
<b>WEB</b>	25	38.08 (19.15)	29.68 (19.38)	3.48*

\*p<.05; Response items range from 1= “strongly disagree” to 6= “strongly agree”

NOTE1: No time frame

Scaling and Interpretation Information:

- 10 items; sum all items (range 10-60)
- Reverse score all items
- Additive = exclude if any missing
- Score >19 indicated battering (Smith, Thornton, DeVellis, Earp, & Coker, 2002)
- Score of 20 or higher is a positive screening test for battering (Coker et al., 2002; Punukollu, 2003)

WEB	Program Entry (N = 33) Percentage (n)	Program Completion (N = 26) Percentage (n)
<b>No Indication of Battering</b>	21.21% (7)	42.31% (11)
<b>Indication of Battering (&gt;19)</b>	78.79% (26)	57.69% (15)

**Conflict Tactic Scale (CTS) – Victimization**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Partner Violence Victimization

<b>Survey Scales</b>	<b>Program Entry</b>	<b>Program Completion</b>	<b>Statistical Findings</b>
	<b>Prevalence Variable Percentages (n)</b>	<b>Prevalence Variable Percentages (n)</b>	<b>Chi-Square</b>
<b>Psychological Aggression</b>			
<b>Minor</b>	No = 2.94%(1) Yes = 97.60% (33)	No = 15.79% (3) Yes =84.21% (16)	6.97**
<b>Severe</b>	No = 17.65% (6) Yes = 82.35% (26)	No = 30.43% (7) Yes = 69.57% (16)	18.55***
<b>Physical Assault</b>			
<b>Minor</b>	No = 2.94%(1) Yes = 97.60% (33)	No = 43.48% (10) Yes = 56.52% (13)	1.36
<b>Severe</b>	No = 32.35% (11) Yes = 66.65% (23)	No = 52.17% (12) Yes = 47.83% (11)	1.50
<b>Sexual Coercion</b>			
<b>Minor</b>	No = 70.59% (24) Yes = 29.41% (10)	No = 82.61% (19) Yes = 17.39% (4)	3.58
<b>Severe</b>	No = 66.67% (22) Yes = 33.33% (11)	No = 69.57% (16) Yes = 30.43% (7)	1.47
<b>Injury Scale</b>			
<b>Minor</b>	No = 21.21 (7) Yes = 78.79% (26)	No = 60.87% (14) Yes = 39.13% (9)	4.11*
<b>Severe</b>	No = 57.58% (19) Yes = 42.42% (14)	No = 73.91% (17) Yes = 26.09% (6)	6.66**
<b>Negotiation Scale</b>			
<b>Emotional</b>	No = 0.00% (0) Yes = 100.00% (34)	No = 16.67% (4) Yes = 83.33% (20)	—
<b>Cognitive</b>	No = 3.13% (1) Yes = 96.88% (31)	No = 13.04% (3) Yes = 86.96% (20)	0.18

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 0= “never happened” to 20= “20 + times”

NOTE 1: Time frame for program entry data collection is past year, program completion data collection is past three months

NOTE 2: Mean, SD, t-test, and effect size are based on rate variable. Percentages are based on actual sum, not rate variable.

NOTE 3: N provided in table is based on the number of participants used to calculate the mean, SD, and t-test. However, the percentages provided in the table are based on a different N because (a) percentages are based on prevalence scores and are thus calculated differently (i.e.,

percentages indicate whether one or more of the acts in the scale were used during the referent period) and (b) missing is handled differently for prevalence scores (i.e., even if there is some missing in a subscale, as long as one of the items occurred the participant is given a score of 1 or “yes” to the scale). The N used to calculate the percentages can be acquired by adding the number of participants who indicated “no” to those who indicated “yes” for each subscale.

#### Scaling Information: Victimization – Scales and Subscales

- Psychological Aggression
  - Minor: 3a, 13a, 19a, 25a (4 items)
  - Severe: 9a, 11a, 24a, 26a (4 items)
- Physical Assault
  - Minor: 4a, 5a, 7a, 17a, 21a (5 items)
  - Severe: 8a, 10a, 12a, 14a, 16a, 23a, 27a (7 items)
- Sexual Coercion
  - Minor: 28a XX XX (3 items) \*\* *two items removed*
  - Severe: 33a, 18a, 34a, 42a (4 items)
- Injury
  - Minor: 31a, 41a (2 items)
  - Severe: 43a, 37a, 39a, 40a (4 items)
- Negotiation
  - Emotional: 1a, 6a, 15a (3 items)
  - Cognitive: 2a, 22a, 29a (3 items)

#### Method of scoring RATE variable

- Recode based on midpoint: (1=1) (2=2) (3=4) (4=8) (5=15.5) (6=20) (7=0)
- Sum across items in subscales (don’t include if any missing)
- Rate variable: divide sum score by number of months in the reference period

#### Method of scoring PREVALENCE variable

- Indicated whether one or more of the acts in the scale were used during the referent period. Does not differentiate on the basis of how many of the acts were used or how often each act was used. This method assigns a score of 1 for any subject who reported one or more instances of any of the acts in the scale. (Create dichotomous versions of each item (0 = did not happen; 1 = happened))

**Conflict Tactic Scale (CTS) – Perpetration**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Partner Violence Perpetration

<b>Survey Scales</b>	<b>Program Entry</b>	<b>Program Completion</b>	<b>Statistical Findings</b>
	<b>Prevalence Variable Percentages (n)</b>	<b>Prevalence Variable Percentages (n)</b>	<b>Chi-Squared</b>
<b>Psychological Aggression</b>			
<b>Minor</b>	No = 2.94% (1) Yes = 97.06% (33)	No = 8.70% (2) Yes = 91.30% (21)	10.98**
<b>Severe</b>	No = 27.27% (9) Yes = 69.57% (24)	No = 43.48% (10) Yes = 56.52% (13)	9.90**
<b>Physical Assault</b>			
<b>Minor</b>	No = 21.21% (7) Yes = 78.79% (26)	No = 39.13% (9) Yes = 60.87% (14)	8.56**
<b>Severe</b>	No = 47.06% (16) Yes = 52.94% (18)	No = 68.18% (15) Yes = 31.82% (7)	1.18
<b>Sexual Coercion</b>			
<b>Minor</b>	No = 94.12% (32) Yes = 5.88% (2)	No = 91.30% (21) Yes = 8.70% (2)	10.98**
<b>Severe</b>	No = 90.63% (29) Yes = 9.38% (3)	No = 86.96% (20) Yes = 13.04% (3)	2.64
<b>Injury Scale</b>			
<b>Minor</b>	No = 48.48% (16) Yes = 51.52% (17)	No = 69.57% (16) Yes = 30.43% (7)	0.47
<b>Severe</b>	No = 90.91% (30) Yes = 9.09% (3)	No = 73.91% (17) Yes = 26.09% (6)	2.96
<b>Negotiation Scale</b>			
<b>Emotional</b>	No = 0.00% (0) Yes = 100.0% (34)	No = 16.67% (4) Yes = 83.33% (20)	—
<b>Cognitive</b>	No = 0.00% (0) Yes = 100.0% (33)	No = 14.29% (3) Yes = 85.71% (18)	—

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 0= “never happened” to 20= “20 + times”

NOTE 1: Time frame for program entry data collection is past year, program completion data collection is past three months

NOTE 2: Mean, SD, t-test, and effect size are based on rate variable. Percentages are based on actual sum, not rate variable.

NOTE 3: N provided in table is based on the number of participants used to calculate the mean, SD, t-test, and effect size. However, the percentages provided in the table are based on a different N because (a) percentages are based on prevalence scores and are thus calculated differently (i.e., percentages indicate whether one or more of the acts in the scale were used during the referent period) and (b) missing is handled differently for prevalence scores (i.e., even if there is some missing in a subscale, as long as one of the items occurred the participant is given a score of 1 or “yes” to the scale). The N used to calculate the percentages can be acquired by adding the number of participants who indicated “no” to those who indicated “yes” for each subscale.

Program completion: 15 participants did not complete this scale because they reported that they were no longer with a partner after MOVE

### Scaling Information: Perpetration – Scales and Subscales

- Psychological Aggression
  - Minor: 3b, 13b, 19b, 25b (4 items)
  - Severe: 9b, 11b, 24b, 26b (4 items)
- Physical Assault
  - Minor: 4b, 5b, 7b, 17b, 21b (5 items)
  - Severe: 8b, 10b, 12b, 14b, 16b, 23b, 27b (7 items)
- Sexual Coercion
  - Minor: 28b XX XX (3 items) \*\* *two items removed* Severe: 33b, 18b, 34b, 42b (4 items)
- Injury
  - Minor: 31a, 41a (2 items)
  - Severe: 43a, 37a, 39a, 40a (4 items)
- Negotiation
  - Emotional: 1a, 6a, 15a (3 items)
  - Cognitive: 2a, 22a, 29a (3 items)

### Method of scoring RATE variable

- Recode based on midpoint: (1=1) (2=2) (3=4) (4=8) (5=15.5) (6=20) (7=0)
- Sum across items in subscales (don't include if any missing)
- Rate variable: divide sum score by number of months in the reference period

### Method of scoring PREVALENCE variable

- Indicated whether one or more of the acts in the scale were used during the referent period. Does not differentiate on the basis of how many of the acts were used or how often each act was used. This method assigns a score of 1 for any subject who reported one or more instances of any of the acts in the scale. Create dichotomous versions of each item (0 = did not happen; 1 = happened)

### **Parenting Stress Inventory (PSI)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting Stress

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>parental distress</b>	29	44.07 (7.78)	48.14 (6.74)	-3.67**
<b>parent-child dysfunctional interaction</b>	27	47.48 (4.56)	47.22 (3.94)	0.29
<b>difficult child</b>	28	43.86 (7.47)	43.61 (6.57)	0.22
<b>Defensive Response</b>	30	24.87 (4.49)	27.83 (4.27)	-4.63***

\*\*\*p<.001; Response items range from 1= "strongly agree" to 5= "strongly disagree"

NOTE 1: No time frame

#### Scaling information:

- Four Subscales
  - parental distress (items 1-12)
  - parent-child dysfunctional interaction (items 13-24)
  - difficult child (items 25-36)
  - Defensive Response (items 1, 2, 3, 7, 8, 9, 11)
- 36 items total; sum responses for all items within each subscale
- If more than one item is missing in an individual subscale, the summative subscale cannot be calculated
- No reverse coding needed

#### Interpretation

- *Defensive Responding*: The extent to which the parent is trying to answer in a way that s/he thinks will make them look best. Low scores indicate high levels of defensive responding. A score lower than 10 indicates caution should be used in interpreting any of the other subscales
- *Parental Distress*: Extent the parent is experiencing stress in their role as a parent. High score indicate greater distress
- *Parent-Child Dysfunctional Interaction*: The extent to which the parent believes that their child does not meet their expectations and their interactions are not satisfying. High score indicate poorer interactions
- *Difficult Child*: Parent perception of how difficult their child is. High scores indicate more perceived difficulty.

**Appendix C: Results from MOVE Children’s Program Pilot Test  
(CHILDREN AGES 5-17)**

**Caregiver Self-Assessment (Program Completion Only)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Depression and Depressive Symptoms

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>Ability to recognize child abuse</b>	15	3.53 (1.30)	4.73(0.80)	2.67**
<b>Understand effects of DV</b>	15	3.27 (1.44)	4.73 (1.03)	2.80**
<b>Ability to protect kids from DV</b>	15	3.33 (1.54)	4.53 (1.25)	2.24*
<b>Ability to get your kids help</b>	15	3.33 (1.59)	4.60 (0.91)	2.57*

\*\*p<.05, \*\*p<.01; Response items range from 1=“Low” to 4=“Very High”

NOTE: Delivered at program completion data collection only, asked respondents to reflect back on their knowledge from before program start

Scaling information:

- 8 items; 4 regarding knowledge previous to MOVE, 4 regarding knowledge after MOVE (range 4-16)
- No Reverse coding
- Additive = exclude if any missing

Interpretation:

- Higher scores reflect great self-perceived agency

**Center for Epidemiologic Studies Depression Scale (CESD)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Depression and Depressive Symptoms

Survey Scale	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
<b>CESD</b>	14	17.43(9.20)	10.93(5.03)	3.41**

\*\*p<.01; Response items range from 0= “rarely or none of the time” to 3= “most or all of the time”

NOTE 1: Time frame for program entry and program completion data collection - past week

Scaling information:

- 20 items; sum all items (range 0-60)
- Reverse code the following items: 4, 8, 12, 16
  - Added “\_REV” to old variable name to create new reverse coded variable name (e.g., “precesd4” became “precesd4\_REV”)
- Additive = exclude if any missing

Interpretation:

- Higher scores indicate the presence of more symptomatology
- A score of 16 points or more is considered depressed

CESD Clinical	Program Entry (N =16) Percentage (n)	Program Completion (N = 22) Percentage (n)
<b>Area of Concern (16 or higher)</b>	62.50% (10)	14.29% (2)
<b>Other (15 or below)</b>	37.50% (6)	85.71% (12)

### **PTSD Checklist- Civilian Version (PCL-C)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Posttraumatic Stress Disorder and Posttraumatic Stress Symptoms

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>PCL-C</b>	15	41.93(15.72)	29.93(12.65)	3.29**

\*\*p<.01; Response items range from 1= "not at all" to 5= "extremely"

NOTE 1: Time frame for program entry data collection is past year; time frame for program completion data collection is last three months

#### Scaling information:

- 17 items; sum all items (range 17-85)
- Additive = exclude case if any item is missing

#### Interpretation:

- Higher scores indicate the presence of more symptomatology
- A score of 44 or above was found to be diagnostic among a predominantly female trauma sample with a sensitivity of 94% and a specificity of 86% (Blanchard, Jones-Alexander, Buckley, & Forneris, 1999)

### **Alcohol Use Disorders Identification Test (AUDIT)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Alcohol Use

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>AUDIT</b>	14	3.29(3.02)	3.21(4.26)	0.05

Response items range from 0= "never" to 4= "almost daily"

NOTE 1: Time frame for program entry data collection is past year; time frame for program completion data collection is last month

#### Scaling information:

- 10 items; sum all items (range 0-40)
- Additive = exclude case if any item is missing

#### Interpretation:

- Higher scores indicate the presence of more severe alcohol use
- A cut-off value of 8 is typically used to identify alcohol dependence symptoms (Allen, Litten, Fertig, & Babor, 1997)
- Cut off score of 3 may be used with female populations to denote "at risk drinking" (Bradley et al., 2003)

### **Drug Use Disorders Identification Test (DUDIT)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Drug Use

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>DUDIT</b>	14	.50(1.29)	0(0)	1.45

\*\*\* $p < .05$  ( $p = .0242$ ); Response items range from 0= "never" to 6= "4 or more times a week"

NOTE 1: Time frame for program entry data collection is past year; time frame for program completion data collection is last month

#### Scaling information:

- 11 items; sum all items (range 0-56)
- Additive = exclude case if any item is missing

#### Interpretation:

- The following substance categories are explored: marijuana, cocaine, hallucinogens, stimulants, tranquilizers, opiates, and "other" substances (i.e., inhalants, steroids, diet pills)
- Higher scores indicate the presence of more severe drug use
- A cut-off value of 8 is typically used to identify drug-related problems (Voluse et al., 2012)
- A cut-off value of 2 has been recommended to identify drug-related problems in women (Berman et al., 2003)

## Healthy Families Parenting Inventory (HFPI)

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting

Survey Scales	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
Social Support	14	18.29(4.78)	20.93(3.87)	-3.38**
Problem-Solving	15	23.20 (4.35)	25.33 (4.19)	-2.87*
Depression	15	38.27 (6.44)	39.60 (5.50)	-1.55
Personal Care	15	19.20 (3.73)	20.47 (3.91)	-1.95*
Mobilizing Resources	14	21.36 (5.53)	25.36 (3.50)	-3.50**
Role Satisfaction	15	24.00 (4.52)	25.27 (3.92)	-1.33
Parent/Child Behavior	15	43.20 (5.62)	45.13 (4.02)	-1.59
Home Environment	15	44.07 (5.08)	45.00 (4.78)	-0.57
Parenting Efficacy	15	24.53 (4.67)	25.20 (4.36)	-0.69

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 1= "rarely or never" to 5= "always or most of the time"

NOTE 1: No time frame

### Scaling information:

- Nine Subscales
  - Social Support: 1, 2, 3, 4, 5 (5 items; range 5-25)
  - Problem-Solving: 6, 7, 8, 9, 10, 11 (6 items; range 6-30)
  - Depression: 12, 13, 14, 15, 16, 17, 18, 19, 20 (9 items; range 9-45)
  - Personal Care: 21, 22, 23, 24, 25 (5 items; range 5-25)
  - Mobilizing Resources: 26, 27, 28, 29, 30, 31 (6 items; range 6-30)
  - Role Satisfaction: 32, 33, 34, 35, 36, 37 (6 items; range 6-30)
  - Parent/Child Behavior: 38, 39, 40, 41, 42, 43, 44, 45, 46, 47 (10 items; range 10-50)
  - Home Environment: 48, 49, 50, 51, 52, 53, 54, 55, 56, 57 (10 items; range 10-50)
  - Parenting Efficacy: 58, 59, 60, 61, 62, 63 (6 items; range 6-30)
- Sum responses for all items within each subscale
- Reverse Coding: 12, 15, 16, 17, 18, 19, 31, 32, 33, 34, 35, 36, 37, 38, 42
- Additive = exclude if any missing

### Interpretation:

- Social Support: A score 14 or lower indicates area of concern
- Problem-Solving: A score 17 or lower indicates area of concern
- Depression: A score 23 or lower indicates area of concern
- Personal Care: A score 14 or lower indicates area of concern
- Mobilizing Resources: A score 17 or lower indicates area of concern
- Role Satisfaction: A score 17 or lower indicates area of concern
- Parent/Child Behavior: A score 29 or lower indicates area of concern
- Home Environment: A score 29 or lower indicates area of concern
- Parenting Efficacy: A score 17 or lower indicates are of concern

Program Entry Frequencies for HFPI Subscales by Interpretation

<b>Social Support</b>	<b>Program Entry (N = 15) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
Area of Concern (14 or lower)	20.00% (3)	6.67%(1)
Other (15 and above)	80.00% (12)	93.33% (14)
<b>Problem Solving</b>	<b>Program Entry (N = 16) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
Area of Concern (17 or lower)	18.75% (3)	6.67% (1)
Other (18 and above)	81.25% (13)	93.33% (23)
<b>Depression</b>	<b>Program Entry (N =16) Percentage (n)</b>	<b>Program Completion (N =15) Percentage (n)</b>
Area of Concern (23 or lower)	12.50% (2)	0.00% (0)
Other (24 and above)	87.50% (14)	100.00% (15)
<b>Personal Care</b>	<b>Program Entry (N =16) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
Area of Concern (14 or lower)	18.75% (3)	6.67% (1)
Other (15 and above)	87.25% (13)	93.33% (14)
<b>Mobilizing Resources</b>	<b>Program Entry (N = 15) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
Area of Concern (17 or lower)	20.00% (3)	0.00% (0)
Other (18 and above)	80.00% (12)	100.00% (15)
<b>Role Satisfaction</b>	<b>Program Entry (N = 16) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
Area of Concern (17 or lower)	12.50% (2)	6.67% (1)
Other (18 and above)	87.50% (14)	93.33% (14)

<b>Parent/Child Behavior</b>	<b>Program Entry (N =16) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
<b>Area of Concern (29 or lower)</b>	0.00% (0)	0.00% (0)
<b>Other (30 and above)</b>	100.00% (16)	100.00% (15)

<b>Home Environment</b>	<b>Program Entry (N = 16) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
<b>Area of Concern (29 or lower)</b>	6.25% (1)	0.00% (0)
<b>Other (30 and above)</b>	93.75% (15)	100.00% (15)

<b>Parenting Efficacy</b>	<b>Program Entry (N = 16) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
<b>Area of Concern (17 or lower)</b>	6.25% (1)	0.00% (0)
<b>Other (18 and above)</b>	93.75% (15)	100.00% (15)

**Adult-Adolescent Parenting Inventory (AAPI)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting and Child-Rearing Attitudes

Survey Scales	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
<b>Inappropriate Expectations</b>	15	27.07 (2.87)	27.40 (2.87)	-0.47
<b>Empathy</b>	15	34.73 (4.61)	36.07 (4.70)	-2.39*
<b>Corporal Punishment</b>	15	41.80 (6.36)	44.87 (5.24)	-3.22**
<b>Role Reversal</b>	15	33.93 (6.31)	36.40 (6.05)	-1.92

\*p<.05; \*\*p<.01; Response items range from 1= “strongly agree” to 5= “strongly disagree”

NOTE 1:No time frame

Scaling information:

- Four Subscales
  - Inappropriate expectations: 6, 10, 16, 17, 20, 27 (6 items; range 6-30)
  - Empathy: 5, 18, 21, 23, 24, 26, 28, 31 (8 items; range 8-40)
  - Corporal Punishment: 2, 8, 9, 12, 13, 15, 19, 22, 25, 29 (10 items; 10-50)
  - Role Reversal: 1, 3, 4, 7, 11, 14, 30, 32 (8 items; 8-40)
- 32 items total; sum responses for all items within each subscale
- No reverse coding needed
- Additive = exclude if any missing

Interpretation:

Inappropriate Expectations	Program Entry (N = 16) Percentage (n)	Program Completion (N = 15) Percentage (n)
<b>High Risk (under 20)</b>	0.00% (0)	0.00% (0)
<b>Some Risk (20-22)</b>	6.25% (1)	6.67% (1)
<b>Average (23-24)</b>	18.75% (3)	13.33% (2)
<b>Positive (25-28)</b>	43.75% (7)	26.67% (4)
<b>Extremely Positive (29-30)</b>	31.25% (5)	53.33% (8)

Empathy	Program Entry (N = 16) Percentage (n)	Program Completion (N = 15) Percentage (n)
<b>High Risk (under 22)</b>	0.00% (0)	0.00% (0)
<b>Some Risk (22-27)</b>	6.25% (1)	13.33% (2)
<b>Average (28-30)</b>	18.75% (3)	0.00% (0)
<b>Positive (31-36)</b>	25.00% (4)	26.67% (4)
<b>Extremely Positive (37-40)</b>	50.00% (8)	60.00% (9)

<b>Corporal Punishment</b>	<b>Program Entry (N = 16) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
<b>High Risk (under 26)</b>	0.00% (0)	0.00% (0)
<b>Some Risk (26-31)</b>	0.00% (0)	0.00% (0)
<b>Average (32-37)</b>	31.25% (5)	13.33% (2)
<b>Positive (38-43)</b>	31.25% (5)	26.67% (4)
<b>Extremely Positive (44-50)</b>	37.50% (6)	60.00% (9)

<b>Role Reversal</b>	<b>Program Entry (N = 16) Percentage (n)</b>	<b>Program Completion (N = 15) Percentage (n)</b>
<b>High Risk (under 20)</b>	6.25% (1)	6.67% (2)
<b>Some Risk (20-24)</b>	6.25% (1)	0.00% (0)
<b>Average (25-28)</b>	0.00% (0)	0.00% (0)
<b>Positive (29-34)</b>	37.50% (6)	20.00% (3)
<b>Extremely Positive (35-40)</b>	50.00% (8)	73.33% (11)

### **Women's Experience with Battering (WEB)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Battering

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>WEB</b>	10	32.90 (20.23)	29.80 (19.71)	2.01*

\*\*p<.01; Response items range from 1= "strongly disagree" to 6= "strongly agree"

NOTE1: No time frame

### **Scaling and Interpretation Information:**

- 10 items; sum all items (range 10-60)
- Reverse score all items
- Additive = exclude if any missing
- Score >19 indicated battering (Smith, Thornton, DeVellis, Earp, & Coker, 2002)
- Score of 20 or higher is a positive screening test for battering (Coker et al., 2002; Punukollu, 2003)

<b>WEB</b>	<b>Program Entry (N = 16) Percentage (n)</b>	<b>Program Completion (N = 10) Percentage (n)</b>
<b>No Indication of Battering</b>	25.00% (4)	50.00% (5)
<b>Indication of Battering (&gt;19)</b>	75.00% (16)	50.00% (5)

**Conflict Tactic Scale (CTS) – Victimization**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Partner Violence Victimization

<b>Survey Scales</b>	<b>Program Entry</b>	<b>Program Completion</b>	<b>Statistical Findings</b>
	<b>Prevalence Variable Percentages (n)</b>	<b>Prevalence Variable Percentages (n)</b>	<b>Chi -Squared</b>
<b>Psychological Aggression</b>			
<b>Minor</b>	No = 6.25%(1) Yes = 93.75% (15)	No = 60.00% (6) Yes = 40.00% (4)	4.44*
<b>Severe</b>	No = 12.50% (2) Yes = 87.50% (14)	No = 20.00% (2) Yes = 80.00% (8)	10.00**
<b>Physical Assault</b>			
<b>Minor</b>	No = 0.00% (0) Yes = 100.00% (16)	No = 60.00% (6) Yes = 40.00% (4)	—
<b>Severe</b>	No = 50.00% (8) Yes = 50.00% (8)	No = 70.00% (7) Yes = 30.00% (3)	0.48
<b>Sexual Coercion</b>			
<b>Minor</b>	No = 68.75% (11) Yes = 31.25% (5)	No = 80.00% (8) Yes = 20.00% (2)	1.41
<b>Severe</b>	No = 81.25% (13) Yes = 18.75% (3)	No = 80.00% (8) Yes = 20.00% (2)	0.28
<b>Injury Scale</b>			
<b>Minor</b>	No = 31.25% (5) Yes = 68.75% (11)	No = 80.00% (8) Yes = 20.00% (2)	1.07
<b>Severe</b>	No = 56.25% (9) Yes = 43.75% (7)	No = 80.00% (8) Yes = 20.00% (2)	3.75
<b>Negotiation Scale</b>			
<b>Emotional</b>	No = 0.00% (0) Yes = 100.00% (16)	No = 40.00% (4) Yes = 60.00% (6)	—
<b>Cognitive</b>	No = 6.25% (1) Yes = 93.75% (15)	No = 30.00% (3) Yes = 70.00% (7)	0.48

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 0= “never happened” to 20= “20 + times”

NOTE 1: Time frame for program entry data collection is past year, program completion data collection is past three months

NOTE 2: Mean, SD, t-test, and effect size are based on rate variable. Percentages are based on actual sum, not rate variable.

NOTE 3: N provided in table is based on the number of participants used to calculate the mean, SD, and t-test. However, the percentages provided in the table are based on a different N because (a) percentages are based on prevalence scores and are thus calculated differently (i.e.,

percentages indicate whether one or more of the acts in the scale were used during the referent period) and (b) missing is handled differently for prevalence scores (i.e., even if there is some missing in a subscale, as long as one of the items occurred the participant is given a score of 1 or “yes” to the scale). The N used to calculate the percentages can be acquired by adding the number of participants who indicated “no” to those who indicated “yes” for each subscale.

#### Scaling Information: Victimization – Scales and Subscales

- Psychological Aggression
  - Minor: 3a, 13a, 19a, 25a (4 items)
  - Severe: 9a, 11a, 24a, 26a (4 items)
- Physical Assault
  - Minor: 4a, 5a, 7a, 17a, 21a (5 items)
  - Severe: 8a, 10a, 12a, 14a, 16a, 23a, 27a (7 items)
- Sexual Coercion
  - Minor: 28a XX XX (3 items) \*\* *two items removed*
  - Severe: 33a, 18a, 34a, 42a (4 items)
- Injury
  - Minor: 31a, 41a (2 items)
  - Severe: 43a, 37a, 39a, 40a (4 items)
- Negotiation
  - Emotional: 1a, 6a, 15a (3 items)
  - Cognitive: 2a, 22a, 29a (3 items)

#### Method of scoring RATE variable

- Recode based on midpoint: (1=1) (2=2) (3=4) (4=8) (5=15.5) (6=20) (7=0)
- Sum across items in subscales (don’t include if any missing)
- Rate variable: divide sum score by number of months in the reference period

#### Method of scoring PREVALENCE variable

- Indicated whether one or more of the acts in the scale were used during the referent period. Does not differentiate on the basis of how many of the acts were used or how often each act was used. This method assigns a score of 1 for any subject who reported one or more instances of any of the acts in the scale. (Create dichotomous versions of each item (0 = did not happen; 1 = happened))

**Conflict Tactic Scale (CTS) – Perpetration**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Partner Violence Perpetration

<b>Survey Scales</b>	<b>Program Entry</b>	<b>Program Completion</b>	<b>Statistical Findings</b>
	<b>Prevalence Variable Percentages (n)</b>	<b>Prevalence Variable Percentages (n)</b>	<b>Chi- Square</b>
<b>Psychological Aggression</b>			
<b>Minor</b>	No = 6.25% (1) Yes = 93.75% (15)	No = 20.00% (2) Yes = 80.00% (8)	4.44*
<b>Severe</b>	No = 31.25% (5) Yes = 68.75% (11)	No = 40.00% (4) Yes = 60.00% (6)	6.43*
<b>Physical Assault</b>			
<b>Minor</b>	No = 26.67% (4) Yes = 73.33% (11)	No = 50.00% (5) Yes = 50.00% (5)	1.41
<b>Severe</b>	No = 50.00% (8) Yes = 50.00% (8)	No = 70.00% (7) Yes = 30.00% (3)	4.29*
<b>Sexual Coercion</b>			
<b>Minor</b>	No = 93.75% (15) Yes = 6.25% (1)	No = 80.00% (8) Yes = 20.00% (2)	4.44*
<b>Severe</b>	No = 100.00% (16) Yes = 0.00% (0)	No = 80.00% (8) Yes = 20.00% (2)	—
<b>Injury Scale</b>			
<b>Minor</b>	No = 50.00% (8) Yes = 50.00% (8)	No = 70.00% (7) Yes = 30.00% (3)	1.84
<b>Severe</b>	No = 87.50% (14) Yes = 12.50% (2)	No = 80.00% (8) Yes = 20.00% (2)	4.44*
<b>Negotiation Scale</b>			
<b>Emotional</b>	No = 0.00% (0) Yes = 100.0% (16)	No = 40.00% (4) Yes = 60.00% (6)	—
<b>Cognitive</b>	No = 0.00% (0) Yes = 100.0% (16)	No = 3.33% (3) Yes = 66.67% (6)	—

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 0= “never happened” to 20= “20 + times”

NOTE 1: Time frame for program entry data collection is past year, program complete data collection is past three months

NOTE 2: Mean, SD, t-test, and effect size are based on rate variable. Percentages are based on actual sum, not rate variable.

NOTE 3: N provided in table is based on the number of participants used to calculate the mean, SD, t-test, and effect size. However, the percentages provided in the table are based on a

different N because (a) percentages are based on prevalence scores and are thus calculated differently (i.e., percentages indicate whether one or more of the acts in the scale were used during the referent period) and (b) missing is handled differently for prevalence scores (i.e., even if there is some missing in a subscale, as long as one of the items occurred the participant is given a score of 1 or “yes” to the scale). The N used to calculate the percentages can be acquired by adding the number of participants who indicated “no” to those who indicated “yes” for each subscale.

Program completion: 15 participants did not complete this scale because they reported that they were no longer with a partner after MOVE

#### Method of scoring RATE variable

- Recode based on midpoint: (1=1) (2=2) (3=4) (4=8) (5=15.5) (6=20) (7=0)
- Sum across items in subscales (don't include if any missing)
- Rate variable: divide sum score by number of months in the reference period

#### Method of scoring PREVALENCE variable

- Indicated whether one or more of the acts in the scale were used during the referent period. Does not differentiate on the basis of how many of the acts were used or how often each act was used. This method assigns a score of 1 for any subject who reported one or more instances of any of the acts in the scale. Create dichotomous versions of each item (0 = did not happen; 1 = happened)

### **Parenting Stress Inventory (PSI)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting Stress

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>parental distress</b>	14	44.93 (7.35)	49.07 (7.74)	-2.93*
<b>parent-child dysfunctional interaction</b>	11	48.00 (4.12)	48.00 (4.65)	0
<b>difficult child</b>	13	43.77 (7.81)	44.54 (7.15)	-0.50
<b>Defensive Response</b>	14	25.29 (4.41)	28.43 (4.43)	-3.72**

\*p<.05, \*\*p<.001; Response items range from 1= "strongly agree" to 5= "strongly disagree"

NOTE 1: No time frame

#### Scaling information:

- Four Subscales
  - parental distress (items 1-12)
  - parent-child dysfunctional interaction (items 13-24)
  - difficult child (items 25-36)
  - Defensive Response (items 1, 2, 3, 7, 8, 9, 11)
- 36 items total; sum responses for all items within each subscale
- If more than one item is missing in an individual subscale, the summative subscale cannot be calculated
- No reverse coding needed

#### Interpretation

- *Defensive Responding*: The extent to which the parent is trying to answer in a way that s/he thinks will make them look best. Low scores indicate high levels of defensive responding. A score lower than 10 indicates caution should be used in interpreting any of the other subscales
- *Parental Distress*: Extent the parent is experiencing stress in their role as a parent. High score indicate greater distress
- *Parent-Child Dysfunctional Interaction*: The extent to which the parent believes that their child does not meet their expectations and their interactions are not satisfying. High score indicate poorer interactions
- *Difficult Child*: Parent perception of how difficult their child is. High scores indicate more perceived difficulty.

### **Conflict Tactics Scale on Parenting (CTSParenting)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Corporal Punishment of Children

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>Use of "Time Out"</b>	18	3.44 (1.72)	4.22 (1.83)	-1.83
<b>Shouted, yelled or screamed</b>	18	3.22 (1.73)	3.22 (2.32)	0.00
<b>Spanked with bare hand</b>	16	2.63 (2.90)	2.75 (2.91)	-0.17
<b>Swore or Cursed</b>	16	1.44 (2.37)	1.19 (2.43)	1.46
<b>Explained why something was wrong</b>	18	4.61 (1.97)	5.33 (1.37)	-1.61

Response items vary: 1="Once in the past year;" 2="Twice in the past year;" 3="3-5 times in the past year;" 4="6-10 times in the past year;" 5="11-20 times in the past year;" 6="20+ times in the past year;" 7="Not in the past year but this has happened;" and 0="This has never happened."

## Strengths and Difficulties Questionnaire (SDScale)

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Strengths and Difficulties

Survey Scales	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
Emotional Problems	20	6.6 (1.76)	9.25 (1.83)	-5.90***
Conduct Problems	19	6.21(2.18)	6.79 (1.75)	-1.21
Hyperactivity	21	9.52(2.52)	6.43(1.36)	5.61***
Prosocial Scale	21	4.38(1.12)	5.52(1.21)	-4.10***
Total Difficulties	17	27.24(5.38)	28.06(4.88)	-0.58
Internalizing	19	10.84(1.89)	14.84(2.63)	-6.64***
Externalizing	19	15.84(4.14)	13.26(2.75)	2.75*

\* $p < .05$ , \*\*\* $p < .001$ ; Response items range from 0= "Not True" to 2= "Certainly True"

NOTE 1: No time frame

### Scaling information:

- Five Subscales:
  - Emotional Problems: 4, 9, 13, 16, 24 (scores range 0-10)
  - Conduct Problems: 6, 8, 12, 18, 22 (scores range 0-10)
  - Hyperactivity: 1, 3, 15, 21, 25 (scores range 0-10)
  - Peer Problems: 7, 11, 14, 19, 23 (scores range 0-10)
  - Prosocial Scale: 2, 5, 10, 17, 20 (scores range 0-10)
- 25 items total;
- If an item is missing in an individual subscale, the summative subscale cannot be calculated
- Reverse coding: 8, 11, 14, 21, 25

### Interpretation

- *Total Difficulties Score*: Summing score from all the scale except prosocial. Resultant score ranges from 0-40
- *Externalizing Score*: Sum of conduct and hyperactivity scales, score ranges from 0-20
- *Internalizing Score*: Sum of emotional and peer problems scales, score range from 0-20
  - Using these two amalgamated scales may be preferable to using the four separate scales in community samples, whereas using the four separate scales may add more value in high-risk samples (*see Goodman & Goodman.2009 Strengths and difficulties questionnaire as a dimensional measure of child mental health. JAm Acad Child Adolesc Psychiatry 48(4), 400-403*).

### **Beck Anxiety Inventory (BAI)**

The items in this inventory reflect children's fears, worrying, and physiological symptoms associated with anxiety

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>BAI</b>	11	20.27 (11.18)	19.09 (10.29)	0.39

Response items range from 0="Never" to 3="Always"

#### Scaling information:

- No Subscales (This is a subscale of the full "Beck Youth Inventory")
- 21 items total; scores range from 0-63
- If an item is missing, the summative scale cannot be calculated

#### Interpretation

- Score 0-7 reflect Minimal levels of anxiety
- Score 8-15 reflect Mild Anxiety
- Scores 16-25 reflect Moderate Anxiety
- Scores 26-63 reflect Severe Anxiety

<b>BAI</b>	<b>Program Entry (N = 13) Percentage (n)</b>	<b>Program Completion (N = 11) Percentage (n)</b>
<b>Minimal Anxiety</b>	15.38% (2)	9.09% (1)
<b>Mild Anxiety</b>	15.38% (2)	36.36% (4)
<b>Moderate Anxiety</b>	38.46% (5)	36.36% (4)
<b>Severe Anxiety</b>	30.77% (4)	18.18% (2)

### **Beck Self-Concept Inventory for Youth (BSCI)**

Reflects youth's cognitions of competence, potency, and positive self-worth

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>BSCI</b>	9	41.67(6.61)	43.56 (8.02)	-0.91

Response items range from 0="Never" to 3="Always"

#### Scaling information:

- No Subscales (This is a subscale of the full "Beck Youth Inventory")
- 25 items total; scores range from 0-75
- If an item is missing, the scale cannot be calculated

#### Interpretation

- Higher scores reflect better self-concept

### **Violence Exposure Scale for Children-Revise (VEX)**

A self-report measure of community violence exposure for children ages 4-10 that includes drawings to accompany questions and thermometer-type rating scale. The measure includes questions about minor and severe violence victimization and witnessing violence in the home, school and neighborhood

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>VEX-Witness</b>	12	15.83 (8.19)	9.25 (7.62)	1.96*
<b>VEX- Victimization</b>	12	11.08 (8.25)	7.75 (6.41)	1.13

Response items range from 0="never" to 3="Lots of times;" No time frame given

#### Scaling information:

- Two Subscales:
  - Witness (all "other" variables)
  - Victim (all "me" variables)
- 24 items total
- If an item is missing from a subscale, the subscale cannot be calculated
- Reverse coding: Item 15
- No not code: Santa, shopping, cartoon

#### Interpretation:

- Higher scores indicate more exposure to violence

**Qualitative Results:**

*What is the difference between feeling safe and feeling unsafe:*

**Program Entry:**

- “I’m not sure.”
- “Safe is when I’m happy, Unsafe is when I’m sad.”
- “When you’re safe you are happy. When you are unsafe you feel sad.”

**Program Completion:**

- “When you feel safe, you are calm and content. You know that nothing can harm you. When you feel unsafe you are uneasy and could be hurt. Also usually when you are unsafe the people around you act differently.”
- “When you feel safe, you’re not worried at all.”
- “When you feel unsafe, you’re nervous. You’re worried and you feel something is going to happen.”

*What can you do to make yourself feel safe?*

**Program Entry:**

- “I would hide in my room, under the bed or in my bathroom”
- “Close my eyes.”
- “I don’t know.”

**Program Completion:**

- “Lock my doors, call 911, make sure someone is there to keep you safe.”
- “Call the police, get out of the area, go to my safe place.”

*Scales not included here:*

Child Exposure to Domestic Violence: N=6

Child Outcome Rating Scale: Deemed an unreliable measure by the research team

**Appendix D: Results from Mother-Child Dyad Pilot Test  
(CHILDREN AGES 0-4)**

**Caregiver Self-Assessment (CSA-Program Completion Only)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Self-Assessed Abilities to Recognize Abuse and Protect Their Children from Abuse

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>Ability to recognize child abuse</b>	20	4.80 (0.70)	3.70(1.17)	3.24**
<b>Understand effects of DV</b>	20	4.80 (0.89)	3.40 (1.23)	3.62***
<b>Ability to protect kids from DV</b>	20	4.75 (0.91)	3.40 (1.47)	3.18**
<b>Ability to get your kids help</b>	20	4.85 (0.67)	3.30 (1.59)	3.69***

\*\*p<.01, \*\*\*p<.001; Response items range from 1=“Low” to 4=“Very High”

NOTE: Delivered at program completion only, asked respondents to reflect back on their knowledge from before program start

Scaling information:

- 8 items; 4 regarding knowledge previous to MOVE, 4 regarding knowledge after MOVE (range 4-16)
- No Reverse coding
- Additive = exclude if any missing

Interpretation:

- Higher scores reflect great self-perceived agency

**Center for Epidemiologic Studies Depression Scale (CESD)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Depression and Depressive Symptoms

Survey Scale	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
<b>CESD</b>	22	16.23(9.49)	11.09(8.46)	2.28*

\*p=.0169; Response items range from 0= “rarely or none of the time” to 3= “most or all of the time”

NOTE 1: Time frame for program entry data collection and program completion data collection - past week

Scaling information:

- 20 items; sum all items (range 0-60)
- Reverse code the following items: 4, 8, 12, 16
  - Added “\_REV” to old variable name to create new reverse coded variable name (e.g., “precesd4” became “precesd4\_REV”)
- Additive = exclude if any missing

Interpretation:

- Higher scores indicate the presence of more symptomatology
- A score of 16 points or more is considered depressed

CESD Clinical	Program Entry (N =22) Percentage (n)	Program Completion (N = 24) Percentage (n)
<b>Area of Concern (16 or higher)</b>	45.45% (10)	77.27% (17)
<b>Other (15 or below)</b>	54.55% (12)	22.73% (5)

### **PTSD Checklist- Civilian Version (PCL-C)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Posttraumatic Stress Disorder and Posttraumatic Stress Symptoms

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>PCL-C</b>	24	41.63(12.11)	29.92(13.13)	4.42***

\*\*\*p<.001; Response items range from 1= "not at all" to 5= "extremely"

NOTE 1: Time frame for program entry is past year; time frame for program completion is last three months

#### Scaling information:

- 17 items; sum all items (range 17-85)
- Additive = exclude case if any item is missing

#### Interpretation:

- Higher scores indicate the presence of more symptomatology
- A score of 44 or above was found to be diagnostic among a predominantly female trauma sample with a sensitivity of 94% and a specificity of 86% (Blanchard, Jones-Alexander, Buckley, & Forneris, 1999)

### **Alcohol Use Disorders Identification Test (AUDIT)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Alcohol Use

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>AUDIT</b>	24	4.04(4.73)	2.63(3.27)	1.84*

\*\*\*p<.05 (p=.039); Response items range from 0= "never" to 4= "almost daily"

NOTE 1: Time frame for program entry is past year; time frame for program completion is last month

#### Scaling information:

- 10 items; sum all items (range 0-40)
- Additive = exclude case if any item is missing

#### Interpretation:

- Higher scores indicate the presence of more severe alcohol use
- A cut-off value of 8 is typically used to identify alcohol dependence symptoms (Allen, Litten, Fertig, & Babor, 1997)
- Cut off score of 3 may be used with female populations to denote "at risk drinking" (Bradley et al., 2003)

### **Drug Use Disorders Identification Test (DUDIT)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Drug Use

<b>Survey Scale</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>DUDIT</b>	24	3.29(6.06)	1.5(2.8)	2.08*

\*\*\* $p < .05$  ( $p = .0242$ ); Response items range from 0= "never" to 6= "4 or more times a week"

NOTE 1: Time frame for program entry is past year; time frame for program completion is last month

#### Scaling information:

- 11 items; sum all items (range 0-56)
- Additive = exclude case if any item is missing

#### Interpretation:

- The following substance categories are explored: marijuana, cocaine, hallucinogens, stimulants, tranquilizers, opiates, and "other" substances (i.e., inhalants, steroids, diet pills)
- Higher scores indicate the presence of more severe drug use
- A cut-off value of 8 is typically used to identify drug-related problems (Voluse et al., 2012)
- A cut-off value of 2 has been recommended to identify drug-related problems in women (Berman et al., 2003)

## **Healthy Families Parenting Inventory (HFPI)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>Social Support</b>	24	19.42 (6.09)	20.5 (4.59)	-1.17
<b>Problem-Solving</b>	24	21.5 (4.86)	24.46 (4.03)	-3.82***
<b>Depression</b>	23	37.54 (6.69)	38.57 (5.70)	-1.38
<b>Personal Care</b>	24	19.29 (4.35)	19.87 (4.87)	-1.48
<b>Mobilizing Resources</b>	23	22.78 (4.34)	24.88 (4.66)	-2.82**
<b>Role Satisfaction</b>	24	22.38 (4.79)	25.46 (3.89)	-3.54*
<b>Parent/Child Behavior</b>	23	43.58 (4.77)	45.91 (4.20)	-2.86*
<b>Home Environment</b>	24	41.83 (7.44)	42.833 (7.38)	-0.91
<b>Parenting Efficacy</b>	24	24.79 (5.00)	25.29 (4.39)	-0.62

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 1= "rarely or never" to 5= "always or most of the time"

NOTE 1: No time frame

### Scaling information:

- Nine Subscales
  - Social Support: 1, 2, 3, 4, 5 (5 items; range 5-25)
  - Problem-Solving: 6, 7, 8, 9, 10, 11 (6 items; range 6-30)
  - Depression: 12, 13, 14, 15, 16, 17, 18, 19, 20 (9 items; range 9-45)
  - Personal Care: 21, 22, 23, 24, 25 (5 items; range 5-25)
  - Mobilizing Resources: 26, 27, 28, 29, 30, 31 (6 items; range 6-30)
  - Role Satisfaction: 32, 33, 34, 35, 36, 37 (6 items; range 6-30)
  - Parent/Child Behavior: 38, 39, 40, 41, 42, 43, 44, 45, 46, 47 (10 items; range 10-50)
  - Home Environment: 48, 49, 50, 51, 52, 53, 54, 55, 56, 57 (10 items; range 10-50)
  - Parenting Efficacy: 58, 59, 60, 61, 62, 63 (6 items; range 6-30)
- Sum responses for all items within each subscale
- Reverse Coding: 12, 15, 16, 17, 18, 19, 31, 32, 33, 34, 35, 36, 37, 38, 42
- Additive = exclude if any missing

### Interpretation:

- Social Support: A score 14 or lower indicates area of concern
- Problem-Solving: A score 17 or lower indicates area of concern
- Depression: A score 23 or lower indicates area of concern
- Personal Care: A score 14 or lower indicates area of concern
- Mobilizing Resources: A score 17 or lower indicates area of concern
- Role Satisfaction: A score 17 or lower indicates area of concern
- Parent/Child Behavior: A score 29 or lower indicates area of concern
- Home Environment: A score 29 or lower indicates area of concern

- Parenting Efficacy: A score 17 or lower indicates are of concern

Program Entry Frequencies for HFPI Subscales by Interpretation

<b>Social Support</b>	<b>Program Entry (N = 24) Percentage (n)</b>	<b>Program Completion (N = 25) Percentage (n)</b>
Area of Concern (14 or lower)	16.7% (4)	12.0%(3)
Other (15 and above)	83.3% (20)	88.0% (22)
<b>Problem Solving</b>	<b>Program Entry (N = 24) Percentage (n)</b>	<b>Program Completion (N = 24) Percentage (n)</b>
Area of Concern (17 or lower)	25.0% (6)	8.33% (2)
Other (18 and above)	75.0% (22)	91.67% (22)
<b>Depression</b>	<b>Program Entry (N =24 ) Percentage (n)</b>	<b>Program Completion (N =23) Percentage (n)</b>
Area of Concern (23 or lower)	8.33% (2)	0.00% (0)
Other (24 and above)	91.67% (22)	100.00% (23)
<b>Personal Care</b>	<b>Program Entry (N =24 ) Percentage (n)</b>	<b>Program Completion (N = 24) Percentage (n)</b>
Area of Concern (14 or lower)	8.33% (2)	16.70% (4)
Other (15 and above)	91.67% (22)	83.30% (20)
<b>Mobilizing Resources</b>	<b>Program Entry (N = 23) Percentage (n)</b>	<b>Program Completion (N = 24) Percentage (n)</b>
Area of Concern (17 or lower)	8.70% (2)	16.70% (4)
Other (18 and above)	91.30% (21)	83.30% (20)
<b>Role Satisfaction</b>	<b>Program Entry (N = 24) Percentage (n)</b>	<b>Program Completion (N = 24) Percentage (n)</b>
Area of Concern (17 or lower)	16.70% (4)	4.17% (1)
Other (18 and above)	83.30% (20)	95.83% (23)

<b>Parent/Child Behavior</b>	<b>Program Entry (N =24 ) Percentage (n)</b>	<b>Program Completion (N = 23) Percentage (n)</b>
<b>Area of Concern (29 or lower)</b>	0.00% (0)	0.00% (0)
<b>Other (30 and above)</b>	100.00% (24)	100.00% (23)

<b>Home Environment</b>	<b>Program Entry (N = 24) Percentage (n)</b>	<b>Program Completion (N = 24) Percentage (n)</b>
<b>Area of Concern (29 or lower)</b>	4.17% (1)	8.33% (2)
<b>Other (30 and above)</b>	95.83% (23)	91.67% (22)

<b>Parenting Efficacy</b>	<b>Program Entry (N = 24) Percentage (n)</b>	<b>Program Completion (N = 24) Percentage (n)</b>
<b>Area of Concern (17 or lower)</b>	4.17% (1)	0.00% (0)
<b>Other (18 and above)</b>	95.83% (23)	100.00% (24)

**Adult-Adolescent Parenting Inventory (AAPI)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting and Child-Rearing Attitudes

Survey Scales	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
<b>Inappropriate Expectations</b>	23	26.17 (3.51)	26.83 (3.35)	-1.01
<b>Empathy</b>	23	34.43 (4.90)	34.52 (5.11)	-0.13
<b>Corporal Punishment</b>	23	40.96 (6.51)	43.30 (5.53)	-2.53*
<b>Role Reversal</b>	22	33.32 (6.96)	35.36 (6.22)	-2.40*

\*p<.05; Response items range from 1= “strongly agree” to 5= “strongly disagree”

NOTE 1:No time frame

Scaling information:

- Four Subscales
  - Inappropriate expectations: 6, 10, 16, 17, 20, 27 (6 items; range 6-30)
  - Empathy: 5, 18, 21, 23, 24, 26, 28, 31 (8 items; range 8-40)
  - Corporal Punishment: 2, 8, 9, 12, 13, 15, 19, 22, 25, 29 (10 items; 10-50)
  - Role Reversal: 1, 3, 4, 7, 11, 14, 30, 32 (8 items; 8-40)
- 32 items total; sum responses for all items within each subscale
- No reverse coding needed
- Additive = exclude if any missing

Interpretation:

<b>Inappropriate Expectations</b>	<b>Program Entry (N = 24) Percentage (n)</b>	<b>Program Completion (N = 23) Percentage (n)</b>
<b>High Risk (under 20)</b>	4.17% (1)	0.00% (0)
<b>Some Risk (20-22)</b>	8.33% (2)	13.04% (3)
<b>Average (23-24)</b>	25.00% (6)	17.39% (4)
<b>Positive (25-28)</b>	25.00% (6)	21.74% (5)
<b>Extremely Positive (29-30)</b>	37.50% (9)	47.83% (11)

<b>Empathy</b>	<b>Program Entry (N = 24) Percentage (n)</b>	<b>Program Completion (N = 23) Percentage (n)</b>
<b>High Risk (under 22)</b>	0.00% (0)	0.00% (0)
<b>Some Risk (22-27)</b>	8.33% (2)	17.39% (4)
<b>Average (28-30)</b>	20.83% (5)	4.35% (1)
<b>Positive (31-36)</b>	25.00% (6)	30.43% (7)
<b>Extremely Positive (37-40)</b>	45.83% (11)	47.83% (11)

<b>Corporal Punishment</b>	<b>Program Entry (N = 23) Percentage (n)</b>	<b>Program Completion (N = 24) Percentage (n)</b>
<b>High Risk (under 26)</b>	0.00% (0)	0.00% (0)
<b>Some Risk (26-31)</b>	8.07% (2)	0.00% (0)
<b>Average (32-37)</b>	17.39% (4)	16.67% (4)
<b>Positive (38-43)</b>	30.43% (7)	33.33% (8)
<b>Extremely Positive (44-50)</b>	43.48% (10)	50.00% (12)

<b>Role Reversal</b>	<b>Program Entry (N = 22) Percentage (n)</b>	<b>Program Completion (N = 23) Percentage (n)</b>
<b>High Risk (under 20)</b>	9.09% (2)	4.35% (1)
<b>Some Risk (20-24)</b>	9.09% (2)	4.35% (1)
<b>Average (25-28)</b>	0.00% (0)	0.00% (0)
<b>Positive (29-34)</b>	31.82% (7)	26.09% (6)
<b>Extremely Positive (35-40)</b>	50.00% (11)	65.22% (15)

**Women’s Experience with Battering (WEB)**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Battering

Survey Scale	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
<b>WEB</b>	23	36.96 (19.55)	28.09 (19.19)	3.38**

\*\*p<.01; Response items range from 1= “strongly disagree” to 6= “strongly agree”

NOTE1: No time frame

Scaling and Interpretation Information:

- 10 items; sum all items (range 10-60)
- Reverse score all items
- Additive = exclude if any missing
- Score >19 indicated battering (Smith, Thornton, DeVellis, Earp, & Coker, 2002)
- Score of 20 or higher is a positive screening test for battering (Coker et al., 2002; Punukollu, 2003)

WEB	Program Entry (N = 23) Percentage (n)	Program Completion (N = 23) Percentage (n)
<b>No Indication of Battering</b>	30.43% (7)	47.83% (11)
<b>Indication of Battering (&gt;19)</b>	69.57% (16)	52.17% (12)

### **Conflict Tactic Scale (CTS) – Victimization**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Partner Violence Victimization

<b>Survey Scales</b>	<b>Program Entry</b>	<b>Program Completion</b>	<b>Statistical Findings</b>
	<b>Prevalence Variable Percentages (n)</b>	<b>Prevalence Variable Percentages (n)</b>	<b>Chi-Squared</b>
<b>Psychological Aggression</b>			
<b>Minor</b>	No = 4.17%(1) Yes = 94.4% (23)	No = 15.79% (3) Yes =84.21% (16)	5.62*
<b>Severe</b>	No = 20.83% (5) Yes = 79.17% (19)	No = 31.58% (6) Yes = 68.42% (13)	14.70***
<b>Physical Assault</b>			
<b>Minor</b>	No = 4.17% (1) Yes = 95.83% (23)	No = 36.84% (7) Yes = 63.16% (12)	1.81
<b>Severe</b>	No = 33.33% (8) Yes = 66.67% (16)	No = 47.37% (9) Yes = 52.63% (10)	1.31
<b>Sexual Coercion</b>			
<b>Minor</b>	No = 75.0% (18) Yes = 25.0% (6)	No = 78.95% (15) Yes = 21.05% (4)	4.46*
<b>Severe</b>	No = 69.57% (16) Yes = 30.43% (7)	No = 68.42% (13) Yes = 31.58% (6)	2.54
<b>Injury Scale</b>			
<b>Minor</b>	No = 21.74% (5) Yes = 78.26% (18)	No = 57.89% (11) Yes = 42.11% (8)	4.94*
<b>Severe</b>	No = 65.22% (15) Yes = 34.78% (8)	No = 73.68% (14) Yes = 26.32% (5)	7.36**
<b>Negotiation Scale</b>			
<b>Emotional</b>	No = 0.00% (0) Yes =100.00% (24)	No = 5.00% (1) Yes = 95.00% (19)	—
<b>Cognitive</b>	No = 4.55% (1) Yes = 95.45% (21)	No = 5.26% (1) Yes = 94.74% (18)	17.00***

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 0= “never happened” to 20= “20 + times”

**NOTE 1:** Time frame for program entry data collection is past year, program completion data collection is past three months

**NOTE 2:** Mean, SD, t-test, and effect size are based on rate variable. Percentages are based on actual sum, not rate variable.

**NOTE 3:** N provided in table is based on the number of participants used to calculate the mean, SD, and t-test. However, the percentages provided in the table are based on a different N because (a) percentages are based on prevalence scores and are thus calculated differently (i.e.,

percentages indicate whether one or more of the acts in the scale were used during the referent period) and (b) missing is handled differently for prevalence scores (i.e., even if there is some missing in a subscale, as long as one of the items occurred the participant is given a score of 1 or “yes” to the scale). The N used to calculate the percentages can be acquired by adding the number of participants who indicated “no” to those who indicated “yes” for each subscale.

#### Scaling Information: Victimization – Scales and Subscales

- Psychological Aggression
  - Minor: 3a, 13a, 19a, 25a (4 items)
  - Severe: 9a, 11a, 24a, 26a (4 items)
- Physical Assault
  - Minor: 4a, 5a, 7a, 17a, 21a (5 items)
  - Severe: 8a, 10a, 12a, 14a, 16a, 23a, 27a (7 items)
- Sexual Coercion
  - Minor: 28a XX XX (3 items) \*\* *two items removed*
  - Severe: 33a, 18a, 34a, 42a (4 items)
- Injury
  - Minor: 31a, 41a (2 items)
  - Severe: 43a, 37a, 39a, 40a (4 items)
- Negotiation
  - Emotional: 1a, 6a, 15a (3 items)
  - Cognitive: 2a, 22a, 29a (3 items)

#### Method of scoring RATE variable

- Recode based on midpoint: (1=1) (2=2) (3=4) (4=8) (5=15.5) (6=20) (7=0)
- Sum across items in subscales (don’t include if any missing)
- Rate variable: divide sum score by number of months in the reference period

#### Method of scoring PREVALENCE variable

- Indicated whether one or more of the acts in the scale were used during the referent period. Does not differentiate on the basis of how many of the acts were used or how often each act was used. This method assigns a score of 1 for any subject who reported one or more instances of any of the acts in the scale. (Create dichotomous versions of each item (0 = did not happen; 1 = happened))

### **Conflict Tactic Scale (CTS) – Perpetration**

Participant’s Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Experiences of Partner Violence Perpetration

<b>Survey Scales</b>	<b>Program Entry</b>	<b>Program Completion</b>	<b>Statistical Findings</b>
	<b>Prevalence Variable Percentages (n)</b>	<b>Prevalence Variable Percentages (n)</b>	<b>Chi-Square</b>
<b>Psychological Aggression</b>			
<b>Minor</b>	No = 0.0% (0) Yes = 100.0 (24)	No = 5.26% (1) Yes = 94.74% (18)	—
<b>Severe</b>	No = 30.43% (7) Yes = 69.57% (16)	No = 42.11% (8) Yes = 57.89% (11)	8.65**
<b>Physical Assault</b>			
<b>Minor</b>	No = 12.50% (3) Yes = 87.50% (21)	No = 31.58% (6) Yes = 68.42% (13)	7.72**
<b>Severe</b>	No = 50.0% (12) Yes = 50.0% (12)	No = 66.67% (12) Yes = 33.33% (6)	0.45
<b>Sexual Coercion</b>			
<b>Minor</b>	No = 91.67% (22) Yes = 8.33% (2)	No = 89.47% (17) Yes = 10.53% (2)	8.97**
<b>Severe</b>	No = 90.91% (20) Yes = 9.09% (2)	No = 84.21% (16) Yes = 15.79% (3)	1.97
<b>Injury Scale</b>			
<b>Minor</b>	No = 43.48% (10) Yes = 56.52% (13)	No = 68.42% (13) Yes = 31.58% (6)	0.05
<b>Severe</b>	No = 91.30% (21) Yes = 8.70% (2)	No = 73.68% (14) Yes = 26.32% (5)	2.96
<b>Negotiation Scale</b>			
<b>Emotional</b>	No = 0.00% (0) Yes = 100.0% (24)	No = 5.00% (1) Yes = 95.00% (19)	—
<b>Cognitive</b>	No = 0.00% (0) Yes = 100.0% (23)	No = 5.88% (1) Yes = 94.12% (16)	—

\*\*\*p<.001, \*\*p<.01, \*p<.05; Response items range from 0= “never happened” to 20= “20 + times”

**NOTE 1:** Time frame for program entry data collection is past year, program completion data collection is past three months

**NOTE 2:** Mean, SD, t-test, and effect size are based on rate variable. Percentages are based on actual sum, not rate variable.

**NOTE 3:** N provided in table is based on the number of participants used to calculate the mean, SD, t-test, and effect size. However, the percentages provided in the table are based on a

different N because (a) percentages are based on prevalence scores and are thus calculated differently (i.e., percentages indicate whether one or more of the acts in the scale were used during the referent period) and (b) missing is handled differently for prevalence scores (i.e., even if there is some missing in a subscale, as long as one of the items occurred the participant is given a score of 1 or “yes” to the scale). The N used to calculate the percentages can be acquired by adding the number of participants who indicated “no” to those who indicated “yes” for each subscale.

Program completion: 15 participants did not complete this scale because they reported that they were no longer with a partner after MOVE

#### Method of scoring RATE variable

- Recode based on midpoint: (1=1) (2=2) (3=4) (4=8) (5=15.5) (6=20) (7=0)
- Sum across items in subscales (don't include if any missing)
- Rate variable: divide sum score by number of months in the reference period

#### Method of scoring PREVALENCE variable

- Indicated whether one or more of the acts in the scale were used during the referent period. Does not differentiate on the basis of how many of the acts were used or how often each act was used. This method assigns a score of 1 for any subject who reported one or more instances of any of the acts in the scale. Create dichotomous versions of each item (0 = did not happen; 1 = happened)

### **Parenting Stress Inventory (PSI)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Their Parenting Stress

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>parental distress</b>	23	43.64 (7.90)	46.82 (6.25)	-2.59
<b>parent-child dysfunctional interaction</b>	20	46.95 (4.95)	46.35 (3.77)	0.59
<b>difficult child</b>	20	43.4 (7.17)	42.3 (6.05)	0.74
<b>Defensive Response</b>	23	24.43 (4.57)	27.13 (25.39)	-3.91***

\*\*\*p<.001; Response items range from 1= "strongly agree" to 5= "strongly disagree"

NOTE 1: No time frame

#### Scaling information:

- Four Subscales
  - parental distress (items 1-12)
  - parent-child dysfunctional interaction (items 13-24)
  - difficult child (items 25-36)
  - Defensive Response (items 1, 2, 3, 7, 8, 9, 11)
- 36 items total; sum responses for all items within each subscale
- If more than one item is missing in an individual subscale, the summative subscale cannot be calculated
- No reverse coding needed

#### Interpretation

- *Defensive Responding*: The extent to which the parent is trying to answer in a way that s/he thinks will make them look best. Low scores indicate high levels of defensive responding. A score lower than 10 indicates caution should be used in interpreting any of the other subscales
- *Parental Distress*: Extent the parent is experiencing stress in their role as a parent. High score indicate greater distress
- *Parent-Child Dysfunctional Interaction*: The extent to which the parent believes that their child does not meet their expectations and their interactions are not satisfying. High score indicate poorer interactions
- *Difficult Child*: Parent perception of how difficult their child is. High scores indicate more perceived difficulty.

### **Conflict Tactics Scale on Parenting (CTSParenting)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Corporal Punishment of Children

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>Use of "Time Out"</b>	23	4.26 (6.68)	3.39 (2.06)	0.63
<b>Shouted, yelled or screamed</b>	23	2.52 (2.37)	1.83 (1.40)	1.42
<b>Spanked with bare hand</b>	22	1.45 (1.74)	1.09 (1.23)	1.19
<b>Swore or Cursed</b>	22	0.55 (1.14)	0.68 (1.62)	-0.38
<b>Explained why something was wrong</b>	23	4.39 (2.37)	4.52 (2.13)	-0.29

Response items vary: 1="Once in the past year;" 2="Twice in the past year;" 3="3-5 times in the past year;" 4="6-10 times in the past year;" 5="11-20 times in the past year;" 6="20+ times in the past year;" 7="Not in the past year but this has happened;" and 0="This has never happened."

## Strengths and Difficulties Questionnaire (SDScale)

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding Strengths and Difficulties

Survey Scales	N	Program Entry M(SD)	Program Completion M(SD)	Statistical t-test Findings
Emotional Problems	20	6.6 (1.76)	9.25 (1.83)	-5.90***
Conduct Problems	19	6.21(2.18)	6.79 (1.75)	-1.21
Hyperactivity	21	9.52(2.52)	6.43(1.36)	5.61***
Prosocial Scale	21	4.38(1.12)	5.52(1.21)	-4.10***
Total Difficulties	17	27.24(5.38)	28.06(4.88)	-0.58
Internalizing	19	10.84(1.89)	14.84(2.63)	-6.64***
Externalizing	19	15.84(4.14)	13.26(2.75)	2.75*

\* $p < .05$ , \*\*\* $p < .001$ ; Response items range from 0= "Not True" to 2= "Certainly True"

NOTE 1: No time frame

### Scaling information:

- Five Subscales:
  - Emotional Problems: 4, 9, 13, 16, 24 (scores range 0-10)
  - Conduct Problems: 6, 8, 12, 18, 22 (scores range 0-10)
  - Hyperactivity: 1, 3, 15, 21, 25 (scores range 0-10)
  - Peer Problems: 7, 11, 14, 19, 23 (scores range 0-10)
  - Prosocial Scale: 2, 5, 10, 17, 20 (scores range 0-10)
- 25 items total;
- If an item is missing in an individual subscale, the summative subscale cannot be calculated
- Reverse coding: 8, 11, 14, 21, 25

### Interpretation

- *Total Difficulties Score*: Summing score from all the scale except prosocial. Resultant score ranges from 0-40
- *Externalizing Score*: Sum of conduct and hyperactivity scales, score ranges from 0-20
- *Internalizing Score*: Sum of emotional and peer problems scales, score range from 0-20
  - Using these two amalgamated scales may be preferable to using the four separate scales in community samples, whereas using the four separate scales may add more value in high-risk samples (*see Goodman & Goodman.2009 Strengths and difficulties questionnaire as a dimensional measure of child mental health. JAm Acad Child Adolesc Psychiatry 48(4), 400-403*).

### **Bates Infant Characteristics (BIC)**

Participant's Survey Responses (Means, Standard Deviations, and t-test Findings) Regarding their Baby's temperament

<b>Survey Scales</b>	<b>N</b>	<b>Program Entry M(SD)</b>	<b>Program Completion M(SD)</b>	<b>Statistical t-test Findings</b>
<b>Fussy/Difficult</b>	6	23.67(9.97)	20.33(5.54)	1.03
<b>Unadaptable</b>	8	17.5(7.4)	13.75(6.09)	4.36**
<b>Dull</b>	8	7.75(3.49)	8.00(3.42)	-0.19
<b>Unpredictable</b>	8	15.50(5.15)	11.00(3.25)	1.87

\*p<.05, \*\*\*p<.001; Response items range from 1= "Very Easy" to 2= "Very Difficult"

NOTE 1: No time frame

#### Scaling information:

- Four Subscales:
  - Fussy/Difficult (1, 5, 6, 12, 13, 14, 17, 22, 24)
  - Unadaptable (7, 9, 10, 11, 20)
  - Dull (15, 16, 18, 23)
  - Unpredictable (2, 3, 4, 8, 19, 21)
- 24 items total;
- If an item is missing in an individual subscale, the summative subscale cannot be calculated
- Reverse coding: 15

#### Scale Interpretation:

- Higher score indicate a more difficult temperament.