The Developmental Impact of Intimate Partner Violence and Evidence-Based Treatments for School-Aged Children

Graham Smith

University of Victoria

A Project Submitted for Completion of the

Requirements for the Degree of

MASTER OF ARTS

Faculty of Human and Social Development

Supervisory Committee

The Developmental Impact of Intimate Partner Violence and Evidence-Based Treatments for School-Aged Children

by

Graham Smith

BA, University of the Fraser Valley, 2004

Supervisory Committee

Dr. Sibylle Artz (School of Child and Youth Care)
Supervisor

Dr. Daniel Scott (School of Child and Youth Care)
Department Member

Deborah Joyce, MA, MACP, RCC (Family Resource Association)
Community Committee Member

Acknowledgements

First and foremost, I would like to acknowledge my children Kylea and Adam who have allowed me to take time to advance my knowledge and skill in working children and youth and families. They have shown genuine interest in my progress and supported me with grace and understanding as I have redirected a fair amount of my attention to this project. In addition, I would like to acknowledge my late wife Shannon for her motivation and support as I embarked on this educational journey, and for continued support in spirit.

Dr. Sibylle Artz has provided me with academic support and encouragement from first meeting her at the beginning of my graduate studies. I have appreciated your balance of compassion and emotional support and your ability to inspire quality academic work. You possess a wealth of knowledge that you are always willing to share to support the learning and growth of others in the field. I know that I have benefited from working with you and have definitely grown as a practitioner. I have experienced moments of encouragement and feelings of success along with moments of frustration and discouragement. In both of these situations you have known what I have needed and this has helped me immensely along the way.

To Dr. Daniel Scott I owe thanks for the guidance he has provided as I have worked to build a framework for this project. I have benefited from your knowledge around program manual development and you have kept me on track in terms of thoroughly understanding my goals for this project and the intended audience. This has helped guide my writing every step of the way. I have also appreciated your editorial guidance.

Finally, I would like to acknowledge Deborah Joyce, Executive Director of the Family Resource Association. She has provided me with inspiration for this project and possesses a definite passion to support children who have been impacted by violence. I have appreciated your innovative spirit and your willingness to encourage and motivate me to expand my knowledge and enhance my practice. It has been most helpful to discuss my learning as the project has progressed and I have used many of our discussions to keep me focused. I look forward to working with you as we apply what we have learned.

The Developmental Impact of Intimate Partner Violence and Evidence-Based Treatments for School-Aged Children

Table of Contents

Executive Summary p. 8

Introduction p. 13

Chapter One: Developmental Impact of Intimate Partner Violence

Prevalence of Intimate Partner Violence p. 16

The Developmental Process and IPV p. 18

Social Ecological Context and IPV p. 19

Gender and IPV p. 21

Poly-Victimization p. 23

Impacts of IPV in the Prenatal and Infant Stages p. 25

Impacts of IPV on the Toddler and Preschool Stages p. 28

Neurobiological Impacts p. 28

Traumatic Effects of IPV p. 31

Cognitive Functioning and Cognitive Schemas p. 35

Internalizing and Externalizing Behaviours p. 36

The Impact of IPV on School Aged Children p. 40

Impact of IPV on Cognitive and Emotional Dimensions p. 41

Family Dynamics and the Impact of IPV p. 47

Externalizing and Internalizing Behaviours p. 51

Impacts of IPV on Social Competence p. 55

Impacts of IPV on Physical Health p. 56

IPV Exposure and Trauma p. 57

IPV and the Adolescent Stage of Development p. 60

Aggression and Violence p. 61

Witnessing IPV and Adolescent Substance Use p. 65

The Impact of IPV Exposure on the Mental Health of Adolescents p. 66

Impact of IPV on Delinquency in Adolescence p. 67

Chapter Two: Evidence-Based Interventions for School-Aged Children Exposed to Intimate Partner Violence

Current Practices for FRA: The Children Who Witness Abuse Program p. 74

Resilience and Protective Factors Moderating Impact of IPV p. 75

Interventions for Treating the Impact of IPV p. 79

The Kid's Club Program & Mom's Parenting Empowerment Program p. 83

Effectiveness of the Kids' Club and MPEP p. 87

The ARC Framework (Attachment, Regulation and Competency) p. 90

The Attachment Component of the ARC Framework p. 91

The Self-Regulation Component of the ARC Framework p. 100

The Competency Component of the ARC Framework p. 111

Trauma Experience Integration and the ARC Framework p. 119

The Effectiveness of the ARC Framework p. 125

Project Support p. 128

The Effectiveness of Project Support p. 137

Trauma Focused Cognitive Behaviour Therapy (TF-CBT) p. 138

The Process and Components of TF-CBT p. 139

Effectiveness of the TF-CBT Intervention p. 150

Chapter Three: Conclusions and Recommendations p. 152

References p. 170

Executive Summary

Intimate Partner Violence (IPV) is a pervasive issue impacting children, youth and families. While IPV creates immediate risks that relate to safety and well-being, this form of violence also impacts life course development in multiple and serious ways. For children, IPV exposure can set in motion a trajectory of difficulties or a cascading effect that results in compounding difficulties as exposed children move through their growth and development (Smith et al, 2010; Graham-Bermann & Levendosky, 2011 & Artz et al., 2014).

Developing a clearer understanding of the developmental impact of intimate partner violence on children and youth is a focus for the Family Resource Association (FRA). This agency has the goal of providing well-informed, evidence-based services that are based on the most recent developmental research related to impacts and treatment of IPV. To support the goals of this agency, this project examines in detail the research on IPV impact from development in utero through to developmental outcomes in adolescence. Incorporated in this exploration is a focus on specific impacts of IPV on boys. Over time, staff at FRA have experienced a noticeable increase in male child referrals to current violence related services and therefore welcome the opportunity to expand on their knowledge and understanding in this area.

This project, in the first chapter, focuses on the following key areas of IPV impact on children in successive developmental stages:

A. Prenatal and Infant Stage
    a. Attachment schemas between mother and children in utero.

b. The developing hypothalamic-pituitary-adrenal (HPA) axis and resulting effect on cortisol levels.

B. Toddler and Preschool Stage

a. Additional concerns about neurobiological impact of IPV as it relates to HPA functioning and cortisol levels as well as the functioning of the autonomic nervous system.

b. Developing traumatic stress symptoms.

c. Exposure and the effect on cognitive functioning and developing perspectives and understandings.

d. Developing internalizing and externalizing behaviour challenges.

C. School-Age Stage

a. Cognitive functioning specifically related to distorted perspectives about the perpetrator; the victimized parent; the conflict; themselves (self-blame and responsibility) and their environment (threat).

b. Emotional development focusing on difficulties for children around emotional security as well as identifying, understanding, regulating and expressing emotions.

c. Challenges with the family dynamic as it relates to safety, stability and support.

d. Internalizing and externalizing behaviour challenges specifically around depression, self-esteem, hyperactivity, aggression, oppositional defiance and delinquency.

   e. Social competency and challenges with developing healthy relationships with peers and school achievement.
   f. Physical health issues.
   g. Compounding traumatic stress.

D. Adolescent Stage of Development
   a. The cumulative impact on internalizing behaviour outcomes relating to depression and anxiety.
   b. The cumulative impact on externalizing behaviour outcomes like aggression, dating violence, substance use, criminal and sexual delinquency.

Along with focusing on the child and youth specific impacts on development, this project also examines the impacts of IPV on children`s caregiving systems especially as it relates to victimized mothers. Research indicates that IPV also affects caregiving guidance and support because this experience adversely impacts the mental, emotional and physical health of the victimized parent, which in turn creates additional adverse developmental impact for children.

The second goal for this project is to determine the most effective treatment interventions to address the impacts of IPV. Family Resource Association Staff noted that the greatest need is for more knowledge about effective interventions for children in the school-aged stage, ages 6-12 years old. With that in mind, Chapter Two reviews, in detail, four programs that have been shown to be effective, for school-aged children who have been exposed to IPV. All of these interventions incorporate support for the caregivers as well as for their children. To purposely expand the FRA's ability to meet

the diverse needs of their clients, these interventions approach treatment from a variety of modalities that include individual and group based work for both children and caregivers; working with parents and children together; psychoeducational approaches; trauma processing and parenting skills development. Resilience to violence exposure is also is discussed in this chapter in order to advance our understanding about why some children are better able to manage the impact of IPV than others. The four interventions include the Kid`s Club (Graham-Bermann, 1992) and Mothers Parenting Empowerment Program (Graham-Bermann & Levendosky, 1994); The Attachment, Regulation and Competency (ARC) Framework (Kinniburgh et al, 2005); Project Support (Jouriles et al., 1998) and Trauma-Foucsed Cognitive Behaviour Therapy (Cohen et al., 2006).

Over all, these interventions encourage practitioners to help families focus beyond the behavioural challenges of IPV exposed children and work with the underlying impacts. These interventions guide practitioners to support children and their caregivers with:

A. Developing a sense of safety and comfort.
B. Understanding the cognitive and emotional impacts of intimate partner violence.
C. Cognitive coping skills to address distorted perspectives children hold around themselves and their experiences that can influence difficulties in functioning.
D. Emotional awareness and functioning specifically identifying emotions in context, self-regulation and emotional expression.
E. Building children`s self-esteem, competence and confidence as well as problem solving and conflict resolution skills to enhance social emotional functioning.

F. Trauma processing to assist children in developing mastery and control over past experiences to lower the impact of traumatic stress related to PIV.

Additionally, and equal in importance, these interventions guide practitioners in supporting caregivers. Together, these interventions provide a framework for:

A. Assisting caregivers to tune-in to the needs of their children, managing their own emotions and providing structure and consistency.
B. Focusing on parenting skills and strategies to support the healing, development and growth of children.
C. Supporting caregivers in identifying and accessing resources needed for their family.
D. Working with children and caregivers together to coach and reinforce the building of skill between child and caregiver.

Bringing together the knowledge gained from evidence presented in the first two sections of project, Chapter Three provides recommendations to support the Family Resource Association in working towards their goal of program development. The five main recommendations include:

1. Supporting parent/caregivers.
2. Providing professional, ethical and client-centred services.
3. Employing a variety of modalities and mediums.
4. Using phase oriented, component-based approaches.
5. Working together with children and parent caregivers on skills and strategies.

Introduction

Exposure to Intimate Partner Violence (IPV) and its effects on the developing child has become an increasingly important issue for those who work in the fields of health and welfare of children. The Family Resource Association (FRA), on Central Vancouver Island, has recognized the importance of supporting children and families affected by IPV and have provided services such as the BC Association of Specialized Victim Assistance and Counselling Program's Stopping the Violence (McEvoy and Ziegler, 2006) and the BC Yukon Society of Transition House's Children Who Witness Abuse (Barbeau, 2009) for a number of years. In an effort to provide the most current and relevant services to IPV exposed children, this agency has identified a need, within the communities of School District 69, to develop a program that considers more closely the impact of IPV on children's development.

The motivation for the Family Resource Association is not to replace current services for children, but to provide a solid base from which a comprehensive non-one-size-fits-all program can be developed for FRA counselors, as well as other social workers, child and youth care workers and counselors. The goal is to be able to more comprehensively meet the diverse needs of IPV exposed children therefore moving away from the idea every child should fit into the same mold. The framework for this project, developed in partnership with the Family Resource Association, will provide a well-informed base of knowledge through which to meaningfully expand the association's ability to meet the needs of children in middle childhood. To achieve this end, this project will: 1) identify the impact of IPV at various ages and stages and the resulting developmental outcomes, 2) look at differences in the ways that boys and girls are

impacted in their development 3) review evidence-based treatment strategies shown to be effective in treating the development impact of IPV on children in middle childhood and provide recommendations for treatment.

Chapter One of this project defines IPV, provide information related to its prevalence and discusses the social ecological perspective as a framework for understanding the impact of IPV exposure on children. This chapter comprehensively exams the current evidence-based literature detailing effect of IPV on developmental trajectories from the early years to behavioral outcomes at the intermediate school aged level and outcomes such as crime, delinquency and substance use in adolescence. Chapter Two, supported by the identified impacts in Chapter One, will provide a detailed review of the leading evidence-based interventions related to treating school-aged children (6-12) who have experienced IPV. The conclusion of the project provides recommendations based on the findings of both chapters to provide a foundation for program development.

In order to search for the literature that is relevant to this project the following keywords were used: "intimate partner violence," "domestic violence," "family violence "and "inter-parental violence," "exposure or witnessing violence," "children/child/boys," "impacts of violence exposure," "best practices" and "evidence-based interventions/treatments ". Other keywords were used for more specific searches related to known outcomes: "externalizing behaviours," "aggression," "delinquency," "crime," behavioral problems" and "conduct problems/disorders, "trauma," "attachment/parent-child relationship," "emotional regulation/emotional security," "cognitive contextual," "social competence" and "family functioning" were employed to deepen the search. The databases used for the literature searches included: Summon, EBSCO, PsycINFO and

Google Scholar. This review included peer-reviewed articles and books in English language only. Some articles based on meta-analyses and narrative reviews of the existing research were included, however the majority of included materials were articles that focused on original research. References from selected articles were scanned and relevant articles were also identified and included. All included sources were drawn from the last six years (2010-2016) to ensure that the most current information on the impacts of IPV and the evidence-based interventions for children who witnessed IPV were reviewed.

Chapter One:

Developmental Impact of Intimate Partner Violence

Over the last thirty years, researchers have been building a body of knowledge aimed at identifying and understanding the impacts of intimate partner violence on child development (e.g., Sousa et al., 2011; Artz et al., 2014). Intimate partner violence is defined by the World Health Organization (2012) as "…any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship." (p. 1). IPV has been concretely described as involving acts of physical violence such as hitting, slapping, kicking and beating; acts of sexual violence such as forced sexual intercourse and sexual coercion; emotional abuse such as insults, belittling, humiliation, intimidation and threats; and controlling behaviours such as isolating a person, restricting access to finances, employment, education and medical care.

As Sinha (2013) notes, in Canada, our understanding of family violence has changed from being thought of as a private behind closed doors family issue to being recognized as a social and criminal issue. In the Statistics Canada publication, *Family Violence in Canada: A Statistical Profile 2011*, Sinha (2013) states that perpetrators of family violence can now face a multitude of charges (i.e. assault, sexual assault and harassment) and "the criminal code considers the abuse of a spouse or child or any position of trust or authority to be an aggravating factor at sentencing" (p. 6).

Prevalence of IPV in Canada

The latest publication released by Statistics Canada, *Family Violence in Canada: A Statistical Profile 2013*, (Canadian Centre for Justice Statistics, 2015) includes a new

section on intimate partner violence that focuses specifically on the prevalence of intimate partner violence in Canada and shows that in 2013, 90,720 or 27% of the 336,000 reports of violent victimization reported to police, were related to intimate partner violence. Further, 53% of these cases were identified as involving dating violence and 47% involved spousal abuse (Beaupre, 2015). Additionally, of the spousal abuse cases, 80 % of the victims were female and females were 3.5 more likely to experience intimate partner violence than males. Finally, 76% of the reported cases of intimate partner violence involved physical assaults while threats and criminal harassment were reported at a significantly lower rate of 8% and 7% respectively (Beaupre, 2015).

Trocmé, Fallon, MacLaurin, Sinha, Black, Fast, Felstiner, Hélie, Turcotte, Weightman, Douglas, and Holroyd's (2008), Public Health Agency of Canada funded report, the *Canadian Incidence Study of Reported Child Abuse and Neglect (CIS),* reported incidences of child maltreatment focusing on populations of children and families investigated by child welfare agencies in all provinces and territories across Canada. This study found that exposure to intimate partner violence was the most substantiated category of child maltreatment in Canada. According to the CIS, 29,259 cases, that is, 34% of all reported child maltreatment cases, were related to intimate partner violence when compared to neglect (28,939, 34%), physical abuse (17, 212, 20%), emotional maltreatment (7, 423, 9%) and sexual abuse (2,607, 3%). In Canada, IPV is perpetrated more often than any other form of child maltreatment. Understanding the impacts of IPV exposure and the best ways to support exposed children is therefore incumbent on us all.

The Developmental Process and IPV

The current research on child exposure to IPV highlights the potential negative impacts on children's emotional and social development and adjustment (Bayarri, Ezpeleta & Granero, 2011; Hungerford, Wait, Fritz and Clement, 2012; Holmes, 2013; Enlow, Blood & Egeland, 2013 & Overbeek, de Schipper, Lamers-Winkle & Schuengel, 2014). This research also points to links between witnessing intimate partner violence and behavior challenges for children (Koss, George, Davis, Cicchetti, Cummings and Sturge-Apple, 2013; Harding, Morelen, Thomassin, Bradbury & Shaffer, 2013 & Bair-Merritt, Ghazarian, Burrell, Crowne, MacFarlane & Duggan, 2015).

Smith, Elwyn, Ireland and Thornberry (2010) and Graham-Bermann and Levendosky (2011) examine the impact of IPV on long-term development. Smith et al. discuss the concept of the cascading effect in their research on the impact of IPV exposure on substance use. They propose that "exposure to family violence along with other family processes potentially contributes to a cascading series of consequences that lead from short-term reactive responses to entrenched longer term consequences such as drug and alcohol problems" (p. 220). Graham-Bermann and Levendosky (2011) focus on early stages of development and the influences of IPV exposure on children's developmental trajectories. Graham-Bermann and Levendosky refer to developmental trajectories as "the pathways, which begin earlier in childhood, begin to come to fruition in adolescence, potentially sending these youth on negative trajectories into early adulthood" (2011, p. 7). They suggest that IPV exposure can lead to behaviour adjustment issues in middle childhood and crime and delinquency in adolescence.

Graham-Bermann and Levendosky (2011) also employ Sroufe's (1997) developmental psychopathology model to achieve a better understanding of the developmental impact of IPV on children. The model suggests that psychopathology, connected to experiences such as IPV or physical abuse, can lead to deviations in development over time. Some children may exhibit internalizing responses, some may exhibit externalizing responses while others are resilient. Sroufe suggest however that even though functioning in earlier developmental stages can influence a child's current and future developmental experience, change can be possible at any stage of development; developmental progression can either increase or decrease the risk of later developmental issues depending on the opportunities for change (Graham-Bermann and Levendosky, 2011).

Along the same line, Herman-Smith (2013) cautions that not all symptoms of exposure to intimate partner violence may manifest in the developmental stage in which they occur and may exhibit themselves in later on in life. He suggests that mental health practitioners, supporting families impacted by IPV, approach support with a long-term view. He encourages practitioners to follow children over longer periods of time monitoring their health and development to help to account for this issue.

Social Ecological Context and IPV

As the family is one of the primary socialization agents for children, repeated IPV within the family home can pose a risk to children. Aside from effect of direct exposure, there are secondary effects related to the impact of IPV on their mothers, which create additional risks and vulnerabilities for children. Mothers who experience male partner perpetrated violence are often impacted by the overwhelming stress and conflict

associated with this experience. This can lead to mothers' modeling of intense and dis-regulated emotional behavior resulting in their being less able to provide emotional support and guidance for their children (Fainsilber Katz, Stettler and Gurtovenkop, 2016). Further to this, "the violent and emotionally dis-regulated perpetrator is also a socializing agent, and presents another model of emotional liability that may impact a child's social and emotional development and wellbeing" (Fainsilber Katz et al., 2016, p. 49). As a result of both of these factors, there can be multiple and layered emotional demands placed upon children who may not be equipped to manage them.

Voith, Gromoske and Holmes (2014) studied violence exposure on children using a social ecological perspective and emphasize the importance of being aware of violence exposure within the child's microsystem, mesosystem and exosystem. Cross, Barnes, Papgeorgiou, Hadwen, Hearn and Lester (2015), summarize Brofenbrenner's (1979) ecological theory of development and agree that the systems closest to a child that involve direct interaction of a child with environments such as home, family, school and peers that can influence a child's attitudes and behavior. They also suggest that the interactions of proximal systems for example between family and school can have more of an effect on the developing child than more distal systems such as social, cultural, and economic factors. According to Cross et al. considering systems around a child (in other words, the child's immediate contexts) can be helpful in understanding the impact of IPV and looking for possible opportunities to mediate and intervene.

Guided by the aforementioned perspectives on development and social ecological influences, this chapter reviews the literature on the impact of IPV from prenatal to adolescence. The most significant issues through developmental issues are highlighted

with the understanding that difficulties related to IPV in one stage can impact a child later on in life.

Before entering into the review on developmental impacts of IPV, there are two aspects in the literature that a number of investigators have included in this area of research. Gender of children and the concept of poly-victimization are often discussed as variables to be considered. These two areas are explored in the following two sections.

Gender and IPV

Through review of literature on IPV, findings on differences between the impacts on boys versus girls appears to be quite mixed. Some investigators have found that there are no identified gender differences (Olaya, Ezpeleta, de la Osa, Granero & Domenech, 2010; Bayarri, Ezpeleta & Granero, 2011 & Georgsson, Almqvist & Broberg, 2011) and that when exposed to IPV, both girls and boys are equally at risk for maladaptive outcomes. Other investigators have found that under certain circumstances girls are more at risk. Calvete & Orue, 2013 in their study exploring the differences in gender and cognitive schemas about violence (e.g. justifying violent behavior related to witnessing domestic violence), found an overall stronger connection between aggression in girls when exposed to family violence. Bair-Merritt, Ghazarian, Burrell, Crowne, McFarlane & Duggan (2015), in their study on how intimate partner violence impacts school-aged children's internalizing and externalizing problems, found that girls exposed to IPV showed more externalizing behaviours (such as aggression moderated by maternal depression and parenting stress) than boys.

On the other hand, some investigators have found that there are particular impacts

of intimate partner violence that exist just for boys, mainly in the area of increased externalizing behaviours in middle childhood and adolescence. Included in these findings are a number of variables related to the degree they are affected. These variables include the age and stage of when the IPV has occurred (Moylan, Herrenkohl, Sousa, Tajima, Herrenkohl & Russo, 2010), how boys process social information (Calvete & Orue, 2012), emotion socialization by aggressive fathers and how boys understand gender roles and aggression (Wood & Sommers, 2011), level of attachment and communication with mothers in childhood and adolescence (Renner & Boel-Studt, 2013; Blair, MacFarlane, Nava, Gilroy & Maddoux, 2015), boys who live in severely violent homes (Graham-Bermann & Perkins, 2010; Knous-Westfall, Ehrensaft, MacDonell & Cohen, 2012) and boys who fathers are aware of their son's emotions and how they interact around these emotions (Maliken & Fainslber Katz, 2012).

Looking at some of these studies in more detail, Graham-Bermann and Perkins (2010) examined the impact of cumulative violence on children. They found that the earlier boys experienced violence, the greater the chances that boys would experience externalizing problems. Knous-Westfall, Ehrensaft, Madonell & Cohen (2012) examined intimate partner violence, parenting practices and peer bullying in adolescence. They found that boys, who had come from homes with more severe violence, were more at risk of using both relational and overt aggression. Maliken and Fainsilber Katz (2012) investigated IPV, fathers' emotional awareness and the impact of both on their sons' development of empathy and externalizing problems. The preliminary results of their study show some gender related differences in boys' reactions to their "father's gender-stereotyped parenting practices" (p. 729). Boys in this study experienced higher levels of

aggression and lower levels of empathy than the sample of girls. Renner and Boel-Studt (2013) also investigated the relationship between IPV, parenting stress and children's behavior in a sample of children ages 6 -12. Their research showed

> several unique distinctions on the complex study of family violence and yielded different effects on child behavior problems based on children's developmental stage and gender…among children ages 6-12, boys experienced statistically significantly higher levels of both externalizing and internalizing behavior problems compared to girls (p. 208).

Finally, Calvette and Orue (2013) also studied gender differences among adolescents who had experienced family violence and the effect of violence on cognitive reasoning. They found that boys engaged in more proactive aggression, acting more aggressively without provocation than in reaction to threat.

Due to the fact that there are such clear variations in the gender-based findings for IPV exposure, many investigators have suggested that this area of research needs more attention and advise caution when attributing outcomes of IPV to gender (Bayarri, Ezpeleta & Granero, 2011 & Artz, Jackson, Rossiter, Nijdam-Jones, Geczy and Porteous, 2014). With this in mind, findings particular to boys and IPV will be highlighted in this review in order to meet the needs of the agency for whom this project is being conducted.

Poly-Victimization

Poly Victims or poly-victimization, refers to a "multiply victimized group of youth who experience so much victimization, including frequent serious victimization,

and who manifest substantial traumatic symptomology" (Finkelhor, Shattuck, Turner, Ormrod & Hamby 2011, p. 292). In examining the literature related to children who experience other forms of abuse as well as exposure to IPV, some investigators found no differences in impact between IPV exposure alone and poly-victimization (Lamers-Winkleman, Willeman & Visser, 2012; Moylan et al., 2010). A greater number however, have found that poly-victimization has a more profound impact on children than IPV exposure alone (Finkelhor, Shattuck, Turner, Ormrod & Hamby, 2011; Graham-Bermann, Castor, Miller & Howell, 2012; Turner, Finkelhor, Ormrod, Hamby, Leeb, Mercy & Holt, 2012; Enlow, Blood & Egeland, 2013; Voith, Gromeske & Holmes, 2014 & Telman, Overbeek, de Schipper, Lamers-Winkelman, Finkenauer & Schuengel, 2016).

Finkelhor et al. (2011), looked at the concept of poly-victimization for children ages 2-17 years of age and found that children who have experienced multiple - victimizations are "more likely to be distressed and have higher level of other adversities" (p. 297). They point out that studies often focus on singular forms of victimization but fail to assess for other types of victimization that children may have experienced. They caution that failing to consider all potential areas of victimization can lead to an over-focus on a single type, neglecting other possible types of victimization or a combination of factors. How poly-victimization presents in developmental stages may differ, however, evidence indicates that the key dynamics of poly-victimization exists across all developmental stages (Finkelhor et al., 2011).

Voith, Gromoske and Holmes (2014) also examine the cumulative effects of violence exposure (including intimate partner violence), in multiple ecological systems, on children's trauma and depressive symptoms. The results of their study found that there

were poorer outcomes for those children who were exposed to multiple experiences of victimization. Voith et al. showed that children aged 8-12 who had experienced direct victimization and family violence were significantly more at risk for emotional problems than those with direct victimization or violence exposure alone. Additionally, Voight et al. found that those children who had experienced violence in individual, family and neighborhood domains also reported higher levels of trauma and depression than those who reported direct victimization alone. Given the importance of the cumulative and far-reaching impact of poly-victimization and how it relates to IPV, this concept must be taken in consideration when examining best practices for supporting children. This is supported by Telman et al. (2016) whose research is based on the connection between exposure to IPV and children's post-traumatic stress symptoms. They argue that approaches to intervening with intimate partner violence should include an assessment of other trauma related experiences such as child abuse so that the possibility of poly-victimization can be considered.

Impacts of IPV in the Prenatal and Infant Stages

Within the research focused on intimate partner violence and early stages of life, there appear to be two general areas of focus. The first is the impact of IPV on the attachments between mother and child that form in pregnancy through to infancy (Bogat, Levendosky, von Eye, and Davidson II, 2011). The second is the impact of prenatal exposure on neurobiological development (Artz et al., 2014; Martinez-Torteya, Bogat, Levendosky, & von Eye, 2016; Glover, O'Connor & O'Donnell, 2010; Davis & Sandman, 2012).

The impact of IPV in prenatal stages of life and the effect on subsequent functioning is discussed in the research done by Bogat, Levendosky, Von Eye and Davidson II (2011). In their longitudinal mother-infant study, they investigated prenatal exposure to IPV and attachment between mother and child during pregnancy. Their intention was to take into consideration the bonds that form between mother and child in-utero. They found that mothers' internal-working models of relationships can be impacted by the experience of IPV and affect how they understand the relationship between themselves and their unborn child. They therefore argue that pregnancy is a key period in which IPV can impact the mother-child relationship and that the mother's developing representations of herself as a mother and her ability to care for her child can be negatively impacted. Bogat et al. also found that the mother-child dyad can be damaged by IPV. Their findings indicated that distorted or disengaged maternal representations and resulting insecure attachments were related to the experience of prenatal IPV. Other findings within this study showed that IPV exposure could also bring up mother's feelings about unresolved issues in childhood and lead to negative overall perceptions of relationships between mothers and children.

Risk factors (e.g. lack of social supports, maternal mental health and social economic status) and protective factors (i.e. healthy relationships as children and good support networks) found in this study by Bogat et al. (2011), were shown to mediate either negatively or positively, the damage from IPV. These researchers suggest there is the potential of making positive changes on relationships between mother and child affected by IPV through focusing treatment efforts on improving the relationship as opposed to over-focusing on maternal mental health as the point of intervention. As

mentioned earlier in this review, family relationships provide a template for other relationships, so investing earlier appears to be key in terms of managing the potential long-term relational impacts of IPV for children.

Artz et al. (2014), conducted a narrative review of the research looking at the connection between witnessing IPV and neurological disorders, physical health, mental health, behavioral problems, crime and delinquency, victimization and outcomes related to academic performance and employability. Artz et al. summarize the research, published between 2006 and 2014 and state, that in terms of witnessing IPV and neurobiological impacts

> chronic exposure to stress-provoking condition such as IPV…evokes an environment where the hypothalamic-pituitary–adrenal system calibrates to address recurrent hostilities associated with long-term dysfunction in cortisol regulation (down regulation or up-regulation) mediating risk for maladaptive patterns of behavioral adjustment (e.g., internalizing and externalizing problems) (p. 505).

Martinez-Torteya et al. (2016), in their study on IPV exposure, hypothalamic-pituitary-adrenal axis functioning and childhood behaviours, examined the long-term effects of IPV, during pregnancy, on stress induced cortisol levels and how this related to internalizing and externalizing symptomology at the age of 10. They found that there were patterns of high cortisol secretion in children who experienced the stress of IPV and these children displayed more child-reported internalizing problems and more child and mother reported externalizing behavior later on in childhood. Martinez et al. suggest that

these findings provide support for the ongoing impact of prenatal stress (through IPV), long after birth.

Impacts of IPV on the Toddler and Preschool Stages

Research on the impacts of IPV on children aged 3-6 shows that these children are significantly more aware of and more affected by IPV because of the amount of time spent with their parents than children in any other developmental stage. They are unable to escape the violence through means such as attending school and therefore face the greatest risk for incurring negative impacts from exposure to IPV. (Howell and Graham-Bermann, 2011; Holmes, 2013; Huang, Viske, Lu & Yi, 2015; Herman-Smith, 2013; Miller, Howell & Graham-Bermann, 2012; Graham-Bermann, Castor, Miller & Howell 2012).

The research on IPV exposure during this stage tends to focus on IPV exposure as a traumatic form of child maltreatment that exerts it greatest impact of IPV on neurobiological development and the potential long-term impacts of impaired neurological development. Also implicated in this stage are the impacts of IPV on cognitive functioning and internalizing and externalizing behaviours and potential risk factors and protective factors associated with a child's ecological system.

Neurobiological Impacts. The research on the long–term developmental impact of IPV exposure on toddlers and preschool children, shows that this exposure has a direct impact on cortisol regulation and the autonomic nervous system. Howell and Graham-Bermann (2011), in their of review of physiological regulation and children exposed to IPV, discuss the operation of the autonomic nervous system and highlight the functioning

of the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS). According to Howell and Graham-Bermann, the SNS functions to protect us when there is a perceived threat or danger and it prepares the body (i.e. increases heart rate and blood flow) to either fight against a stressful or fearful situation or to run away from it. The PNS works to decrease the effects of the SNS by lowering heart rate, blood flow and the rate of breathing. The ideal state involves a balance between the SNS and PNS (Howell and Graham-Bermann, 2011). However, as Howell and Graham-Bermann point out when there is continual activation of the SNS (as in cases of prolonged and intense IPV), resulting in prolonged states of emotional arousal the balance between the SNS aand PNS is adversely affected and children may experience more difficulty in regulating their arousal related behavior. Thus, for children who experience IPV exposure, "evidence of dysregulation can be seen as arousal that does not habituate, does not reduce in intensity or is inefficient in strength to produce an adaptive response to the stressor" (Howell & Graham_Bermann, (2011, p. 90).

El-Sheikh, Hinnant, and Erath (2011) studied the relationship between family conflict and children's long-term behavioral adjustment by looking at the functioning of the autonomic nervous system (ANS). They found that within the context of marital conflict there was subsequent impact on behavioral outcomes for children in the later stages of development, such as delinquent behavior in middle childhood. El-Sheikh et al. highlight, that when the ANS is functioning adaptively (achieving a balance between the sympathetic nervous system and the para-sympathetic nervous system), this can be protective for children in the face of marital conflict and support problem solving and

conflict resolution. On the other hand, when the ANS is maladaptive in its functioning this

> …may pose risk by making avoidant, angry or impulsive responses to parental conflict more likely. Patterns of physiological, cognitive and behavioral responding learned and evoked in the conflictual situation are thought to carry over to multiple domains of children's lives, including developmental processes leading to varying trajectories of externalizing behaviours and delinquency (El-Sheikh et al., 2011, p. 18).

Exposure to IPV also affects other hormone systems: Sturge-Apple, Davies, Cicchetti & Manning (2012) who in their study of the impacts of IPV exposure on two year olds, found that inter-parental violence and maternal emotional unavailability were associated with lower cortisol reactivity and an under reacting response of the Hypothalamic-Pituitary-Adrenal axis (HPA) which is primarily responsible for activating the resources needed to respond to environmental threat and stress.

Hibel, Granger, Blair, Cox and the Family Life Project Key investigators (2011) found adrenocortical response in the other direction. In their research of children from infancy to toddler stage, when examining the effect of IPV on cortisol levels related to reactivity and regulation in early childhood, they discovered that overall, those children who were exposed to high rates of IPV reacted with a significant adrenocortical reaction (physiological response to a challenge or stressor). They report higher cortisol reactivity to emotional arousal, at year two, than those who were not exposed. Interestingly, Hibel et al. found that this same heightened reactivity was not found at seven months or fifteen months but existed at two years. Exploring this further, they suggest that when children

are exposed to repeated threatening family environments at seven and fifteen months, their adrenocortical system has not experienced the same "wear and tear" (Hibel et al., 2014) as it has at two years old where the stress of repeated threatening family violence has begun to impact them. Hibel et al. argue that this issue is compounded by the lack of habituation to challenges, compared to those who are not exposed, meaning that for these children, not only do they have difficulty dealing with current stressors and challenges and regulating their physiological responses, they are also being constantly exposed to new situations in the context of IPV that trigger additional physiological reactions. Hibel et al. note that this age effect can be attributed to the fact that developmentally children at two years old are more able to understand the emotions of others, the consequences of actions, pay more attention and have more developed executive cognitive skills. As with the research completed by Sturge-Apple et al. (2012), Hibel et al., also found that maternal insensitivity can compound the impact of IPV on children and their physiological regulation.

Traumatic Effects of IPV. With a focus on traumatic stress and intimate partner violence exposure in preschool aged children, Howell and Graham-Bermann (2011) found children's arousal capabilities, startle response and emotional reactivity are all affected by exposure to family violence. They also found developmentally specific symptoms for IPV exposed preschool children "…such as intrusive ruminative thoughts about the trauma, difficulty sleeping, new fears for safety, trauma-specific reenactment, repetitive play and pessimistic feelings about hopelessness about the future" (p. 91).

In seeking to better understand children, their attachment relationships and trauma, Lieberman, Chu, Van Horn and Harris (2011) examined trauma (including

witnessing domestic violence) in early childhood (birth to five). Their research shows that because young children often look to the primary attachment figure for protection, traumatic experiences, such as IPV can damage the trust and reliability of protection especially when the primary attachment figure is unable to respond. They also point out that children, in cases of trauma exposure, can face overwhelming sensory stimulation (i.e. visual and auditory) and may not have the coping mechanisms to handle the stimulation. At the same time these children face a kind of double indemnity because they are unable to rely on either of their caregivers given that one caregiver is being victimized and the other is the perpetrator. Additionally, Lieberman et al. show that when traumatic experiences become chronic this can lead to symptoms like hyper-vigilance, being unable to feel safe and comfortable to explore and learn, play that involves traumatic themes, and the trauma triggering nightmares and distress.

Turner, Finkelhor, Ormrod, Hamby, Leeb. Mercy and Holt (2012) explored family context, child victimization and childhood trauma symptoms with children between the ages of two to nine. They found that there is a clear linear relationship between levels of trauma symptoms and situations in which children experience a lack of feeling safe, stable and nurtured. They point out that hostile and inconsistent parenting (paternal and maternal) is common within households where there is parental conflict and these environments are the "…strongest independent predictor of children's symptomatology…" (p. 215). Inconsistent, hostile and coercive parenting along with unfair discipline can have an impact on children's social competence and aggression and can evoke fear and negatively impact a young child's sense of self-concept (Turner et al., 2012)

Levendosky, Bogat and Martinez-Torteya (2013) conducted a developmentally based, longitudinal study of PTSD in six different stages in early childhood. They found that children who had witnessed IPV showed a traumatic response in each stage and an increase in traumatic symptoms as children exposed to IPV got older. Based on mothers' reports they also found that in each developmental stage particular symptoms were foregrounded: For ages one to five, arousal symptoms such as problems with regulating emotions were most significant. For children five to seven avoidance behaviours such as inability to recall the details related to an event, were most strongly associated with witnessing IPV, while re-experiencing symptoms such as bad dreams or flashbacks were only associated with seven year olds in the study. Given their findings, Levendosy et al. suggest, that because of the level of cognitive development in earlier years is lower, children at earlier stages (ages one to five) will experience more of an emotional response, whereas older children (ages five to seven) have the ability to have a more cognitive-based response thus explaining the difference in symptoms (arousal versus avoidance and re-experiencing) between ages.

Levendosky et al. (2013) also paid attention to the ecological and relational contexts of the children who participated in their study and found a high co-occurrence between maternal and child PTSD symptoms and note that because young children are so likely to be physically and emotionally close to their mothers, their response to being exposed to IPV will influence their mothers' traumatic response and the children's responses will equally be influenced by their mother's response when it comes to affect regulation.

Enlow, Blood and Egeland (2013) discuss other contextual factors that are related to how children respond to interpersonal trauma. In their sample of 200 children whom they followed from birth to first grade, they explored socio-demographic risk, factors, intimate partner violence and other maltreatment of children, in relation to children's PTSD symptoms. Enlow et al. found that socio-demographic risk included factors such as maternal age (under the age of 18 at birth), low social economic status, mother unmarried at birth of a child and mother not having completed high school by the time of the child's birth. Enlow et al. also found that those children who had greater socio-demographic risk were more likely to experience IPV exposure and taken together, higher socio-demographic risk and IPV exposure were associated with more severe PTSD symptomology. Enlow et al. further suggest that higher rates of mental health challenges found in disadvantaged neighborhoods are likely connected to higher rates of trauma in these populations. They encourage practitioners who work with children living in adverse conditions to assess for trauma histories and work with traumatic stress symptoms.

As a final note related to young children and PTSD, Graham-Bermann, Castor, Miller and Howell (2012) studied the impact of IPV and other traumas on trauma symptoms and PTSD in preschoolers. They found that children who experience exposure to intimate partner violence, along with other traumas, are at risk of being labeled aggressive when in fact, their behavior is a trauma-based reaction to IPV exposure. In these circumstances, if treatment becomes more focused on the behavioral symptoms instead of on the underlying stress associated with trauma, then an important dimension of the necessary intervention is missed. As Graham-Bermann et al. caution, focusing on the behavior and not the potential trauma behind the behaviours, poses a problem because

often, other behaviours such as delinquency and substance use can be related to PTSD that is untreated. Rahim (2014) has also examined the current criteria for PTSD diagnosis, and points out that the current protocols do not account for variables such as witnessing violence, loss of attachment figures and bullying. Without these considerations, Rahim argues that there is a danger of children receiving a misdiagnosis with behavioral outcomes such as aggressiveness and impulsiveness being attributed to the anxiety rather than the trauma.

Cognitive Functioning and Cognitive Schemas. Preschoolers, who have been exposed to intimate partner violence, can experience difficulty with cognitive functioning and distorted cognitive schemas (Graham-Bermann, Howell, Miller, Kwek & Lilly, 2010). In their study of preschooler's verbal ability, Graham-Bermann et al. found that traumatic stressors such as IPV contributed to lower verbal scores in children as young as four years old. Their findings also revealed that additional traumatic events, along with IPV exposure, can lead to even more damage to verbal abilities. These findings are supported by Hungerford, Wait, Fritz & Clements (2012) in their review of IPV exposure and children's cognitive functioning which in turn supports Ybarra et al.'s (2007) findings that exposed children aged three to five scored lower on both verbal and full-scale IQ scores than those who were not exposed to IPV.

Focusing on cognitive schemas, Howell and Graham-Bermann (2011), in their discussion about the impacts of IPV on preschool children, explain that IPV exposed children are at risk of developing distorted ideas of gender and family roles and inappropriate strategies of conflict resolution. They found that IPV exposed children exhibit cognitive representations that are skewed and based on less positive

representation of their mothers, a less positive self-image and less emotional understanding. Miller, Howell and Graham-Bermann (2014), investigated cognitions around threat and blame for IPV exposed preschoolers. They found that there are no changes in the participants' cognitive appraisals of threat but increased appraisals of self-blame over a six to eight-month period. Of special note, was Miller et al.'s finding that despite the decreasing of IPV exposure over time, children's appraisals of threat and self-blame did not decrease accordingly. They therefore suggest that these appraisals may place children who are exposed to IPV at greater risk for developmental pathology, especially during a key period of life for cognitive, emotional, social and behavioral development. Additionally, Miller et al. also showed that while boys and girls showed no differences in their appraisals of threat, preschool aged girls who were exposed to IPV showed higher rates of self-blame than IPV exposed preschool boys.

Internalizing and Externalizing Behaviours. There is evidence to show that the experience of intimate partner violence for children during the early years, can connect to internalizing and externalizing behavioural difficulties throughout their developmental years. According to Howell and Graham-Bermann (2011), preschool children who have been exposed to family violence are 2.16 times more likely to be within the clinical range for internalizing problems and 2.38 times more likely to be within the clinical range for externalizing problems.

In examining the relationship between exposure of preschool children to IPV and the impact on self–esteem, Clements, Martin, Randall and Kane (2014) found that perceptions of preschool children with regard to inter-parental conflict had significant and unique associations with child reported levels of self-esteem. More specifically,

"child-reported self-esteem was solely predicted by their perceptions of inter-parental conflict" (p. 120). Based on these findings, Clements et al. suggest that the self-esteem of children exposed to IPV may suffer because they may attribute the cause of the conflict to themselves and/or that they feel helpless and unable to do anything to stop the conflict. Additionally, Clements et al. suggest that once these perceptions of self and situation are established they will play an on-going role in these children's assessments of their wellbeing, competence and self-esteem.

Towe-Goodman Stifer, Coccia, Cox and The Family Life Project Key Investigators (2011) examined the connection between witnessing inter-parental aggression, attention skills and behavioral outcomes for children in early childhood. They found that exposure to chronic inter-parental aggression can impair the development of attention skills in infancy. They also found that the attention resources that infants who have experienced IPV possess might be primarily used to maintain vigilance against the threats to their emotional security in their family environments, thus depleting these attention resources for use in other situations. As Towe-Goodman et al. (2011) note, "Specifically, reduced attention skills and greater inter-parental aggression in toddlerhood increase the risk for developing conduct problems and ADHD symptoms at age three" (p. 573). Additionally, Towe-Goodman et al., found some gender differences in the longitudinal connection of inter-parental aggression, attention and behavior problems in early-childhood: Boys with attention difficulties had increased rates of conduct problems at age three. They suggest that given boy's higher vulnerability where attention development is concerned, exposure to inter-parental aggression puts boys at higher risk for attention-related conduct problems later in development.

Holmes (2013) examined the relationship between aggressive behaviours of children three to eight, exposure to IPV and the mediating effect of maternal mental health and warmth. She found no direct relationship between IPV and aggression however she did find that the combination of IPV, poor maternal mental health, low warmth and psychological abuse was associated with higher levels of aggressive behavior in the children under study. She therefore, concludes that maternal mental health mediates the interaction between child IPV exposure and child aggression. Thus, as Holmes suggests, if a mother's behaviours with the child are directly impacted by IPV and she is depressed or using substances as a way to deal with her own exposure to violence, this may cause more negative interactions between mother and child and contribute to the mother being less emotionally responsive and showing less empathy, which in turn, can contribute a child's increase in aggression which may be an attempt to gain the mother's attention.

Also in the area of IPV impact in early childhood, Burnette (2013) examined early family environments and physical abuse in relation the development of Oppositional Defiance Disorder (ODD) in early to middle childhood highlighting differences related to gender. Burnette found that within the context of IPV, for girls the experience of harsh parenting was a clear risk factor for ODD, while for boys, emotional responsiveness was shown to be a protective factor. Overall the experience of IPV exposure and low parental acceptance increased the probability of ODD symptoms in both sexes (Burnette, 2013).

Finally, Huang, Viske, Lu and Yi (2015) explored the effects of IPV exposure on early delinquency up to the age of nine. Using a longitudinal approach, they investigated children's experiences at years one, three, five and nine and found that if children were

exposed to IPV at year one and year three, this was predictive of a tendency towards delinquent behavior at nine. This association remained significant even after parent-child engagement; child neglect and physical punishment were controlled for at age five. Further to this, Huang et al. found that if neglect and physical punishment were present at year five, this was also associated with delinquent behavior at age nine and that if mothers experienced IPV at year one and year three, these mothers reported child neglect and reduced parent-child engagement at year five and were also more likely to use physical punishment with their children. Huang et al., however caution against blaming these mothers for not protecting their children. They point out that mothers who experience IPV are under an incredible amount of stress, and often suffer from depression and anxiety. Huang et al. suggest that rather than adding to this by also holding them responsible for the well-being of their children in these adverse circumstances, they encourage more of a focus on how a father's positive and ongoing involvement in children lives can mediate their behavioral outcomes.

Howell and Graham-Bermann (2011) clearly state that children who are exposed to IPV in early childhood can experience long-term consequences through to middle childhood and adolescence. They encourage evaluation of the effects of IPV exposure from a developmental perspective. Based on this perspective, many impacts that have been discussed in this section will relate to and be expanded on in the next section, which focuses on a review of the impacts of IPV exposure during the intermediate school-age years.

The Impact of IPV on School Aged Children

Research on intimate partner violence and the impact on school-aged children, focuses on better understanding the experiences of IPV through a child's eyes. Since children in this age group have developmentally greater cognitive abilities (Graham-Bermann & Perkins, 2010; Renner & Boel-Studt, 2013), many researchers have included or relied on child reports about the impacts of IPV. In line with this perspective, Hungerford, Ogle and Clements (2010) explore the relationship between parent reports and child reports about child exposure to IPV and the adjustment of children. Overall, they found that parents and their children were in disagreement 33% of the time about the levels of child exposure to IPV: 12% of the children reported exposure to IPV where the parent reported none, and 21% of parents reported exposure to IPV that children did not report. Hungerford et al. also found that when parents did not report IPV exposure that children reported, this led to fewer positive thoughts and feelings about their family relationships. As a result of these findings, they argue that there is value in examining child reports and the parent-child agreement of children's exposure to IPV to ensure that a child's experiences are well understood and differences in perception between child and parent can be focused on during intervention.

Research on the impact of IPV exposure on school aged children also appears to focus more on gender and relationships in children's ecological systems (i.e. parent to parent relationship and the impact of community). It also expands our knowledge about the impacts of IPV exposure on cognitive and emotional development, family dynamics, trauma and externalizing and internalizing behavioral outcomes.

Impact of IPV on Cognitive and Emotional Dimensions. DeBoard-Lucas and Grych, (2011) investigated perceptions of cause, consequence and ways of coping with IPV exposure in a sample of thirty-four, seven to twelve-year-old children. They found that three quarters of these children were able to talk about their worries and fears, the well-being of their mothers, what would happen to them, the possibility of injuries and about how or if the conflict would end. DeBoard-Lucas and Grych (2011) further found that IPV exposed children had fewer concerns about their own wellbeing (despite having experienced direct abuse) than they did about their mothers' well-being and on a number accounts reported on children trying to intervene in the conflict between mothers and the perpetrator. They examined children's thoughts about intervening and found that many of the children (41 %) felt some responsibility for stopping the violence, and many intervened directly (trying to distract their parents or through physical intervention) or indirectly (enlisting help from others or calling 911). Additionally, DeBoard and Grych found that older children (over the age of ten) showed more concern about the potential for injury and other possible negative outcomes that might affect mothers, than children under this age. They attributed this to the fact that older children had experienced more violence that involved conflict resulting in injury to their mothers. Given the role that fears and worries about their mothers play in these experiences, DeBoard and Grych recommend that practitioners should work with children to help them understand thoughts supporting these emotions as part of the intervention process. As an important final note, DeBoard and Grych report that almost a quarter of the children in the study could not recall thoughts about their experience of violence highlighting some concerns around dissociation or avoidance.

Also related to difficulties in expressing thoughts and emotions about experiences of IPV, Georgsson, Almqvist and Broberg (2011), also investigated how children, eight to twelve-years-old related to their experiences of IPV. They, like DeBoard-Lucas and Grych, (2011) above, found that the descriptions children used contained "expressions of difficulty in terms of handling an unintelligible situation" (p. 126), that is, they had difficulties in describing their experiences and were not able to answer question related to these experiences. They also found that most of the children they interviewed did not voluntarily talk about their experiences and that those who did, when prompted, focused on the vulnerability of their mother, their own behavior, and trying to make sense of their father's behavior. In addition, Georgsson et al. found that, children's concerns about their mother and her vulnerability remained even after IPV had ended. Thus Georgsson et al. argues that for some children, making sense of IPV experiences can be difficult, painful and worrisome and will therefore be avoided. They suggest that a child's inability or unwillingness to talk about their IPV exposure may be an indication that they do not have enough emotional support within their families and therefore find themselves holding painful memories of the IPV exposure experience that requires support from resources outside of the family. Finally, Georgsson et al. report that for children in their study, IPV exposure related experiences and the impact on the understanding of conflict seemed to affect children's poor functioning in other conflict situations. They suggest that these children may have a higher sensitivity to conflict in general because it triggers unwanted memories connected to IPV.

Hungerford et al. (2012), who reviewed the research on IPV exposure and children's psychological adjustment, cognitive functioning and social competence, offers

a cognitive-contextual framework based on the work of Fosco, DeBoard, and Grych (2007), who examined children's interpretations and appraisals of inter-parental conflict and its impacts on children's adjustment. Following Fosco et al, Hungerford et al. show that school-aged children are able to consider and assess their own perceptions of self-blame and are able to understand how well they are able to cope with the violence they experience. These children are also able to perceive and gauge threat to themselves and other members of their family. Hungerford et al. argue that this increased awareness can impact a child's development of self-esteem, self-worth and self-confidence which in turn can lead to internalizing and externalizing difficulties.

Jouriles, Rosenfield, McDonald and Mueller (2014), in a study of seven to ten-year-old children and their involvement in inter-parental conflict (IPC), found that for children who had greater involvement in IPC, both mother and child reported greater subsequent externalizing problems. Also, they found that involvement in IPC did not have to be frequent for it to become a problem for children in their sample. Jouriles et al. suggest that from a learning perspective, IPC involvement could be reinforced and become more likely to happen again, if the involvement is perceived by the intervening child to be successful. They further suggest that, "The idea that involvement may be maintained by principles of reinforcement is potentially important because the measure of children's involvement included items that involve aggressive and disruptive behavior (e.g., Yell at them when they argue or fight)" (Jouriles et al., 2014, p. 701). Even though the intervention from a child may help to reduce the conflict between their parents, the behaviours used by children may not reflect appropriate approaches to managing conflict

and set a tone for using yelling or other dis-regulated behavior in other conflict experiences.

Grip, Almqvist, Axeberg and Broberg (2014) studied the impacts of IPV on the perceptions of quality of life and health complaints in children aged nine to thirteen. They found that IPV exposed children perceived a greater quality of life when they had a higher ability to manage feelings of anger, sadness and fear; experienced fewer negative emotions and had a stronger perceived attachment to their parents. Grip et al. also showed that these children were more competent in emotional regulation, had the ability to adapt and functioned better overall. On the other hand, Grip and colleagues found that those children who struggle with high negative emotionality can be at risk of "maladaptive social functioning" (p. 688). They therefore suggest that the degree of adaptability or maladaptation will have an influence on the quality of life for children exposed to IPV. Thus children, who have the capacity to regulate their emotions and not be impacted by negative emotions and behavior, may have greater ability to self-soothe while children, who are wrought with negative emotionality and have difficulty with emotional regulation, may have difficulty self-soothing. Finally, Grip et al. found a connection between perceived attachment and emotional regulation in their research. IPV exposed children who reported more secure attachment to both their mothers and fathers also reported a better quality of life. In contrast, those IPV exposed children who reported low attachment and emotional regulation and had a higher experience of negative emotions appeared to be particularly susceptible to the negative impacts of IPV and a lower quality of life.

Blair, Macfarlane, Nava, Gilroy and Maddoux (2015) in their study of children who witness domestic abuse, found that boys showed more clinically significant internalizing and externalizing (especially aggression and hostility) behaviours than girls. Blair et al. also found that IPV exposed boys reported an increase in perceptions of threat when they perceived that conflict was increasing. When compared to non-IPV exposed boys, these boys also expressed greater approval of violence and believed that violent acts improve their reputation. In seeking to explain their findings, Blair et al. point to the teaching of gender roles and how this can be related to the outcomes of experiencing IPV for boys. They point out that boys are often taught to be strong and not show weakness and that crying and displaying other emotions is not acceptable within this stereotypical gender script. With IPV exposure and the witnessing of male caregivers' behavior (i.e. aggression), boys may be encouraged to develop a dominance and aggression power dynamic and make use of similar behaviours in their own relationships. Blair et al. argue that it is important to assess boys and girls for differences in perceptions and ways of coping to ensure the use of interventions that will meet the needs of each gender.

Exploring the emotional dimensions of the impact of IPV, Deboard-Lucas and Grych (2011) examined child-reported emotions related to the experience of witnessing IPV. They found that a large number of children reported higher levels of sadness (50%) and anger (47.1%) when compared to feeling scared (14.7%). They found that in the face of parental violence, boys in the study were less likely to be scared than girls, but at the same time, if the perpetrator was a biological father, boys reported 6.8 times greater chance of experiencing fear than those boys who witnessed IPV in non-biological fathers.

Given these findings, it is suggested that treatment for children who witness IPV should include working with these children to help them express their emotions about the experience (Georgsson et al., 2011). DeBoard-Lucas and Grych also suggest that working with children to identify thoughts and feelings related to IPV exposure, can be the first step in assisting children who witness IPV to develop coping skills and regulate emotions.

The impact of IPV on emotional dimensions can also be framed through Emotional Security Theory. According to Hungerford, Walt, Fritz and Clement (2012) "Emotional security theory broadens attachment theory's focus on the parent-child relationship to include the inter-parental relationship as a source of security for children" (p. 377). These researchers have reviewed the research on psychological adjustment, cognitive functioning and social competence and discuss emotional security theory in the context of child exposure to intimate partner violence. They argue that children's emotional (e.g., anger, fear, sadness) and behavioral reactions (e.g., being aggressive, uttering threats, insults and shouting) to IPV are efforts made by these children to garner security in a situation that is outside their control. Hungerford et al. found evidence in their review that suggests when children are exposed to destructive conflict between parents. negative representations of family can be formed. These negative represetations along with the children's negative emotional and behavioral reactions, can be clear indications that exposed children are experiencing emotional insecurity. They also connect inter-parental conflict with emotional insecurity by suggesting that the conflict can compromise the quality of parenting and therefore undermine the security of the parent-child relationship, leading to negative outcomes for children.

When it comes to the interaction between children's perceptions, thoughts and feelings, DeBoard-Lucas and Grych (2011) found that children's assessment of responsibility for the conflict was attributed mainly to the perpetrators and the inability to control their anger. They also found that a part of the responsibility was assigned to the victim and linked to the perception that they provoked the perpetrator or failed to comply with the perpetrator in some way. These researchers suggest that it is important to understand how children perceive responsibility as it may set the tone for how IPV exposed children may come to understand the concept of aggression. DeBoard-Lucas and Grych argue that though most often violence is viewed as wrong, the concept of provocation could alter a child's understanding of aggression. They found that in cases where children perceived provocation, there was a potential that children would legitimize the aggression of the perpetrator. They state, "If children perceive intimate partner violence as an appropriate response to being wronged in some way, they may also be less likely to have empathy for the victim and respond to perceived provocation with aggression in their own relationships" (2011, p. 351). Finally, Jouriles, Vu, McDonald and Rosenfield (2014) focused on children's appraisal in the context of severe IPV, beliefs about aggression and the resulting externalizing problems in a sample of children seven to ten-years-old and found that for these children, both feeling threatened by IPV and justifying aggression were significantly related to externalizing behaviours.

Family Dynamics and the Impact of IPV. Interactions in the family and the influences of children on inter-parental conflict have been examined in the literature as follows in this section. Schermerhorn, Chow and Cummings (2010) studied child emotions and behaviours during parental conflicts in a sample of 111 children ages eight

to sixteen and found that when children could actively help during inter-parental conflict, there was a link to more resolution and positive endings of marital conflict. On the other hand, Schermerhorn et al. also found that when children responded to inter-parental conflict with misbehavior, negative emotions such as fear, anger and sadness, and behaviours such as yelling and aggression, these marital conflicts involved more negativity and less resolution. They suggest that based on these findings, children's emotions and behavior are not just a result of experiencing IPV because these same emotions and behaviours can have an impact on the negative dynamic of the marital conflict thus implicating the children in what they have witnessed. Schermerhorn et al. therefore argue that if children's behavior adds to the negativity of marital conflict, this behavior could indirectly contribute to the risk of these children developing mental health issues as a result of marital conflict.

Turner, Finkelhor, Ormrod, Hamby, Mercy and Holt (2012), who focused on family environment and the impact on children who experience multiple forms of victimization including witnessing family violence, found that conditions within the family and behaviours of family members that are unstable, unsafe and neglectful, can add to the risk of IPV trauma for children. Turner et al. found that circumstances like low nurturance or housing instability along with poor parental mental health and drug and alcohol abuse added to the negative outcomes (i.e. becoming fearful and damage to self-concept) for these children who had experienced victimization and family violence. In addition, Turner et al. found that when there was inconsistent and hostile parenting in the household, as can be common in households with significant parental conflict, there was a connection with sibling victimization. They suggest that when there is inconsistency

and anger associated with discipline from parents, that this can encourage fighting and hostility between siblings that parents may not be able to handle. Finally, Turner et al. addresses the concept of residential instability that can be seen in high-risk families. They found that frequent moves can create chaotic environments making it is difficult for parents to attend or respond to the needs of their children.

In seeking to understand the dynamics between children and their father within the context of IPV, Maliken and Katz (2012) examined gender-based emotional socialization in men who perpetrate IPV and the effect of this on the adjustment of children, specifically in terms of their socio-emotional development. Maliken and Katz used the parental-meta-emotion philosophy, developed by Gottman (1997) to illustrate that parents work from a set of beliefs and feelings about emotions that guide how they respond to the emotions of children. Maliken and Katz found that for violent men, beliefs about feelings and emotions, usually acquired during their own childhoods, support authoritarian behavior and are grounded in stereotypical beliefs about gender. These beliefs foreground and valorize macho masculinity and reflect less understanding about or willingness to acknowledge or consider feelings. As well, these gender-stereotyped beliefs also have an impact on how these fathers socialize children in terms of emotions. Additionally, Maliken and Katz, found that fathers' awareness of increasing fear in their children when combined with non-supportive responses significantly contributed to children showing less empathy and more externalizing behaviours. They suggest that when violent fathers recognize fear and potential sadness in their boys a defensive reaction may be triggered in these fathers resulting in their son's emotions being invalidated or trivialized and/or resulting in punishment. This leads to an unfortunate

result, with fathers' fears and aversions in dealing with vulnerable emotions being transferred to their sons

Hunter and Graham-Bermann (2013) also looked at the father and child relationship in the context of IPV and child adjustment. They studied a community sample of 219 ethnically diverse school-aged children (six to twelve-years-old) who experienced IPV and examined the connection between father contact and the children's adjustment. They found that 72% of children in their sample had direct contact with their fathers, with 28% having contact with their fathers weekly or bi-weekly, with less contact if IPV was more frequent and severe. Within this sample, they found that when children experienced more severe and frequent IPV it is more likely that these children were traumatized, they had more difficulty in dealing with the impact of IPV and displayed more aggression and other behavior problems. These researchers found that, "the relationship between IPV and child behavior problems was stronger for children with father contact than for children without father contact" (p. 441).

Given these findings, Hunter and Graham-Berman suggest that the children of violent fathers will need more intense intervention and that if father contact is to be reinstated, fathers will need to be less angry and aggressive and more positive in their behavior to prevent further traumatization. On the other hand, Hunter and Graham-Bermann report that their finding also suggests that fathers who are less aggressive and who are able to model appropriate ways to manage emotions and help children deal with their feelings about IPV, may provide a protective role in lessening the intensity of behavior problems. They caution however that each situation should be assessed

invidually in terms of the level of violence, the use of weapons and acts of child abuse before father contact is considered.

Finally, in researching the behavior of fathers who perpetrate IPV and their impact on their children, Jouriles and McDonald (2015) sought to understand if physical IPV that involves coercive control (behaviours that are hostile, punitive and threatening), is more threatening than physical IPV for any other reason. They also were interested to know to what degree physical IPV involving coercive control is more threatening to children and how it relates to externalizing and internalizing behaviours. Through their study on a sample of 107 mothers and their children aged seven to ten, Jouriles and McDonald found that physical IPV that involves coercive control is significantly correlated to children's internalizing and externalizing problems for both the children and their mothers. Thus, children who witness physical IPV are affected not only by witnessing the act of violence itself, but also by the intentions, the hostile, threatening and controlling behaviours that accompany that violence. Jouriles and McDonald argue that there is knowledge to be gained by looking at the aims and purposes that relate to IPV as these reveal the potential messages about violence that are conveyed to a child that may contribute to that child's short and long-term functioning.

Externalizing and Internalizing Behaviours. Researchers investigating the impact of IPV on school-aged children have identified a variety of internalizing and externalizing behavioral outcomes related to the experience of witnessing IPV. Where internalizing symptoms related to school-aged children's exposure to IPV are concerned, Kennedy, Bybee, Sullivan and Greeson, (2010) examined the impact of family and community violence on depression trajectories of school-aged children with

consideration given to level of family support and gender. They found that when compared with acute IPV exposure, chronic, that is ongoing IPV exposure, was related to greater risk to the mental health issues for exposed children. These researchers also investigated within-person changes in depression and found that this was positively associated with changes in IPV exposure. With a reduction in IPV exposure over time, there was a reduction in depression except for boys who had low initial family support. Higher initial family support on average, led to lower depression levels for all children. Kennedy et al. also found that higher depression levels in children who had higher levels of initial exposure to violence, their depression levels did not decrease even when their rate of IPV exposure decreased.

Bayarri, Ezpeleta, and Granero (2011) also looked at IPV exposure, psychological impacts and functional impairment in children and adolescents aged four to seventeen. They found that IPV exposed children are similarly at risk of psychological problems regardless of whether they experienced direct verbal and/or physical aggression, participated in the aggression directed at their mother or witnessed the aggression. Additionally, Bayarri et al. found that the boys in their study reported more mood disorders than girls and that boys who were also victims of direct aggression reported a higher rate of mood disorders than those who did not experience direct aggression.

El-Sheikh, Hinnant and Erath (2011), who studied the impact of martial conflict on the autonomic nervous system (ANS), and the connection of this to delinquency in middle to late childhood, found a connection between IPV exposure and maladaptive ANS functioning. When children experience maladaptive ANS functioning, they become at risk for reacting in ways that are angry, impulsive and avoidant and with that, can

develop negative patterns of responding both physiologically and cognitively. This, in turn, can led to the development of problematic externalizing behaviors and delinquency in subsequent developmental stages, especially for boys. As a result of their study, El-Sheikh et al. warn that, “boys are more susceptible to delinquent behavior in the context of family and physiological risk factors…” (2011, p. 25).

Georgsson, Almqvist, and Broberg (2011) examined child reported symptoms related to experiencing IPV in a sample of seven to nineteen-year-olds. They found that children in their study reported significantly more negative mental health symptoms as compared to the study’s reference group, even when IPV exposure had been terminated. These IPV exposed children reported difficulties with hyperactivity, emotions, conduct and peer relationships. The impact of poly-victimization was also found in this study with approximately 80% of mothers reporting that their children had experienced verbal and/or physical abuse by their fathers. Further, Georgsson et al. also found that boys were less affected overall if the perpetrator was their father while conversely, girls were less affected if the perpetrator was not the father. They suggest that this gender difference may be related to IPV being perpetrated by a male onto a female, which could result in a difference of threat perception for boys and girls.

Renner and Boel-Studt (2013), who looked at the relationship between IPV, parenting stress and the behavior problems of children aged six to twelve and again at ages thirteen to seventeen, found that the impact of IPV was moderated by both developmental stage and gender. Specifically, they found that IPV exposed boys aged six to twelve, demonstrated significantly higher levels of both internalizing and externalizing symptoms when compared with same aged exposed girls. Burnette (2013),

who employed a longitudinal approach, also examined the contribution of IPV exposure to behavioral problems, specifically to the development of oppositional defiance disorder (ODD). She gathered data on the children in her study at ages 0-6 months, 3,6,9,12,15 and 18 and found that when participating children were approximately nine years old, boy's levels of ODD symptoms were higher than girls. In addition, Burnette found that the differences in impact for boys and girls were related to parenting practices. Oppositional behavior was stronger for girls if there was harsh and coercive parenting while the emotional responsiveness of mothers tended to be a protective factor for boys.

Koutselini and Valanidou (2014) examined behavior, self-image and school performance in children aged nine to eleven in Cyprus. They found that children, exposed to IPV, were more aggressive than non-exposed children and appeared to gravitate towards violent solutions rather than to more constructive solutions, especially if they had experienced direct violence. Where gender was concerned, Koutselini and Valanidou found that IPV exposed boys tended to be more aggressive and more intense in their displays of anger than IPV exposed girls.

Koutselini and Valanidou (2014) also examined self-image in the IPV exposed children and found that children experienced lower levels of self-esteem and felt inferior compared to those children who were not exposed to IPV. They found that IPV exposed children feel that they are less accepted by their peers, less popular with teachers, friends and other children in their classrooms. In line with the concept of poly-victimization, these researchers also found that exposed children who experienced both psychological and emotional maltreatment, also experienced negative impacts on their self-esteem and self-confidence.

Finally, Koutselini and Valanidou (2014) found that the IPV exposed children had negative perceptions about success in school and believed they lack the competence and confidence that they can do well, and evaluated themselves as failures. As a result of this, Koutselini and Valanidou suggest that, "pedagogical approaches and practices must treat vulnerable children in terms of their whole life history where the context of their development extends beyond discussions of the effectiveness of teaching in the classroom" (2014, p. 226). They recommend practices in which attention is paid to personal, family and school experiences to deal with the negative effects of IPV. They see teachers as valuable resources for providing IPV exposed children with collaborative relationships in which they are able to achieve success, gain confidence and trust in themselves. The aim of including teachers in interventions is that they can assist these children with gaining social and academic confidence. Finally, Koutselini and Valanidou suggest that the results of their study indicate that fathers of these IPV exposed children may not be aware of the impacts of IPV and need to be educated about the multiple and extended impacts of IPV on their children.

Most recently, Fainsilber, Katz, Stettler and Gurtovenko (2016) examined the role of parents' emotional socialization on depression in children who witness IPV. They found that the emotional socialization of the parents has an indirect influence on symptoms of depression in their children. Thus, if the parents exhibited higher awareness and acceptance of children's emotions such as sadness, anger and fear, the awareness and acceptance of these emotions resulted in children showing a greater ability to regulate these emotions and exhibited lower levels of depression. Fainsilber Katz et al. therefore argue that parental emotional socialization of children can act as a protective factor that

contributes to lower levels of psychopathology and that interventions should focus on the development of parental emotional awareness and on coaching parents to offer emotional support to their IPV exposed children.

Impacts of IPV on Social Competence. Hungerford, Wait, Fritz and Clements (2012) who reviewed the research on intimate partner violence exposure and children's social competence, found that there is relatively less attention given to social variables than to other variables and issues associated with IPV exposure. Their review highlights two studies: The first of these is by McCloskey and Stuewig (2001), who conducted research on children aged six to twelve who had been exposed to IPV and found that IPV exposure was associated with conflict with friends, difficulties with peers and being lonely at school. The second is by Katz, Hesslerand and Annest (2007), who studied the relationship between IPV exposure and social competence at the age of eleven and found that children who were exposed to IPV at age five had difficulty with managing their emotions and as per self-reports and maternal observations, had also experienced negative peer interactions and general difficulties with peers at age nine and a half. Hungerford et al. also reported that quality of parenting and family functioning can provide a protective factor for social competence. These findings fit with those of Georgsson, Almqvist and Broberg (2011) and Koutselini and Valanidou (2014), who both found that children exposed to IPV reported difficulties with peers as noted in the section on externalizing behaviours and IPV exposure.

Impacts of IPV on Physical Health. Research has shown that child exposure to IPV can also have implications for children's physical health. Synopses of three relevant studies of this follows: 1) Olofsson, Lindqvist, Gadin, Braback and Danielsson (2011)

studied maternal reported physical symptoms for children exposed to domestic violence and found an increased risk for allergy and asthma and for poor general health for both IPV exposed boys and girls. Olofsson et al. suggest that aside from IPV exposure, these health outcomes can also be attributed to the direct violence that children can experience because their mothers struggle to handle their own experience of IPV and other forms violence outside the home.

2) Lamers-Winkelman, De Schipper and Oosterman (2012) explored the health complaints of IPV exposed children aged six to twelve. Using reports from mothers, they found that many experienced eating problems, sleeping problems, expressed complaints of aches and pains and had a higher rate of self-harming and suicide talk. Lamers-Winkleman et al. suggest that these children's eating, sleeping and pain related issues greatly influenced their overall physiological and psychological health and therefore suggest that, based on the evidence, IPV holds the same degree of impact on physical health as neglect and abuse.

3) Grip, Alwqvist, Axberg and Broberg (2014) studied quality of life and health complaints of nine to thirteen-year-olds who were IPV exposed. They found that approximately a third of their sample complained of a number of reoccurring health issues that could impact their daily functioning. Grip et al. also found that when children reported greater exposure to violence and higher negative emotions related to IPV, they also reported a higher number of health complaints. Grip et al. note that greater IPV exposure, coupled with experiences of higher intense emotions can increase stress and increased degrees of stress and adversity can manifest in physical health symptoms. They caution that school children who continually complain of re-occurring health issues,

could be reacting to the experience of IPV and therefore encourage health professionals to be aware of this potential factor when assessing physical health issues.

IPV Exposure and Trauma. IPV exposure and the connection to traumatic stress continues to be a concern for school-aged children. Georgsson, Almqvist and Broberg (2011), in their study of children's self-reported symptoms of experiencing IPV, found that close to 67% of their sample of children aged seven to nineteen-years-old, "were either at or above the clinical cut-off for PTSD" (p. 551), and many of them showed evidence of posttraumatic stress symptoms and internalizing and externalizing behavior challenges. A particularly important finding in the study completed by Georgsson et al was that traumatic symptoms related to IPV can persist overtime and often are seen in children long after termination of the violent parental relationship.

Margolin and Vickerman (2011) also looked at posttraumatic stress symptoms in children and youth who experienced family violence. They argue that because family violence can be chronic in nature and children can be constantly confronted by threat, family violence can be a significant traumatic event. They also argue that for children who are exposed to IPV, the concept of home being a safe place is compromised by real and repeated violence from which they are unable to escape. Further, Margolin and Vickerman discuss that parents' emotional unavailability can add to IPV exposure as a traumatic event as the experience of IPV can undermine a parent's ability to be potential protectors and sources of support for their children. As a consequence of the emotional dysregulation that children experience in the midst of the traumatic events such as IPV, simple stressors seen as minor by others, can cause significant distress in exposed children. Focusing on posttraumatic stress, Margolin and Vickerman highlight the

following symptoms for school-aged children as laid out by Kerig et al. (2000): problems with getting to sleep, oppositional behavior problems and obsessing over the details of the traumatic event. They suggest that these symptoms should be explored as signaling that children may be IPV exposed.

Voith, Gromoske and Holmes (2014) examine the effect of cumulative violence on children's trauma and depression symptom. In line with other research on poly-victimization, they investigated the cumulative effect of direct abuse, witnessing violence and residing in violent neighborhoods. They report results showing that when children experience violence in several ecological domains over time, this constitutes an increased risk for greater trauma and depression symptoms. Voith et al. also found that when violence was experienced in ecological domains more proximal to the child, there was an increase in their trauma and depression symptoms over time. Specifically, Voith et al. found that if children experienced direct abuse at time one in the study and then family violence at time two, these children reported a higher level of trauma and depression symptoms than those who reported direct abuse alone. Additionally, if children experienced direct abuse at time one, and then experienced direct abuse, family violence and violence in their neighborhood, at time two, they also reported increased trauma and depression symptoms than when they experienced direct abuse alone. Further if children experienced both abuse and family violence, neighborhood violence did not increase trauma and depression symptoms. This again underlines the greater impact of proximal experiences over distal ones.

In a very recent study, Fainsibler Katz, Stettler and Gurtovenko (2016) examined traumatic stress symptoms in IPV exposed children aged six to twelve. They included a

focus on the role of parents in the emotional socialization of their children along with a focus on children's ability to emotionally regulate. These researchers found that if the parents in their study were aware and accepting of their children sadness, their children were better able to regulate sadness and exhibited lower post-traumatic stress symptoms (PTSS). Fainsibler Katz et al. also found a similar result with fear, such that more awareness of fear from parents resulted in better child regulation of fear and lower PTSS. These researchers argue that their results provide support for the importance of parental awareness and acceptance of their children's emotional experiences. These finding also highlight the importance of parental support in the development of emotional regulation in IPV exposed children. Fainsibler Katz et al. further suggest that their findings reveal a relationship between fear and sadness in that IPV exposed children experience both fear and threat from the violence while at the same time feeling sad about the potential for loss or separation from the perpetrator. These researchers liken these trauma reactions to bereavement, and suggest that these children's bereavement should be taken into account.

Finally, Telman, Overbeek, de Schipper, Lamers-Winkelman, Finkenauer and Schuengel (2016) also looked at the post-traumatic symptoms (PTS) of children who were exposed to inter-parental violence, direct abuse and neglect. They report that in their sample, 21% of IPV exposed children showed rates of clinical PTS symptoms. They also found significant correlations between child abuse, IPV and PTS symptoms that supported the concept of poly-victimization; and they reported that "children's emotional insecurity at the time of the violence might have a greater impact on the association between IPV and PTS symptoms than their emotional insecurity when the threat of violence has ended" (2016, p. 134). Telman et al. also found that high parental stress

related to IPV was an independent factor associated with an increase of PTS symptoms in their children, thus pointing to the importance of overall family function. Unlike single event trauma, Telman et al., did not find any decrease in PTS symptoms over time which suggests, that when children are exposed to continuous IPV, PTS symptoms can become chronic.

IPV and the Adolescent Stage of Development

To fully understand the impact of intimate partner violence on development, a review of the impacts on adolescent development is necessary. It is in this stage that many of the long-term serious impacts of IPV exposure on behavioural outcomes are foregrounded. In this section, the connection of IPV to adolescents' use of aggression and violence, substance use, mental health challenges and delinquency will be explored.

Aggression and Violence. Aggression and violence concerns in adolescence are clearly connected to intimate partner violence exposure especially in the context of peer and dating relationships. This was made clear by Calvete and Orue (2011) who conducted a longitudinal study of six hundred and fifty adolescents aged twelve to seventeen, in which they investigated the relationship between violence exposure and the development of aggressive behavior in adolescence at three data gathering points using Social Information Processing (SIP) (Crick and Dodge, 1994) that focuses on how relationships develop between people and how this influences personal qualities. Calvete and Orue (2011), reflecting on Dodge's (1986) work on children and social competence along with applying SIP theory to children and aggression, found that if the adolescents in the study experienced violence exposure at the T1 there was a "tendency to make negative interpretations about others and the tendency to select aggressive responses when facing

ambiguous social situations at T2…the latter predicted reactive aggressive behavior at T3" (p. 44). Calvete and Orue also found that although victimization and witnessing violence predicted negative appraisals of others, only witnessing violence predicted the selecting of aggressive responses. They therefore conclude that witnessing violence has a greater impact on the development of aggressive behavior than violent victimization.

McNaughton Reyes, Foshee and Bauer (2012) explored the relationship between exposure to violence, heavy alcohol use and dating violence. They found that the strength of the relationship between heavy alcohol use and teen dating violence increases as levels of family violence and friends' participation in dating violence increases because this behavior is modelled for them so often that it is being reinforced as normative. Additionally this violent behavior is supported by the disinhibiting effects of alcohol which further lowers the ability to control the behavior for these teens, who already have a low threshold for engaging in aggression. McNaughton Reyes et al. also found that the risk of heavy drinking and dating violence associated with IPV is higher in earlier adolescence.

Voisin and Hong (2012) who reviewed the extant research on the connection between witnessing IPV, bullying behaviours, and victimization, highlight the work of Baldry (2003), who studied the connection between IPV and bullying behaviours in Italian middle school students. He found that exposure to IPV correlated with bullying acts especially in girls. In further examining Baldry's work, Voisin and Hong found that overall, IPV exposed girls appear to be more inclined than boys to engage in bullying behaviours, whether the perpetrator was their father or mother. Interestingly, they also discuss that mother to father violence in Baldry's study was more likely to predict

chidren's engagement in bullying behaviours and experiencing victimization then other variables such as age, gender or direct child abuse perpetrated by fathers. Beyond their examnation of Baldry's work, Voisin and Hong (2012) also found that the research they reviewed suggests that psychological difficulties such as aggression and PTSD may influence the relationship between IPV exposure and bullying behavior. Accordingly, Voisin and Hong found that a number of studies provided evidence that being exposed to IPV can increase vulnerability to both internalizing and externalizing behaviours and PTSD and suggest that these difficulties may interfere with the development of interpersonal skills and social skills.

In a more recent study, Calvete and Orue (2013) examined the relationship between witnessing IPV and the development of aggression supportive schemas in young people who exhibited aggressive behaviours. They found that witnessing violence had an impact on both proactive and reactive aggression. The two schemas that linked exposure to violence and subsequent aggression were 1) justification of violence, which in this study were shown to be significantly correlated with proactive and reactive aggression, and 2) experiencing grandiosity, "the feeling that one should get everything one wants, and which leads these individuals to commit aggressive acts to achieve their own goals" (p. 81), which was significantly correlated with proactive aggression. Additionally, Calvette and Orue found that proactive aggression was higher in boys than in girls and suggest that this indicates a link to boys' greater tendency to be aggressive.

Temple, Shorey, Tortolero, Wolfe and Stuart (2013) examined the relationship between gender, attitudes about violence and exposure to IPV and teen dating violence. They look at this phenomenon from both father-to-mother violence and mother-to-father

violence. Temple et al. found that overall, IPV exposure is related to both physical and psychological violence in teen dating relationships and that mother-to-father violence has a significant impact on supporting teen dating violence for both genders. They explain this by suggesting that given that they have more daily caregiving contact with their mother, and therefore children look to their mother for examples of normative behavior and accept their mother's violent behaviours as normal.

Latzman, Vivolo-Kantor, Holditch Niolon and Ghazarian (2015) who researched adolescent dating violence (ADV) perpetration and the connection to IPV exposure, included an investigation of parenting practices in their study. They found that despite the fact the impact of IPV on dating violence is complex, "parenting practices may represent an important protective factor impacting later ADV perpetration" (p. 479). Results from their study indicate that when adolescents report their parents as not being as aware of their dating partners, these adolescents were more inclined to report perpetrating physical, verbal or emotional abuse. This finding holds especially for boys, in that Latzman et al. found that when their parents were more positively involved and had greater awawreness of their son's dating relationships, these boys, perpetrated less physical violence on their partners. These researchers therefore argue that programs, addressing the issue of adolescent dating violence, should include a component that teaches parents about the importance of being aware and having knowledge of whom their adolescents, especially their sons, are dating.

Foshee, McNaughton Reyes, Chen, Ennett, Basile, DeGue, Vivolo-Kantor, Moracco and Bowling (2016) examined the use of dating violence, bullying and sexual harassment in adolescents exposed to domestic violence. Their sample included 409

mothers and adolescents twelve to sixteen-years-old whose average length of domestic violence exposure was approximately five years. In their study, Foshee et al. defined their behaviours of interest as follows: bullying behaviours were described as picking on another person; excluding someone from a group; making fun of someone, having pushed; shoved, grabbed or kicked someone or hit somebody with fists; sexual harassment was defined as touching, grabbing or pinching someone in a sexual way and as making sexual looks or gestures towards a person; and dating violence was defined as slapping or scratching a date, twisting arms or bending back fingers, pushing, grabbing, shoving or kicking a date, hitting a date with a fist or something hard, or assaulting a date with a knife or a gun. The intent of Foshee et al. (2016) was to understand shared risk factors for bullying, sexual harassment and dating violence in adolescents who had experienced domestic violence. These researchers report that 70% of the IPV exposed adolescents in their study had engaged in one of the three forms of aggression and that the most significant risk factors for all violent behaviours including bullying, sexual harassment and dating violence were depressed affect and anger reactivity, with very little influence related to challenges in the parent-adolescent relationship dynamic.

Witnessing IPV and Adolescent Substance Use. A number of studies have been directed at understanding the relationship between exposure to intimate partner violence and drug and alcohol use in adolescents. Fagan and Wright (2011) studied the impact of long-term IPV exposure on adolescent violence and drug use in a longitudinal study conducted in Chicago with a sample of 1315 adolescents who provided 2 waves of a longitudinal study. The sample was divided into 2 cohorts ages 12 and 15 when wave one data was collected. The researchers found, at wave one, IPV exposed male adolescents'

frequency of drug use was associated with older age (older youth reported a higher rate of drug use), low social economic status and having experienced direct physical abuse. At wave two of the study, three years after wave one, Fagan and Wright report that drug use for IPV exposed males was again associated with age (older adolescent males reported higher rates of drug use), having peers that used drugs and having experienced prior drug use. In addition, exposed males who were also physically abused reported a higher frequency of drug use than exposed females who had experienced similar abuse.

Wright, Fagan and Pinchevsky (2013) worked with the same population of adolescents that had participated in the Fagan and Wright (2011) study, in order to examine exposure to violence and victimization in domains such as home, school and community to learn about the cumulative impact of violence exposure on substance use in adolescence. They found that older males were more likely than females and younger males to experience multiple forms of violence (i.e. direct abuse, exposure to IPV, school violence and community violence). In addition, Wright et al. found that those who had experienced exposure to violence and direct victimization (poly-victimization) had a significant drug use problem three years later. Overall, “the accumulation of exposure to violence and victimization across life domains is detrimental to later substance use among youth, increasing the frequency of both alcohol and marijuana use…” (Wright et al, 2013, p. 906).

The Impact of IPV Exposure on the Mental Health of Adolescents. IPV exposure during adolescence, as in previous stages, has also been shown to have an impact on the development of internalizing behaviours such as depression and anxiety. Mrug and Windle (2010) examined the effects of violence exposure in multiple contexts

(home, school and the community) on internalizing and externalizing behaviours during early adolescence. They found that violence and victimization in more proximal environments such as home and school were more significant predictors of adjustment difficulties for adolescents. More specifically, they report that exposure to violence at school or home predicted the development of anxiety for adolescents in the study; with exposure to violence at home being a more significant predictor. In addition, they found that there was a connection between depression and witnessing violence at school and being victimized at home. According to these researchers, their findings support the importance of having environments close to the child that are safe and healthy thus reducing the risk of developing internalizing difficulties in adolescence. Finally, Murg and Windle (2010) found that if adolescents witnessed violence in the community this lessened the influence that domestic violence had on anxiety, showing that community violence may desensitize adolescents to violence at home.

Moylan, Herrenkohl, Sousa, Tajima, Herrenkohl and Russo (2010), studied the impact of domestic violence on adolescents' internalizing and externalizing issues. Their longitudinal study included 416 people across three waves of data collection. Wave one occurred when the children in the sample were 18 months to six years of age; wave two data was collected at 8 to 11 years of age and wave three data was collected at 14 to 23 years of age. These researchers found that witnessing violence and experiencing direct abuse (poly-victimization) lead to higher score on outcome measures such as withdrawal, depression, anxiety, psychosomatic complaints, aggression and delinquency in adolescence. In particular, depression and delinquency scores were higher for adolescents who had experienced both IPV and direct victimization. According to Moylan et al. the

findings for depression held constant even when accounting for risk in families and surrounding environments. As well, these researchers did not find a difference between the outcomes for boys and girls related to internalizing and externalizing issues.

Impact of IPV on Delinquency in Adolescence. Various forms of delinquency in adolescence have been associated with experiencing IPV exposure. Sousa, Herrenkohl, Moylan, Tajima, Kilka, Herrenkohl and Russo (2011) completed a longitudinal study of at child abuse and child exposure to domestic violence, parent attachment and antisocial behavior in adolescence. They found that dually exposed adolescents (those experiencing child abuse and witnessing domestic violence), were 2.61 times more likely to commit felony assault; 2.90 times more likely to commit minor assault; 2.43 times more likely to engage in other delinquency and 5.11 times more likely to be involved in status offences than non-exposed adolescents.

Sousa et al. (2011) also examined child abuse and witnessing domestic violence separately and found that adolescents who witnessed domestic violence only (as compared to non-exposed adolescents), were 1.8 times more likely to commit felony assault, 2.58 times more likely to commit minor assault, 1.84 times more likely to engage in other delinquency and 3.2 times more likely to commit a status offence. Sousa et al. therefore conclude that abuse alone and witnessing domestic violence alone, were not significantly different than experiencing dual exposure, and thus suggest that the level of risk can be similar for all three types of exposure. Finally, Sousa et al., show that even under these adverse conditions, the risk for antisocial behavior was less if the parent-child attachment was stronger.

Park, Smith and Ireland (2012) also examined exposure to intimate partner violence and antisocial behavior in adolescents and young adults and did so using data from the Rochester Youth Development Study. According to Browning, Thornberry and Porter (1999) The Rochester Youth Development Study focuses on the connection between delinquency and influences related to family (e.g., attachment, family dynamics and parenting practices), school (e.g., commitment to school, school performance and level of success), peers (e.g., beliefs of peers and social networks) and gang membership. They incorporated the concept of poly-victimization into their study and found that the odds of engaging in general crime and violent crime were higher if adolescents were exposed to both inter-parental violence and maltreatment. Park et al. note findings which show that when children experience both IPV and direct maltreatment, they experience a multitude of risk factors throughout their development. Building on this, Park et al. go on to show that the risk factors that poly-victimized children experience are more than likely directly implicated in either their criminal activity or their substance use or both.

Park et al. (2012) also found that the risk of engaging in general crime and violent crime was lower if only one form of exposure was experienced. From this, Park et al. argue that when co-occurrence of IPV and maltreatment is identified for a child, this may indicate an even greater need of intervention than for those who have experienced IPV or maltreatment alone. Finally, Park et al. (2012) suggest that "exposure to IPV, especially when severe, has an independent impact on violent crime…" (p. 970), and therefore argue that the impact of IPV should not in any way be ignored as this may interfere with providing effective and adequate interventions to these adolescent, putting their welfare and future development at risk.

Howard, Kimonis, Munoz and Frick (2012) also studied the connection between exposure to violence and breaking the law during adolescence. Specifically, they investigated the connections between IPV exposure, callous-unemotional traits (CU), which include showing a lack of remorse and empathy, displaying uncaring behaviours, being unable to express emotions, and breaking the law. Howard et al. found that boys who displayed CU traits were more inclined to violent behavior if they witnessed violence. Howard et al. also found an independent connection between boys witnessing violence and committing violent delinquency (e.g. assault and property damage) but not for violent victimization of boys and violent delinquency. Further, Howard et al. found evidence that adolescents who have been exposed to violence, experienced violence directly and display CU traits, have a higher risk of engaging in drug delinquency. Based on this finding, they suggest that these adolescents may be using drugs to self-medicate in order to deal with their experiences and with that found that this can lead to long-term drug abuse. Finally, Howard et al. found a significant connection between exposure to severe domestic violence and the sexual delinquency of boys without CU traits, although this did not hold true for adolescent boys who were directly violently victimized. They explain that other studies (e.g. Spaccarelli, 1995), suggest that where sexual delinquency is concerned, adolescents who are exposed to domestic violence can have difficulty in forming appropriate interpersonal boundaries, which can heighten the risk of engaging in sexually violent behaviour.

In examining the risk and protective factors for sexual violence perpetration in a narrative review of the literature on this topic, Teten Tharp, DeGue, Valle, Brookmeyer, Massetti and Matjasko (2012), identify moderating variables related to family violence

and sexual violence perpetration in adolescence. In conducting their review, Teten et al. defined sexual violence as any sexual activity where consent is not given and physical, verbal or psychological coercion was used. Their review shows that having reasonable approaches to resolving conflicts in families is associated with a decreased probability of male adolescents engaging in sexual violence. Teten Tharp et al.'s review also shows sexual violence perpetrators endorse belief systems that include the acceptance of violence and that "individuals who experience violence in their family of origin, have peers who support violence and have relationships characterized by violence may have attitudes that support the use of violence and subsequently are at higher risk for perpetrating sexual violence" (p. 142).

Foshee, McNaughton Reyes, Chen, Ennett, Basille, DeGue, Vvolo-Kantor, Moracco and Bowling (2016) studied adolescents aged twelve to sixteen years of age who had been exposed to domestic violence and their perpetration of dating violence, bullying and sexual harassment. They found that twenty percent of adolescents in their sample reported having perpetrated sexual harassment against a peer over the three months prior to the study. As in the study completed by Teten Tharp et al. (2012), attitudes about violence and aggression, in this case, the acceptance of sexual violence significantly raise the risk for the perpetration of sexual harassment. Foshee et al. also found family based factors such as teen-parent conflict, conflict in the family, low monitoring of adolescents and lack of closeness in their relationship with their mother, lack of cohesion in the family, and problems with depression and anger increased risk of perpetrating sexual harassment. Finally, Foshee et al. noted that risk factors such as low conflict management skills and difficulties in the relationship with their mothers

(responsiveness and poor communication) are also correlated with sexual harassment.

This chapter has provided a comprehensive overview of the impacts of IPV exposure across the developmental spectrum from prenatal to adolescence. As the focus of interest for the Family Resource Society (FRA) is on supporting children in the school age range (six to twelve-years-old), Chapter Two of this review investigates evidence based interventions that are directed at addressing the identified impacts of IPV exposure, and on supporting healthier development and assisting school-aged children in their recovery from the impacts of their IPV exposure.

Chapter Two:

Evidence-Based Interventions for School-Aged Children Exposed to Intimate Partner Violence

Sandra Graham-Bermann (2011) has closely studied the impact of intimate partner violence on children and related evidence-based interventions. She suggests that in the past, because of an ongoing lack of resources and mixed or absent levels of expertise and means to evaluate programs, community agencies have utilized programs without knowing if their approach to treating IPV exposure is effective and meeting the needs of the children and families they serve. Reflecting on how practices are changing, Graham-Bermann (2011) suggests that, "although the research on the efficacy of intervention programs for school-aged children is slight, it is evolving" (p. 179). To help children who are exposed to IPV and other traumatic events, she recommends that using evidence-based treatment services, with effectiveness proven through rigorous methods, is essential to help children heal. Graham-Bermann (2011) further argues that many interventions used to assist IPV exposed children in the past take a "…one size fits all approach. That is, these programs serve all of the children needing services, in a given setting, regardless of degree of IPV exposure or the presence or lack of specific symptoms" (p. 180)

In this chapter, a rigorous review of interventions for treating the diverse needs of school-aged children impacted by IPV is provided. The evidence-based interventions discussed below, address the impacts identified in Chapter One and focus on cognitive and emotional functioning; working with family dynamics and children's internalizing and externalizing behaviours; supporting the development of social competence and on

assisting children in managing the traumatic impacts of IPV. Prior to entering into a discussion about evidence-based interventions, the Children Who Witness Violence program currently implemented by the Family Resource Association is briefly reviewed and, in order to acknowledge that not all children experience difficulties and need specific treatment as a result of exposure to IPV, a discussion about resiliency and protective factors is also provided.

Current Practices for FRA: The Children Who Witness Abuse Program

The Family Resource Association (FRA) currently provides services to children who witness intimate partner violence through the Children Who Witness Abuse (CWWA) Program (Barbeau, 2009). According to Barbeau, the author of the best practices manual for the program, CWWA was developed for children aged 3 to 18 to help them with understanding and coping having witnessed IPV against their mothers and with managing the impacts of this on themselves. The goals of CWWA program, as outlined by Barbeau, focus on breaking the intergenerational cycle of violence; supporting children's safety; helping children to understand violence against women and who is responsible for that violence. The program also assists them in dealing with their emotions and helps them to build self-esteem while supporting their mothers through providing resources or referrals to community services that focus on preventing violence against women.

As Barbeau (2009) notes, the CWWA program is theoretically grounded in the feminist perspective and is based on an analysis of patriarchal systems and their constructions of oppression based on race, class, gender and age. Further, this program is

informed by research on child development, attachment theory and brain development. Counsellors, who employ this program work form a feminist standpoint, are consistent, predictable, honor their commitments to the survivors of violence, and support children through “modeling equality in the relationship and helping boys and girls become their most complete and authentic selves” (Barbeau, 2009, p. 13). Additionally, they work from a strength-based perspective assisting survivors and their children to identify name, celebrate and enhance strengths, instead of fixing their weaknesses. The CWWA program uses psycho-educational approaches that support children in understanding their responses to the abuse of their mothers as well as supports children to become empowered through learning ways to deal with the impacts and manage their trauma. While recognizing the value of the psycho-educational underpinnings of CWWA, Barbeau is very clear that providing clinical counselling services are not within the mandate of CWWA. Barbeau (2009) suggests that counselors should steer thoughts and conversations in another direction especially “if a child shows signs of anxiety or agitation, appears detached or dissociated or seems to be having more feelings than she can handle…” (p. 15).

Resilience and Protective Factors Moderating Impact of IPV

DeBoard-Lucas and Grych (2011), in their study on the effects of IPV on school-aged children and resilience, state “the emphasis on documenting the nature of adjustment problems in children from violent homes has drawn attention away from data indicating that many of these children do not appear to be maladjusted” (p. 172). DeBoard-Lucas and Grych show that resilience can be based on three factors. The first of these are personal factors such as higher intellectual functioning and a greater sense of

self-esteem. The second set of factors encompass the degree of family functioning and the degree to which the relationships between children and their parents are supportive and effective parenting practices are used. The third set of factors involve connections to community resources, including good relationships with adults and children's connections to supportive community agencies and schools, all of which have been have been shown to increase resiliency for children who have been exposed to IPV (DeBoard-Lucas & Grych, 2011).

Benavides (2015) provides a review of the research on child-based factors and factors within a child's social ecology related to resiliency that was conducted between 1991 and 2006. She shows that child-based protective factors for resiliency consist of "proactive orientation, self-regulation, intelligence and positive interpersonal relationships" (p. 94). Benavides found that children who were positive about their future, had hope, an internal locus of control and good self-esteem experienced better outcomes in the face of IPV. Benavides suggests hope can motivate children and adolescents to move past the difficulties related to IPV and look towards sustaining a quality of life despite the impact of exposure. As well, she notes that a positive orientation and having an internal locus of control and good self-esteem, can lead to more positive outcomes in adolescence. Specifically, Benavides (2015) highlights the work of Kliewer, Cunningham, Diehl, Parrish, Walker, Atiyeh, Neace, Duncan, Taylor, & Mejia (2004), who studied violence exposure and found that the ability to self-regulate supports resilience in that having the ability to calm oneself and to control both overwhelming positive and negative emotions can help children to experience fewer impacts from IPV exposure. Benavides also notes that as per Jackson (2005) high intelligence is supportive

of resilience. Finally, , Benavides also notes that based on the research that she reviewed, good interpersonal relationships can be supportive of greater feelings of belonging and increased self-esteem resulting in greater ability to build future positive relationships, despite children having been exposed to IPV

Benavides (2015) also found several conditions within a child's ecological system (family, school and community) that act as protective factors against the impact of IPV exposure. As mentioned previously by DeBoard-Lucas and Grych (2011), the quality of positive family relationships and positive parenting behaviours were also found by Benavides to be protective. In this regard, she highlights the work of Howard, Dryden and Johnson (1999) who showed that when positive family relationships begin for children in infancy and when a consistent good quality of care and support is provided throughout childhood, this supports the ability to deal with challenges throughout the lifespan. Along the same lines, Benavides points to Margolin (2006), who showed that having just one person within a family from whom a youth can receive support, care and engagement, can lead to less suffering than evidenced in youth that do not have such a key supportive, caring person on which to rely.

Further connected to children's social ecology, Benavides (2015) found that if parents are able to provide warmth and clear boundaries to children exposed to stress in their lives, these conditions acted as protective factors against the development of internalizing and externalizing behaviours. In this regard, she reflects on the work of McCabe, Clark and Barnett (1999) who examined the impact of stress experiences in the lives of African American children and found that having one parent who was warm and responsive to children resulted in less anxiety, sadness, shyness and withdrawing

behaviours. Further, according to Benavides, McCabe et al. also found a resilience benefit for children whose parents were able to establish clear rules and boundaries, especially when it comes to preventing the development of externalizing behaviours.

In reviewing the research on protective factors in school settings and the community, Benavides highlights the findings of Herrenkohl, Hill, Chung Guo, Abbot and Hawkins (2003) who found that strong-bonds to the school environment acted as protective factors for those children who had witnessed adverse experiences. As well, where community resiliency factors are concerned, Benavides also highlights the work of Rak and Patterson (1996), who found that resilient children often have supportive people around them from outside the family, who act as mentors throughout their development.

Religion, spirituality, gender and age can also have a protective effect. In this regard, Benavides (2015) references Chandy, Blum and Resnick (1996) who demonstrated that youth, who had experienced parental substance abuse and personal sexual abuse and considered themselves religious or spiritual, found that their beliefs acted as a protective factor against developing internalizing difficulties, substance use behaviours and academic difficulties. In examining the research on gender and IPV, Benavides notes that very few studies found gender differences for protective factors. Studies that did find such differences included Criss, Pettit, Bates, Dodge and Lapp (2002) who found that although friendships acted as a protective factor for females for internalizing behaviours, for males, friendships presented as a risk factor for developing externalizing behaviours. As with DeBoard-Lucas and Grych (2011), Benavides cites Grossman, Beinashowitz, Anderson, Sakuria, Finnin, and Flaherty (1992) who found that family support and cohesion and internal locus of control acted as a protective factor

against internalizing and externalizing behaviours and issues of self-esteem and academic performance for females. Grossman et al. also found that family support/cohesion were found to be a protective factor for males against externalizing problems and issues with self -esteem but not for internalizing problems and academic performance. Finally, examining age as a protective factor, Benavide's review showed that the younger the age at which protective factors are present the greater the possibility for resilience. In that regard, she discusses the work of Carbonell, Reinherz, Giaconia, Stashwick, Paradis and Beardslee (2002) who studied depression in young adults at risk and found that those children who experienced protective factors at fifteen years of age were less likely to experience depression in their early adulthood. Benavides suggests that evidence such as this indicates the need to intervene with children who have experienced IPV at an earlier stage in order to increase the possibility of resilience and lower the chance of problematic outcomes.

Interventions for Treating the Impact of IPV

Given that there are a number of approaches that would be beneficial in treating the impacts of IPV on children and their families (e.g., the Coping Power Program, Parent-Child Interaction Therapy, Child-Parent Psychotherapy), the four interventions chosen for this review are ones that appear to most comprehensively address the needs of school age children and their families. The chosen interventions include: The Kids' Club (Graham-Bermann, 1992))and Mother's Parenting Empowerment Program (MPEP) (Graham-Bermann & Levendosky, 1994); The Attachment, Regulation and Competency (ARC) Treatment Framework (Kinniburgh & Blaustein, 2005); Project Support (Jouriles et al., 1998) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen et al.,

al., 2006).

According to Graham-Bermann (2011), the Kid's Club (Graham-Bermann, 1992) and Mothers Parenting Empowerment (MPEP) (Graham-Bermann & Levendosky, 1994) programs, has been used to address the impact of IPV in a number of community social and safe house programs in the United States and the Children's Aid Society in Windsor, Ontario, Canada. This program has received recognition from bodies such as the National Institute of Child Health and Human Development for being an "exemplary" program for the treatment of children who are exposed to IPV and a best evidence model for treating children exposed to family violence by the National Crime Prevention Centre in Canada (Graham-Bermann, 2011). The Kid's Club and MPEP work together to address the impact of IPV exposure on the quality of the parent-child relationship, cognitive-contextual understandings, difficulties with emotional regulation and competence as well as symptoms related to traumatic stress.

The ARC Treatment Framework developed by Blaustein and Kinniburgh (2010), is designed to comprehensively treat traumatic stress in children and adolescents who have been exposed to traumatic events. This intervention has been chosen for this review due to this program's breadth of treatment areas that relate to of the impacts of IPV. This program employs a well-developed framework focusing comprehensively on the parent-child attachment relationship, cognitive and emotional regulation, competency and trauma processing. This approach has been identified as a promising practice in working with the impacts of traumatic experiences such as IPV exposure (Blaustein and Kinniburgh, 2010). Hodgdon, Kinniburgh, Gabowitz, Blaustein and Spinazzola (2013) report that the ARC intervention is recognized as an "evidence based practice (EBP) by

the Substance Abuse and Mental Health Services Administration" (p. 680), and is recognized as an evidence-based practice by the APA task force on identifying evidence-based practices. Further, Hodgdon et al. (2013) found that in 2010, in a cross-site evaluation, the National Child Traumatic Stress Network found that the ARC framework was the most widely used intervention in a national sample of clinically treated children accessing treatment as a result of exposure to traumatic environments like domestic violence, abuse and neglect.

Project Support has been shown to be effective in helping families address the impact associated with intimate partner violence. This intervention focuses mainly on supporting parents to strengthen attachment and improve the parent-child relationship following IPV exposure. Minze, McDonald and Jouriles (2012) describe this program as a compilation of evidence-based interventions for child maltreatment and families at risk that is theoretically focused and empirically proven. Additionally, in their review of the impacts and interventions for children who have been exposed to intimate partner violence, Wathen and MacMillan (2013) highlight Project Support as a leading evidence-based treatment for preventing impairment related to IPV exposure.

Trauma-focused Cognitive Behavioral Therapy, according to Rubin (2012), "…is the gold standard for the treatment of traumatized children and their non-offending caregivers" (p. 123). Even though this model was created to treat the symptoms of sexual abuse, according to Rubin, TF-CBT is being effectively employed for treating posttraumatic stress related to direct physical abuse and exposure to domestic violence. This intervention is included in this review of evidence-based interventions for IPV exposure as it focuses on treating many of the factors associated with the impact of IPV

as described in Chapter One, such as traumatic stress, poly-victimization, emotional and self-regulation, cognitive-contextual impacts, child-parent relationship and family functioning. Wathen and MacMillan (2013), also highlight TF-CBT as a leading evidence-based intervention for preventing impairment related to IPV exposure.

One of the common factors among these interventions is a focus on supporting the child as well as the parent/caregiver as part of the treatment process. Jourilies, Rosenfield, McDonald and Mueller (2014) state that "it is noteworthy that among clinical interventions that have been empirically demonstrated to be effective in helping children who have been exposed to IPV, most address parenting" (p. 701). Turner, Finkelhor, Omrod, Hamby, Leeb, Mercy and Holt (2012) who focused on the relationship between caregivers and children who witness IPV also underline the importance of the child-parent relationship to ensure safety, stability and nurturance and a means of providing a good framework to promote factors related to well-being and suggest that interventions should be focused on the supporting quality of relationship. Finally, Renner and Boel-Studt (2013), who looked at the connections between IPV, parenting stress and child adjustment suggest that providing knowledge and awareness to parents and children about the impacts of IPV on parenting stress and child adjustment will help social workers and mental health professionals provide more effective services to children and parents impacted by IPV.

The Kid's Club (Graham-Bermann, 1992) and Mothers Parenting Empowerment Program(Graham-Bermann & Levendosky, 1994); the ARC Framework, Project Support and Trauma-Focused Cognitive Behavioral Therapy are described in greater detail in the next sections. Included in the review of each of these interventions are studies and

research that support the efficacy of each intervention in treating the impacts of IPV.

The Kid's Club Program

Sandra Graham-Berman (2011) one of the leading investigators in the field of developmental impact and treatment of children who have been exposed to IPV, recommends the Kid's Club Program (Graham-Bermann, 1992) as an effective treatment for school-aged children. This program in conjunction with the Mother's Parenting Empowerment Program (Graham-Bermann & Levendosky, 1994) focuses on supporting children both directly and indirectly through providing support to their mothers. According to Graham-Bermann, the Kid's Club Program is intentionally facilitated in a group format to allow for the building of relationships between participants who have had similar experiences. She suggests that children tend "…to feel less stigmatized and less alone in their distress, to exchange information and impressions and to validate feelings of outrage and sadness" (p. 186). Groups in the Kid's Club program are formed with age in mind (6 to 8-year-old and 9 to 12-year-old groupings) and consist of both girls and boys.

Graham-Bermann (2011) states that The Kids' Club Program (Graham-Bermann, 1992) has several theoretical underpinnings aimed at addressing diverse types of adjustment problems as a result of IPV exposure. The program is based in Bandura's (1986) social learning theory and focuses on the development of a wide range of ways to deal with conflict in order to help children to learn that physical aggression towards others is not an appropriate way to deal with conflict. The Kids Club Program also acknowledges children's challenges with emotional regulation, emotional numbness, and

managing physical reactions as well as recognizes that the ways in which children think about aggression have an impact on IPV exposed children's self-esteem and their feelings of responsibility for violence they have witnessed. Graham-Bermann notes that because of these challenges, the Kids Club program also employs emotional security theory, cognitive contextual theory and trauma theory as part of its framework to address the cognitive, social and emotional needs of exposed children. Thus, overall, given its comprehensive approach, Kids Club can help children to gain an increased ability to cope with the experience of IPV and to function more autonomously. The phases of the program are described in further detail below:

Phase 1: Creating a Sense of Safety and Ownership. As Graham-Bermann (2011) shows, the first phase of the program focuses on group development and the building of the therapeutic alliance between participants and facilitators. The objective is for participants to experience feelings of safety and control through receiving support and working towards normalizing their experience. In the first session, the participant's exposure to IPV is acknowledged by the facilitator but not discussed and the main focus of group interactions are on activities and games that facilitate introductions and relationship building. Activities are planned by group facilitators, developed with guidance of clinical supervision and tailored to participants' ages and developmental stages as well as their gender. According to Graham-Bermann, using displacement tools such as exploring IPV through stories, art, movies and puppets allows children to react to the experience without the pressure of relating to their own family's experience.

Phase 2: Identifying and Expressing Emotion. As Graham-Bermann (2011) notes, in phase 2, children are encouraged to recognize, name and discuss their feelings.

The objective is to help IPV exposed children to increase their emotional vocabulary and explore their emotions through displacement activities such as acting in a play, creating a feelings poster, playing games or singing a song. The goals of this phase are to help children to learn that their responses to the violence in their family are normal, and to support children to learn how to express and explore emotions that are often confusing and hard to grasp.

Phase 3: Guilt and Responsibility for Violence. In this phase the Kids' Club Program (Graham-Bermann, 1992) encourages a focus on the concepts of guilt, shame and self-blame as children who witness IPV can be self-critical in reaction to being unable to do anything about this violence. With that in mind, facilitators work to assist children in the development of self-esteem and self-competence in order to help them to deal with this impact and assist them to shift their perceptions about the violence and redefining who is actually responsible for what happened. Activities in this phase can also be centered around displacement using tools such as vignettes about conflict helping children talk about what is happening in the situation, why it might be happening, what happened before, who did what behavior, possible reasons why and who is to blame for the conflict. To assist with skill building, Graham-Bermann (2011) suggests that the vignettes start with more simple forms of conflict and move towards family violence; often cartoons or movies are used to help children relate more easily to the scenarios.

Phase 4: Naming Fears and Worries. In this phase, Kids' Club (Graham-Bermann, 1992) activities center on assisting children to deal with the fears and worries around the vulnerability of their mother and siblings, as well as the fears and worries that children have about their father committing the violent acts and being arrested. This focus

can be effective in helping children with anxiety, depression, aggression and emotional regulation. The activities in this phase support a gradual progression from working with general and typical concerns and fears, to fears and worries related to the experience of witnessing IPV. The goal is to normalize and legitimize fears and worries around IPV, thus helping children to become more empowered, reduce their feelings of isolation and increase their understanding and their ability to describe their fears and worries thereby creating more safety for themselves.

Phase 5: Additional Session Topics and Goals. This final phase of treatment for the Kids' Club Program (Graham-Bermann, 1992) provides opportunities for facilitators to work on areas such as healthy problem solving and conflict resolution and on addressing children's impressions of gender roles to extend gender role options beyond what they have witnessed. In this final phase, the facilitators also work with the children to identify and name family strengths, discuss termination of the program and celebrate the participation of the children and their mothers (Graham-Bermann, 2011).

Mom's Parenting Empowerment Program. Graham-Bermann (2011) also examines The Moms' Parenting Empowerment Program (MPEP) (Graham-Bermann & Levendosky, 1994, a program for mothers facilitated while children are attending the Kids' Club (Graham-Bermann, 1992) program. This program is intended to build mothers' feelings of empowerment through understanding the impacts of IPV on their children's development, increasing their confidence and competence as parents and helping them to express their fears and worries in a safe environment. In addition, this group helps mothers to develop support networks with other mothers who have also experienced IPV. Much like with the Kids' Club program, MPEP encourages facilitators

to build a therapeutic alliance and a safe environment as part of the healing process. In this program, mothers are supported in developing child focused, developmentally appropriate ways to communicate with their children about the violence that they have endured. The intention is to help mothers build confidence as they work with various internalizing and externalizing behaviours that their children are exhibiting (Graham-Bermann, 2011). Howell, Miller, Lily, Burlaka, Groga-Kaylor and Graham-Bermann (2015) also speak to the psycho-educational component to the MPEP which educates mothers about child development and discusses typical and atypical behaviours and problem solving. The hope of this educational component is to encourage more understanding and flexibility in mothers when working with their children's challenging behaviours.

Effectiveness of the Kids' Club and MPEP. Graham-Bermann, Howell, Lilly and DeVoe (2011) who conducted a random control study to investigate the effectiveness of the Kids' Club Program (Graham-Bermann, 1992) for children 6-12 who were exposed to IPV, found that the more sessions that children and parents attended the better the child's adjustment. They also found that the greater the amount of participation in the program, the greater the reduction in internalizing problems for children exposed to a longer period of violence. Additionally, boys experienced a greater reduction in externalizing behaviour problems than girls, and internalizing behaviours for all children in the study were reduced in conjunction with a reduction in their mothers' PTSD symptomology when both mother and child had higher attendance in the program. Graham-Bermann et al. (2011) suggest that these findings indicate that supporting and helping to reduce the impact of traumatic stress on mothers may "not only improve her

functioning but also significantly benefit her child" (p. 1827). Graham-Bermnn et al., also suggest some important clinical considerations from this study. First, efforts should be made to reduce the barriers to attendance (i.e. transportation) to increase participation in interventions. Secondly, since those children who are exposed to greater violence are most at risk, they potentially may experience the most to benefit from treatment.

Following the Graham-Bermann's (2011) study, Graham-Bermann, Miller-Graf, Howell and Grogan-Kaylor (2015) studied a preschool version of the Kid's Club Program (Graham-Bermann, 1992) and again conducted a random controlled trial with 120 children and their mothers. The mother and child pairs in the experimental group attended, on average 6 sessions of the program facilitated by master's level social workers and graduate students. These facilitators followed a training manual, used activities that were developmentally appropriate and received supervision to insure fidelity to the program. As Graham-Bermann et al. (2015) show, the results of this study were similar to the previous study of school-aged children. The Kids Club Program yielded positive changes resulting in better adjustment for both boys and girls. Given these results, these researchers suggest that this program is one of the most effective group-based programs for delivering service to large numbers of children and their mothers dealing with the impacts of IPV.

The Mother Parenting Empowerment Program (Graham-Bermann & Levendosky, 1994), even though related to the Kids' Club Program (Graham-Bermann, 1992), has also been studied separately. Graham-Bermann and Miller-Graf (2015) used a random controlled trial to examine three treatment conditions for mothers and children including both mother and child receiving the intervention, just the child receiving the intervention

and both mother and child on a waitlist for the program. There were 181 participants in this study that included children 6-12 years old with an attrition rate of 18%. Graham-Bermann et al. (2015) found that the Mother Parenting Empowerment program "was successful in reducing depression and improving parenting over time" (p. 544). Accordingly, Graham-Bermann et al. (2015) suggest that as with the Kids' Club Program, working with factors that increase attendance such as providing transportation is important. They also they suggest that programs such as the MPEP can be effective in providing support to a large number of mothers with varying needs in a community setting.

Further evidence for program effectiveness, was produced by Howell, Miller, Lilly, Burlaka, Grogan-Kaylor and Graham-Bermann (2015), who studied 120 mothers who experienced severe IPV. These mothers from Michigan and Southern Ontario in Canada with children aged 4 to 6, were identified through their participation in a larger study, and were randomly assigned to either the MPEP (Graham-Bermann & Levendosky, 1994) or a waitlist condition. Results of this study indicate that mothers who were part of the MPEP learned and utilized more positive parenting practices such as using firm and fair consequences and rewards, engaging in more activities with their children, using praise to reinforce behaviour, complementing their children and using appropriate levels of affection both verbally and physically. Howell et al. also found that mothers gained from the support and learning of other participants in their group as they collectively became more knowledgeable about the child development therefore framed more realistic expectations of their children and developed a better understanding of difficult behaviours. Howell et al. (2015) suggest that the MPEP intervention may also

have supported mothers with self-care, which in turn may have reflected a more positive approach to parenting as these mothers became more relaxed and calm. Thus Howell et al. argue that there is value in short-term community-based interventions that support women, and note the value of identifying strengths, enhancing skills and building relationships instead of treating mothers who have experienced IPV from a deficit-based perspective.

The ARC Framework (Attachment, Regulation and Competency)

Developed by Kinniburgh, Blaustein, Spinazzola & van der Kolk, (2005) the ARC Framework grew out a need to support children and families whose health and welfare had been affected by complex trauma (Blaustein and Kinniburgh, 2010). Prior to the development of ARC, these theorists noted uncertainty and hesitation in clinicians who were assessing and addressing the traumas that families experienced. Blaustein and Kinniburgh discuss that a framework, based on research evidence as well as knowledge gained from clinicians through their experience working in the field, was needed to effectively treat children and caregivers. The ARC Framework is designed so that it can be utilized across a variety of clinical settings including outpatient community programs, residential and justice facilities, shelters, drop-in programs and with foster children and their families.

According to Blaustein and Kinniburgh (2010), Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Howard, Evans, Andres, Cohen and Blaustein (2011) and Hodgdon, Blaustein, Kinniburgh, Peterson and Spinazzola (2016) the ARC Framework (Kinniburgh et al., 2005) is based on three core components: attachment, self-regulation

and competence. Each of these components are based on a number of intervention targets or “building blocks” (Blaustein and Kinniburgh, 2010, p. 36). These targets support skill building in each of the core component areas.

Prior to engaging in the multi-component intervention, Blaustein and Kinniburgh (2010) encourage practitioners to do a comprehensive assessment in order to understand the people they are serving so that they can formulate interventions that meet their clients’ needs. They state that behaviour challenges can often have a variety of possible explanations and therefore it is important to pay attention to factors such as family history, observations of the child and family context, clinical presentation and factors such as cognitive and emotional functioning before embarking on treatment. Blaustien and Kinniburgh encourage practitioners to consider both positive and stressful factors in the family such as the level of functioning of the caregiver, biological components, and social economic factors and how these experiences and factors have impacted the child developmentally, emotionally and cognitively. They further suggest practitioners assess how patterns of behaviour may be related to the way a child or family is trying to adapt to the experience, how behaviours may be triggered by past experiences and cause stress and what resources the child is currently using to cope. Overall, Blaustein and Kinnibrugh (2010) advise practitioners to resist focusing too intently on behavioural outcomes without understanding the underlying issues. Focusing on understanding client need is an important step in treatment as it allows practitioners to look at why behaviours are occurring and selecting the best treatment for the child.

The Attachment Component of the ARC Framework. The first core component of the ARC framework is attachment, which, according to Blaustein and

Kinniburgh (2010) is the basis for the development of healthy adjustment. In order to build attachment, the ARC Framework (Kinniburgh et al., 2005) focuses specifically on helping caregivers become skilled in the positive management of affection, attunement, providing consistent responses, routines and rituals. Blaustein and Kinniburgh suggest that when trauma exists in a child's life, a safe and healthy relationship with the caregiving system is vital whether caregivers are biological parents, foster parents, adoptive parents, residential treatment workers, or counselors and argues that the development of attachment for children to supportive caregivers, is a cornerstone of the ARC Framework.

Supporting Caregiver Management of Affection. According to Blaustein and Kinniburgh (2010), building caregiver management of affection starts with practitioners teaching parents about trauma and its impacts through psycho-education while also validating and normalizing the response of the caregiver to the traumatic experience. Blaustein and Kinniburgh remind practitioners that caregivers will experience a certain amount of vulnerability, so it is important to communicate an understanding of this with non-judgmental respect. Where managing affection, is concerned, Blaustein and Kinniburgh recommend that practitioners help caregivers enhance their ability to monitor and manage their own emotional response and to build a support network. They encourage caregivers to identify situations that they find most challenging along with situations they find most comforting and to look at the level of competence and confidence that caregivers have when responding to behaviours and emotions of their children. Finally, they encourage workers to assess how a family's culture and traditions may influence the emotional response of caregivers.

Blaustein and Kinniburgh (2010) encourage practitioners to teach caregivers to identify and monitor their own emotional reactions by working with caregivers to help them connect with physiological indicators like heart rate, breathing and muscle tension; cognitive indicators like their thoughts about themselves, their children and their situations and through monitoring their own emotional and behavioral indictors (e.g., being punitive with their children, withdrawing or freezing). Following this, practitioners are encouraged to teach mothers strategies for relaxation and self-care such as time-outs, deep breathing, distracting thoughts or muscle relaxation in order to help them with their emotional self-regulation.

Attunement between Caregiver and Child. Along with underlining the importance of attachment, the ARC Framework (Kinniburgh et al., 2005) also teaches caregivers about attunement. Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Howard, Evans, Andres, Cohen and Blaustein (2011) who researched the effectiveness of the ARC framework with traumatized children, define attunement as the ability of caregivers and their children to understand each other's emotional and physical cues and respond to these in ways that allow for a positive engagement. Blaustein and Kinniburgh (2010) point out that focusing on attunement is important as traumatized children can often struggle with the ability to understand, cope and communicate emotions they are experiencing. As a result, the energy behind these emotions often comes out in difficult behaviours that caregivers can find overwhelming and distressing.

Blaustein and Kinniburgh (2010) further suggest that helping caregivers to understand their child's vigilance and how this is related to exposure to trauma is important. They also highlight the importance of caregivers understanding that children

can become highly sensitive to the emotions of their caregiver and can react to caregiver's behaviours. They therefore encourage practitioners to work with caregivers to help them to understand that children, who have been traumatized can focus on the needs of their caregiver rather than on their own needs so they may become overwhelmed by emotions of the caregiver. Given all this, Blaustein and Kinniburgh recommend that practitioners help caregivers to refocus their interactions so that they are tuning into the perspectives of their children, showing respect for their feelings which are neither right nor wrong, and once the caregiver has a handle on these perspectives and feelings, to take some time to caringly correct any areas of misperceptions.

Teaching caregivers about triggers is another focus that Blaustein and Kinniburgh (2010) encourage. They suggest that practitioners educate caregivers about the nature of triggers and especially those that are common when experiencing a traumatic experience like loss of control, feeling vulnerable or rejected or being anxious about the unpredictability of their environment. They also suggest that practitioners help caregivers understand how these triggers can be connected to their relationships with their children. Blaustein and Kinniburgh explain that children who have experiences like violence, abuse and neglect can transfer feelings from these experiences to other experiences in the relationship with their caregivers and may use the same strategies like being angry or withdrawn, being clingy or appearing manipulative in order to function in the relationship.

Helping caregivers be attuned with the way their child communicates is also important when it comes to attunement. Blaustein and Kinniburgh (2010) therefore suggest that practitioners assist caregivers in understanding the multiple ways that

children communicate and help them become a "feelings detective" (p. 70), tuning in to the patterns of behavior and cues that children exhibit that may indicate a given child's emotional state. To assist with tuning in, these authors suggest that caregivers pay attention to speech and voice, facial expressions, body posture, how children approach situations, for example are they withdrawn, clingy or both, and to any changes in mood and a child's ability to self-sooth.

As part of encouraging caregivers to become attuned with their children, Blaustein and Kinniburgh (2010) recommend that practitioners educate caregivers in the practice of reflective listening that is, hearing, accepting and respecting the feelings of their children. To aid in this, they suggest typical reflective listening skills like eye contact, head nodding, and small encouraging verbal responses along with reflective responses that involve empathy, validation and checking with the child about the accuracy of what they are hearing. Once caregivers are able to be more attuned with their children, Blaustein and Kinniburgh encourage practitioners to work with them to help their children modulate their affect. They suggest that caregivers be consistently curious about their children's feelings, energy and triggers as well as their own emotional climate and responses. In addition, they recommend that practitioners support caregivers in being reflective of what they observe with their children and to model self-monitoring and regulation. Blaustein and Kinniburgh outline activities such as feelings charades and follow the leader games to assist caregivers achieving attunement with their children.

Blaustein and Kinniburgh (2010) also provide some specific suggestions for working with attunement and children in middle childhood. Children at this stage can be more sensitive to the emotional climate and behaviours of their caregivers. Although this

can be positively linked to children having empathy for their caregivers, these authors caution that this can also be a complicating factor resulting in children being overly vigilant in that relationships. Blaustein and Kinniburgh also note that children at this developmental stage can become more susceptible to somatic effects of trauma and stress and therefore encourage practitioners to provide some education to caregivers about somatic symptoms to increase attunement with their children.

Balustein and Kinniburgh (2010) also outline curricula and guidance for teaching attunement to caregivers. These involve: providing psycho-education around attunement; encouraging caregivers to engage in experiential opportunities to practice attunement skills at home and tracking their children's emotions and behaviours between sessions; validating and normalizing caregiver's emotions as they begin to understand and connect with their children and practice self-care during interactions; and on capitalizing on the experiences that involve successful resolution to challenges experienced by caregivers, because "active teaching is better than passive" (p. 76).

Working Towards Consistent Caregiver Response. Assisting caregivers to be consistent in the way that they respond to their children is another target of attachment within the ARC Framework ((Kinniburgh et al., 2005). According to Hodgdon, Blaustein, Kinniburgh, Peterson and Spinazzola (2016), supporting the caregiver to enhance the quality of her relationship with her children through consistency, assists children to experience enhanced feelings of safety. Blaustein and Kinneburgh (2010) note that when trauma occurs within the context of caregiver relationships, children can experience negative emotions about the relationships even if the abuse or violence is not directed at them as it can be "… perceived as an unpredictable punishment from the

environment" (p. 78). Blaustein and Kinniburgh therefore suggest that consistency helps caregivers provide predictable responses based on rules, consequences and expectations for behaviour. In addition, they argue that children, when they experience consistency, will be less likely to be distracted by the trauma and the resulting behavioural impacts and more able to experience normal development.

Blaustein and Kinniburgh (2010) suggest that overall, in order to be able to provide consistent responses, caregivers need to understand the impact of trauma in their children's lives and need to know how to respond to related behaviours. They need to be able to provide support for their child that is predictable, sensitive, appropriate, and promotes safety. To support the development of consistency in parenting, Blaustein and Kinniburgh encourage practitioners to educate caregivers on the following: the use of noticing, praising and reinforcement to encourage positive behavior and on extinguishing bad behaviour by not giving it attention and instead, setting limits and using time-outs. To teach these strategies, Blaustein and Kinniburgh recommend techniques such as role-plays, sessions with the caregiver and child with a practitioner who coaches and, models the desired behavior during the in sessions and assigns homework that helps to reinforce the strategies.

To assist caregivers in experiencing some success, Blaustein and Kinniburgh (2010) recommend that practitioners work with caregiver consistency by beginning with their children's less difficult behaviors and then , moving to more complex and challenging behaviours. Working collaboratively with caregivers is a key part of the process as is caregiver input on the children's behaviours that are selected for skill building, identifying the gradual steps that will indicate success, identifying potential

hurdles like children's triggers, changes in routine such as school vacations and other potential stressors such as play time or birthday parties and tracking the challenges and successes.

Blaustein and Kinniburgh (2010) offer recommendations for middle childhood particularly around the use of reinforcement for children in this developmental stage. They encourage caregivers to routinely reinforce what they see as successes for the child and encourage others in their child's life for example, teachers, other family members, and people in the community, to do the same. Blaustein and Kinniburgh also suggest that middle childhood is a key time for practitioners and caregivers to help children by reinforcing "the child's positive sense of self" (p. 89). Additionally, Blaustein and Kinniburgh suggest that practitioners work with caregivers to establish rules for their family that are simple and indicate what to do versus what not to do.

As a final note about consistent responses, practitioners who are working with caregivers need to keep in mind diversity and an awareness of the cultural beliefs of families and how these beliefs influence what are appropriate and acceptable responses for caregivers. Balustein and Kinniburgh (2010) recognize that there can be generational factors involved in how caregivers have learned to care for their children and that often caregivers have experienced trauma in their own history. Caregivers are doing the best that they can so practitioners need to work towards "empathetic attunement" (p. 80), focusing on promoting change, experiencing success and building an environment in the therapeutic relationship that is based on safety, predictability and boundaries.

Building Routines and Rituals. The final attachment skill recommended by

Hodgdon, Blaustein, Kinniburgh, Peterson and Spinazzola (2016) encourage practitioners to helps caregivers to build routines and rituals into their lives. They advise practitioners to model this concept through the ways in which sessions with the caregivers are structured (e.g., session check-ins and closing rituals). More practically, practitioners are encouraged to work with caregivers to identify areas in which routine and ritual will lead to growth and development in their children's daily functioning (e.g., morning routines, routines around meals, chores, homework and bedtime as well as family time). Blaustein and Kinniburgh (2010) note that routines and rituals are important, as often with experiences of trauma, children's daily environments will have been chaotic and unpredictable. They suggest that chaos and unpredictability can therefore be a negative trigger for children. Building and maintaining routines and rituals will help caregivers create an environment of safety and security for their children. They further suggest that practitioners work with caregivers to focus on routines and rituals that are associated with vulnerable or difficult times in the child's daily life like meal times or bedtimes. Blaustein and Kinnibrugh highlight the role of traditions or celebrations related to family, community and culture. They suggest incorporating these into a traumatized child's life thus allowing them to develop a sense of belonging within their ecological system.

To support all that has been described above, Blaustein and Kinniburgh (2010) suggest that practitioners work with caregivers to continually assess whether rituals and routines are providing security and safety or whether they could be increasing arousal or distress. These authors emphasize the importance of achieving a balance between structure and flexibility and support the notion of equalizing the needs of the child and the goals of particular routines and rituals. Routines and rituals are intended to help

modulate children, helping caregivers to be aware of events and activities that precede routines (e.g., not having an extremely simulating or arousing activity before bedtime) is important. In the same vein, Blaustein and Kinniburgh suggest that building routines or rituals to help children regulate before bedtime or quiet times can be as equally important. Blaustein and Kinnibrugh note that planning family time can be more challenging as children get older, so a more effort may be needed to ensure this occurs. Given that older children can become more involved in the development and facilitation of routines and rituals, parents are encouraged to engage their older children in this process.

Blaustein and Kinniburgh (2010) also underline the importance of incorporating routine and rituals into counseling sessions with children. They suggest these can provide the same sense of predictability, comfort, safety and control that are encouraged in a child's family. To support consistency and predictability in counseling, Blaustien and Kinniburgh recommend opening sessions with check-ins and a discussion of how activities will be regulated and structured, offering free time based on the child's choice, ending sessions with closing check-outs, a clear closing activity and clean up as a closing ritual. They caution however that flexibility within the routines and rituals is important and that such flexibility should be based on individual needs of children.

The Self-Regulation Component of the ARC Framework. The next core component of the ARC Framework (Kinniburgh et al., 2005) focuses more directly on the children and their abilities to self-regulate. Hodgdon, Blaustein, Kinniburgh, Peterson and Spinazzola (2016) state that this component is intended to "support children in developing the skills and tolerance for managing emotional and physiological states" (p.

44). They note that this component of treatment is particularly important for children who have been traumatized by experiences such as IPV exposure, to work towards identifying arousal in their bodies, understanding the arousal in context and how it relates to potential triggers, tolerate the arousal and identify and develop skills that helps them to interact with others in their environment.

To assist with the development of self-regulation, Blaustein and Kinniburgh (2010), outline three points of focus for caregivers: reflection, modeling and stimulation/ soothing. With reflection, caregivers are encouraged to verbally speak about the emotions they observe in their children and mirror these emotions, for example, if a child is laughing, smile at them. With modelling, caregivers are advised to model positive ways of coping for their children for example, if a caregiver is angry or upset she should step back, takes a deep breath and return to the situation looking less stressed. Finally, caregivers are encouraged to provide stimulation for children when their energy is low and soothing during moments where they are highly distressed. The goal in all this is that through modeling, these skills become internalized for children so that they can self-regulate more independently over time.

With trauma and self-regulation, Blaustein and Kinniburgh (2010) suggest that practitioners remain mindful of the dynamics related to trauma such as children feeling shame, alone, and fearful of other people knowing about their trauma related family secret. They therefore encourage practitioners to work with children to acknowledge the whole child and the positive role their strengths and interests can play in their lives, while also validating the behaviours that children have developed to deal with the traumatic experiences. Blaustein and Kinniburgh encourage practitioners to help children

understand their own danger responses and triggers and to continue to work on how their current experiences are related to their past experiences. Within this core component of treatment, there are three targets of treatment that Hodgdon et al. (2016) identify. These targets are affect identification, modulation and affect expression.

Helping Children Identify Affect. According to Arvidson, Kinniburgh, Howard, Spinazzola, Stothers, Evans, Andres, Cohen and Blaustein (2011), helping children with affect identification should be the first target of self-regulation. They recommend that practitioners first work with children to help them understand that everyone experiences feelings; that they come from what people think; that feelings can be based on their experiences in relation to people, experiences in their environment and sensations in their body. Blaustein and Kinniburgh also suggest practitioners share with children that it can be difficult to know feelings especially if they have not been taught by their parents; that feelings can be so big it is hard to tell one feeling from another; that we can turn off feelings or avoid feelings if they are too difficult to face in distressing situations and that feelings can show-up so suddenly it be can difficult to understand. To start working on self-regulation, Blaustein and Kinniburgh suggest helping children to build their emotional vocabulary, an understanding of how emotions are related to events and tuning into internal and external cues are all important parts of self-awareness. Working with children to become feelings detectives teaching them that sensations in the body, expressions on faces, and the tone of one's voice can be helpful in identifying feelings.

Balustein and Kinniburgh (2010) suggest that in working with affect identification a practitioner should start at a basic level through activities such as reading a book and asking the child how a person may be feeling or having children talk about how they are

feeling today. As children progress in the acquisition of their emotional language they can be further encouraged to relate their emotional vocabulary to sensations in their body. For example, they can recognize that a tingly head when they are angry or frustrated; goose bumps when they are excited and so forth.

As children progress into later stages of affect identification Blaustien and Kinniburgh (2010) encourage practitioners to help children gain an understanding of emotions in context (e.g., this person is mad because he fell off his bike) and if the child is ready, to relate these emotions to past experiences and behaviours (e.g., I was upset when my friend ignored me. It kind of reminded me of when I tried to talk with my mother and she didn't listen to me and I got upset and threw something at the T.V.). Blaustein and Kinniburgh also suggest that practitioners help children to understand that some experiences may elicit more than one feeling and that some experiences can include mixed feelings (e.g., loving someone while also experiencing fear). Practical methods to help children identify emotions can be most effectively implemented through listening and reflecting on statements that children make while playing. Finally, these authors caution practitioners that arousal can be evoked through the process of helping children to identify feelings, so some affect modulation may need be taught while children work on this process.

Recognizing and understanding triggers and how they manifest in the body is the next step for affect identification suggested by Blaustien and Kinniburgh (2010). They encourage practitioners to educate children about the body's alarm system and how it alerts people to danger and help them understand the relationship between the danger response, arousal and fuel to take action (e.g., fight, flight or freeze). They also encourage

practitioners to help children understand what happens when the danger response is overactive (the doing brain takes control over the thinking brain), when there are false alarms (reminders outside of a dangerous situation that can trigger a danger response), and how these situations can be connected to overwhelming energy in the body. Finally, Blaustein and Kinniburgh (2010) suggest that as practitioners are working with these feeling related processes with their child clients, they also teach caregivers the these very same skills so that they can reinforce their affect understanding and regulation processes at home between sessions.

Blaustein and Kinniburgh (2010) provide resources (handouts and worksheets) to promote the learning for both children and their caregivers. They identify a number of activities that can aid in the process of affect identification (e.g., feeling flashcards, body awareness and feeling books) and they offer guidance in working with affect identification with individuals and groups. For individual work, as with the Kids Club Program (Graham-Bermann, 1992) they suggest, using methods of displacement such as magazines, puppets or stories, especially if children are initially uncomfortable talking about emotions. In working with affect identification in groups, these authors recommend the use of group check-ins, role-plays, improvisation and skits. As children increase their affect identification skills movies or TV shows can be used to explore triggers and the danger response. Working with children in middle childhood, Blaustein and Kinniburgh share that children at this stage are better able to use words to describe their experiences and recommend that talking or writing be balanced with activities such as drawing.

Assisting Children with Modulation. Modulation is the next area of skill development recommended when supporting children’s self-regulation. According to

Arvidson, Kinniburgh, Howard, Spinazzola, Strothers Evans, Andres, Coen, and Blaustein (2011) as well as Hodgdon, Blaustein, Kinniburgh, Peterson and Spinazzola (2016) there are two goals for modulation: helping children who have been exposed to traumatic experiences to tune into different internal states including levels of emotions, energy and arousal, as well as helping children develop effective strategies in managing their emotions, body responses and arousal.

Blaustein and Kinniburgh (2010) reflect on the impact of trauma on modulation for both caregivers and children. They suggest that trauma exposure can have a negative impact on a caregiver's ability to provide responsive consistent caretaking and the ability to regulate themselves, thus making it more difficult to teach children modulation. In addition, they note that for children, traumatic stress can make learning how to modulate particularly difficult, especially when the stress becomes chronic and overwhelming. When exposed to trauma, Blaustein and Kinniburgh suggest that children can experience functional shifts from the thinking part of the brain (cortical region) to the more primitive doing part of the brain (limbic region). When this shift occurs, coping can be more difficult and when paired with a lack of support from caregivers it can be significantly difficult for children to modulate. Arvidson et al. (2011) suggest that "a child that did not receive a safe, supportive, caregiving environment will develop alternate ways to cope with distress" (p. 42). Blaustein and Kinniburgh describe alternate ways of coping as over controlling feelings or avoiding them; day dreaming and isolating oneself; being physically aggressive; rocking; engaging in sexualized behavior and forcing altered states in which they feel they have more control over their body such as undereating and engaging in self-harm.

In offering guidance for practitioners in how to teach modulation, Blaustein and Kinniburgh (2010), suggest that practitioners help children to modulate their feelings by identifying levels of arousal; noticing when arousal levels shift by paying attention to physiological shifts in their bodies such as one's tummy feeling better when one is less scared; connecting emotional experiences to the levels of energy and arousal in the body (e.g., feeling really agitated when experiencing frustration) and becoming aware of changes in one's emotional and physiological state when using strategies like not clenching ones fists when using a stress ball. Blaustein and Kinniburgh (2010) and Arvidson et al. (2011) share that in the context of trauma treatment, modulation may need to go in both directions, that is, there may be times where children may need to increase their arousal if they are constricted in one situation and decrease their arousal if they are hyper-vigilant in another.

Blaustein and Kinniburgh reflect on the concept of comfort zones and the importance of practitioners understanding where children are most comfortable and at what level they are modulating arousal. They also point out that the current comfort zone may not be effective in helping children function well in the world. Blaustien and Kinniburgh therefore suggest that if practitioners need to help children expand comfort zones, either increasing low energy or decreasing high energy, they do this slowly and cautiously and stay in tune with the child. They also suggest that when helping a child modulate effectively, practitioners need to help children understand that different environments will contain different states of appropriate arousal (i.e. classroom versus the playground). With all this in mind, Blaustein and Kinniburgh (2010) recommend that practitioners engage in modulation through a variety of fun activities or planned

regulation strategies while keeping in tune with the child and helping them notice changes in their physiology. In line with this, Arvidson et al. (2011) reflect on modulation through play and recommends using "…movement and other sensory experiences, while providing reflection and containment allows children to develop an awareness of their internal physiological states and ultimately the ability to tolerate and modulate internal states" (p. 43).

Blaustein and Kinniburgh (2010) offer some teaching points and activities for practitioners to assist children in modulating their affect. They encourage practitioners to help children understand levels of feelings, energy and arousal through using activities such as scales (children identifying their emotion on a scale of one to ten); having children color in the level of intensity on a drawing of a thermometer or by coloring in a portion of a circle as well as having children stack poker chips to indicate level of intensity. Blaustein and Kinniburgh also suggest that practitioners work with children on understanding the building of energy in the body; teaching about the connection between feeling and energy (what feelings may have high or low energy) and as with feelings, helping children explore levels of energy using scales or others ways to measure intensity. Ultimately the intention is to work with children to decide at what level of energy they function the most effectively and help children build a sense that they can control or shift their energy.

Developing an inventory of strategies can be useful in supporting children with modulation. Blaustein and Kinniburgh (2010) suggest practitioners help traumatized children build an inventory of skills through creating a real (objects, pictures drawing or writing material) feelings tool box or a metaphorical (lists of strategies) feelings toolbox

to help them organize safe strategies that they can use to modulate themselves when experiencing a variety of emotions and energy levels. They suggest that this process is not static and that strategies be added to the toolbox as children learn and practice them. Further, Blaustein and Kinniburgh also encourage practitioners to work with children on how to assess if strategies influence changes in energy levels (through measurements such as heart rate and rate of breathing) before they add them to their toolbox. Finally, Blaustein and Kinniburgh identify possible modulation strategies such as diaphragmatic breathing, grounding objects (e.g., stress ball or listing ten favorite things), movement (jumping jacks or dancing to music), muscle relaxation, imagery (imagining a favorite place) and other techniques such as using sounds or tactile experiences. They also offer practitioners activities that assist children in alternating states (e.g., moving in slow motion for up regulation or turning music up for down regulation).

With consideration for developmental level and application to individual or group practice in mind, Blaustein and Kinnibrugh suggest that children in middle childhood can be more involved in their own modulation process with less external input and more awareness around cues from their body. They also suggest that they can be encouraged to more successfully modulate before they reach a crisis level. Working with children individually, they reinforce the use of modulation techniques in sessions especially with transitions that may be difficult for the child, and encourage the use of these strategies in the same way at home. Finally, with group practice, Blaustein and Kinniburgh recommend that modulation activities be used in groups for opening activities, check-in and closings as well as working with group modulation through activities such as drumming.

Both Blaustein and Kinniburgh (2010) and Arvidson et al. (2011) recommend that practitioners involve the caregiver in the learning and coaching of modulation. Blaustein and Kinniburgh suggest several teaching points for practitioners to share with caregivers such as: helping their children identify when they are having difficulty with modulation through stating what they observe without judgment or blame; helping their child use modulation skills by cuing them to the modulation skills they have learned; reinforcing the successful use of modulation skills and helping their child to process what may have come before the challenging emotion.

Assisting Children with Affect Expression. Arvidson et al. (2011) present affect expression, the last intervention target for self-regulation, centred on helping children safely and effectively communicate their emotions. Blaustein and Kinniburgh (2010) notes that when children experience anger and rejection, as with IPV exposure, they can develop a sense of shame and secrecy around their emotions and feel too vulnerable to share because they are afraid. Given these fears, violence affected children are less likely to share their emotional experiences with others and will isolate themselves, pretend everything is fine, or minimize the emotions. Blaustein and Kinniburgh share that when children are unable to express emotions in healthy ways, they can often resort to more unhealthy ways of expression such as punching, yelling or projecting their emotions onto others. Unexpressed emotions can also cause somatic issues such as upset stomachs or headaches and other behaviours such as disorganization and withdrawing. Finally, according to these authors, children who have challenges expressing themselves can also over express, cross boundaries and have difficulties interacting with others. Thus, as Arvidson et al. emphasize, effective affect expression is key in developing and

maintaining healthy attachments needed for children's growth and development.

Blaustein and Kinnibrugh (2010) provide some guidance in working with children on affect expression. They encourage practitioners to work with children around understanding who they can safely express emotions to, knowing when and what to express and developing safe and effective ways to express emotions. Once a child's modulation has been established, Blaustein and Kinnebrgh recommend that practitioners pair the learning of modulation skills with expression skills and help children to understand the language, cultural expectations and boundaries needed in various contexts. Blaustein and Kinniburgh also reinforce the concept of attunement when working with children around communication and suggest that practitioners pay attention to the emotional content of the things that children say, work with them to expand on the emotional content and positively reinforce the times when children have been able to communicate despite feeling vulnerable and uncomfortable.

Blaustein and Kinniburgh outline some activities for practitioners to use in working with children on affect expression. They encourage practitioners to assist children in identifying and making concrete lists of people with whom they experience safety, support children in the use of effective communication skills and work towards emotional expression. Effective communication skills can consist of picking the right moment (good and not so good times to communicate), how to initiate conversations (e.g., by speaking, writing or using gestures, art, playing, drama or music.) and using non-verbal skills (tone of voice, appropriate skills that respect and maintain physical space, and using eye contact). Finally, Blaustein and Kinniburgh encourage practitioners to help children learn how to use "I" statements for self-expression.

In keeping human development in mind, Blaustien and Kinniburgh (2010) mention that children in middle childhood may identify people like friends or teachers as their safe people as well as caregivers and helping them to build social resources are key for children at this stage of development. When working individually with children, these authors recommend that practitioners work with other people in the children's ecological systems, such as teachers, to help children develop plans for communication and identify resources within the school to assist them with the challenges they encounter. Finally, when working with groups, Blaustein and Kinniburgh suggest using activities such as role-playing and improvisation as well as opportunities to practice boundaries and non-verbal communication skills where affect expression is concerned.

Blaustein and Kinniburgh (2010) provide some suggestion for working with caregivers and children around affect expression. They suggest that practitioners help caregivers understand the key concepts connected to affect expression, development and communicating. They also suggest work with caregivers to teach the connection between modulation and expression, as well as the emphasizing the importance of attunement to the child's experience of affect expression. Caregivers are encouraged to take regular opportunities for expression in daily family life, such as sitting down together at dinner and doing daily check-ins.

The Competency Component of the ARC Framework. The final core component of the ARC Framework (Kinniburgh et al., 2005), according to Hodgdon et al. (2016), is competency. This component focuses on supporting children with developing relationships, good communication, self-confidence, identity and how to explore and understand the world. Blaustein and Kinniburgh (2010) share that for

anyone, competencies in each stage of life are built upon experiences in previous developmental stages, so for example, the abilities of children to build peer relationships in middle childhood are dependent on the amount of success these children may have had in experiencing secure attachment to caregivers. Therefore, successful treatment of children in this area goes beyond just reducing symptomatic behavior but also focusing on helping children achieve developmental competencies, not premised primarily on the survival instincts (Arvidson et al. (2011). With this in mind, Arvidson et al., identify two important intervention targets attached to the component of competency: the building of executive functions and the development of self and identity.

Strengthening Executive Functions. Helping to promote understanding around competency, Blaustein and Kinniburgh (2010) describe the "mutual inhibitory" (p. 176) nature of the prefrontal cortex (thinking brain) and limbic region (emotional brain) and note that when emotions are high there is a decrease in thinking. As with the discussion on self-regulation, the authors show that the emotional part of the brain can become over active in traumatized children thus making it difficult for children to experience and develop higher order cognitive functions. They make the case for assisting children to strengthen executive functions in order to help them feel some control over their lives and to think about how to respond rather than to react to situations.

Arvidson et al. (2011) suggests that by assisting children with strengthening executive functions we are assisting them to develop problem-solving skills and helping plan their responses and anticipate consequences based on their choices. Hodgdon et al. (2016) suggest that helping children strengthen executive functions helps them to recognize they have choices, assists them in evaluating situations, being responsive

instead of reactive, and finding potential solutions suitable to their needs.

Blaustein and Kinniburgh (2010) outline ways to teach children problem solving as well as ways to notice when to apply these skills. Practitioners are encouraged to teach children how to notice problems through identifying feelings and building the child's control over situations. They also guide practitioners to help children build safety, assess real versus perceived danger and to work to inhibit reactivity so they can be more thoughtful about their responses. In order to build these skills, Blaustein and Kinniburgh suggest that practitioners encourage children to be problem detectives and understand the problem through backtracking from a problem situation to the root of the problem. Further, Blaustein and Kinniburgh suggest that practitioners help children to non-judgmentally brainstorm possible solutions and look at all possible choices to a response, both internally and in action. Then, after all the possible choices have been uncovered, children can be encouraged to measure these possibilities in terms of the connection to what they are trying to accomplish, evaluating possible consequences of solutions and making the choice of action. Finally, they encourage practitioners to help children put their solutions into practice, evaluate outcomes and either celebrate successes or look at other possible solutions to move themselves ahead.

As with every aspect of the ARC Framework (Kinniburgh et al, 2005), Blaustein and Kinniburgh (2010) also offer suggestions on how to work with children in middle childhood, helping them with the development of executive function and problem-solving skills. They note that children in this stage should have more understanding and control over choices and actions as well as the cognitive ability to work towards goals. They suggest that caregivers and other people in the children lives should help to encourage the

concept of choice in various situations or activities. “It is crucial to notice and name choices when they occur, particularly with children who struggle with them” (Blaustein and Kinniburgh, 2010, p. 177). Blaustein and Kinniburgh encourage practitioners to focus on mastery with children by reinforcing the outcomes of choices and recognizing success both in the outcomes they achieve and in the effort they make during the process. According to Blaustein and Kinniburgh supporting children in using modulation skills in conjunction with problem solving is important so they are able to achieve the best possible outcomes.

Working with individual children in middle childhood, Blaustein and Kinniburgh recommend the use of real life problems so that the child can experience problem solving in situations that make sense to them. Real life problems can also be the focus of group work, with the added emphasis on the value of collaborative problem solving and the process of working together. In addition, they encourage the use of displacement activities such as movies or shows where the problem may not be obvious and the group can work together to identify the problem and use the problem solving process.

With executive function development and problem-solving as with every other aspect of the ARC Framework (Kinniburgh et al., 2005), Blaustein and Kinniburgh (2010) suggest that caregivers be taught the same skills as their children are learning in treatment so that this learning can continue outside the therapeutic environment. They also encourage practitioners to have caregivers focus on choices and outcomes at home and positively reinforce choices when preferred outcomes are achieved.

Self-Development and Identity. Finally, within the competency component of the

ARC framework, Arvidson et al. (2011), identify self-development and identity as the last target for intervention. In this stage children who have experienced trauma are encouraged to focus on themselves and discover the positive and unique pieces of who they are while incorporating experiences from the past. During this section of treatment, children are encouraged to create a story of their life, focus on their attributes and develop a future idea of themselves (Blaustein and Kinniburgh, 2010; Arvidson et al., 2011; Hodgon et al., 2016). Blaustien and Kinniburgh establish that the development of self and identity gradually builds across developmental stages and is influenced mainly by caregivers in the early stages progressing to include peers, teachers and other influential people in middle childhood.

Blaustein and Kinniburgh (2010) highlight three points that speak to the impact of traumatic experiences on self and identity: 1) Children will translate their experiences into messages about themselves such that, “Children who are routinely rejected, harmed, or ignored internalize an understanding of self as unlovable, unworthy, helpless or damaged” (p. 191). 2) Trauma exposure has an impact on the development of the child as a whole. Some children tend to dissociate to manage their experiences, their experiences become fragmented in nature and result in children becoming disconnected from themselves. 3) Children can form multiple identities, that is, multiple selves such as the “scared self,” or “angry self”, selves that they have difficulty combining into a holistic sense of self made up of multiple experiences (combination of positive and negative aspects). Blautsein and Kinniburgh suggest that children who have been exposed to trauma can be so focused on keeping themselves safe that this can prevent them from feeling comfortable to explore their worlds and integrate other experiences into their

identity.

Blaustein and Kinniburgh recommend that practitioners support children in developing an identity or sense of self, as well as self in relation to others and self in different contexts such as family and school. They also recommend that children be encouraged to explore and express their sense of self that is, their identity, within the context of their lives, outside the experience of therapy, using modulation strategies to manage any overwhelming emotions or arousal. There are four targets that Blaustein and Kinniburgh outline as being a part of the process of developing a sense of self: the unique self, the positive self, the coherent self and the future self. These authors describe the unique self as the attributes of a child that allows them to stand out from other children; the positive self as the attributes that helps a child experience successes and achievement; the coherent self as the ways that a child has integrated experiences in the past and present and has brought together many aspects of themselves to define their identity and the future self as the ability for a child to connect with images of themselves in the future and have the ability to connect current behaviours to future outcomes.

Blaustein and Kinniburgh (2010) offer activities that can aid practitioners in helping children connect with all four aspects of self. To help children connect with their unique self they recommend that practitioners use activities such as: "all about me books" books that consist of pages written or drawn by the children about things they like, experiences they have had, their values and achievements; a personal collage made up of stickers, pictures or drawings that represent the child, intrigue them or depict things they enjoy; artistic self-expression using a variety of mediums such as clay or paints to assist children in expressing their uniqueness as opposed to talking; or with the support of a

caregiver, having a child try out a hobby or other activities to see how they relate and connect with this as a form of self-expression.

To assist children with the development of a positive self, Blaustein and Kinneburgh (2016) recommend activities such as a creating a “power book” highlighting aspects such as real or developing strengths, areas of success, experiences that have been positive for the child and personal resources or resources available to them, or a “pride wall” on a board or poster in the therapy room and at home that they make with a caregiver recording the successes of the child. They also recommend practitioners work with children on an imagined “superhero self” defining children’s ideas about what it looks like to have strength, creating a list of qualities, imagining themselves as the superhero and acting out the qualities. To assist children with creating a coherent self Blaustein and Kinniburgh recommend activities such as “life books” that record a narrative about who the child is, where they came from and other life events that are important to the child. Using a timeline and incorporating thoughts and feelings through words, pictures names and symbols that depict these events is a good way to connect children with this process. They also suggest developing a crest or mask, making building blocks or personal puzzles that bring together the aspects of self that are meaningful for the child.

Finally, with regard to the future self, these authors encourage practitioners to engage children in activities such as future self-drawing by encouraging children to think about what they will look like, where they will be or what they might want to be when they grow up in 5, 10, 20 years; older children can be encouraged to identifying the steps to reach that future self. They also suggest a life book addendum that connects past and

present to the future by identifying, through what is recorded in the life book, the qualities or skills that the child has achieved and how their experiences can help them prepare for the future.

Blaustein and Kinniburgh (2010) offers some suggestions for implementing interventions for self-development and identity for children in middle childhood, keeping in mind that for these children a sense of independence is beginning to develop. Practitioners are encouraged to work with caregivers to help their children express this independence through choices like room décor or hairstyle. In addition, as middle childhood is a vulnerable time where peer relationships are concerned, they encourage practitioners to help children look at the unique ways that they stand out from their peers and the ways that they are similar. Blaustein and Kinniburgh encourage practitioners to help children identify and express their values with their caregivers and others and to help them to set goals for the present and the future.

Blaustein and Kinniburgh focus their intervention work with children on helping them to develop the competencies needed for interpersonal relationships, relationship with themselves, as well as on cognitive and regulatory abilities. For middle childhood in particular, they identify the development of social skills such as negotiation, empathy, tolerance, dealing with disappointment, cooperation and compromise along with connection and achievement in school and development of personal responsibilities as key competencies. Practically, knowing the rules and expectations in different environments and understanding the reason for them, taking on responsibilities such as chores and working towards independent mastery are part of the skills achievable in this developmental stage.

Finally, in looking at individual and group work on self-development and identity, Blaustein and Kinniburgh (2010) caution practitioners that "particularly in trauma-focused treatment, it is essential that clinicians communicate an interest in the whole child, rather than in just the trauma experience" (p. 203). When facilitating groups, these authors encourage activities for self-development and identity be incorporated into icebreakers and opening and closing activities.

Trauma Experience Integration and the ARC Framework. Blaustein and Kinniburgh (2010) and Hodgdon et al. (2016) discuss the concept of trauma experience integration and how the core competencies and targets of the ARC Framework (Kinniburgh et al., 2005) support this process. They suggest that trauma experience integration is essentially providing the opportunity "…to actively explore, process, and integrate historical experiences into coherent and comprehensive understanding of self in order to enhance their capacity to effectively engage in present life" (p. 209). Arvidson et al. (2011) explains the elements of the experiences targeted in this process include the memories or reminders of the trauma, arousal or disassociation when triggered and ways of thinking about oneself as a result of the trauma. Blaustein and Kinniburgh (2010) define two types of trauma experience integration:

1. *The Integration of Thematic or Fragmented Self-states and Associated Early Experiences.* Identifying and reflecting upon current fragmented aspects of self-functioning, including emotions, actions or the inability to act, interpersonal relational styles, cognition, physiological states and embedded models of self and linking these to the subjective themes like shame, helplessness, rage,

attachment, loss, and vulnerability and relevant to the repeated experiences of early childhood.

2. *Processing of Specific Events.* Building a narrative about the emotions, actions, inability to act, interpersonal relational styles, cognitions, and physiological states along with embedded models of self and other, evoked in relation to specific past memories of trauma or overwhelming stress and incorporating or shifting these into a more coherent realistic and broader narrative of self and other (p. 210).

Based on these two types of trauma experience integration, Blaustein and Kinniburgh (2010) recommend that practitioners approach this process reflectively as the process of integration is based on being curious about how thoughts, feelings and actions and definitions of self, played out in the present are connected to historical experiences. They suggest that in the beginning stages of integration for many children in their middle childhood and for those who are younger, much of the reflection will come from those external to the child, therefore highlighting the importance of practitioner and caregiver attunement with the goal of children developing the skills of self–reflection and self-attunement. Blaustein and Kinniburgh caution practitioners to be aware of the potential impact on caregivers and themselves as a result of exploring distressing experiences and how this can affect how they may choose to guide their clients. They therefore suggest that practitioners access the supports necessary to manage their own emotional responses. Finally, these authors caution that treating children while they are still being exposed to the traumatic environment may not be possible, as these children will have a difficult

time shifting away from a danger response. .

Integration of Thematic and Fragmented Self-States. Thematically driven and fragmented self-states, according to Blaustein and Kinniburgh (2010), are based on the establishment of patterns that children use to cope when there is stress from traumatic experiences; patterns that they manifest through behaviours, emotions, ways of thinking, somatic responses and in how they relate to others. These patterns of response tend to be centered on survival and based on both actual threats and on the perception of threat.

Blaustein and Kinniburgh (2010) outline ten stages that lead to the integration of thematic and fragmented self-states. The first stage involving attunement, focuses on understanding the children within their contexts and recognizing how they have adapted to their experiences. The second stage, also about attunement involves tuning into the children and noting their patterns of behaviour in the moment and sharing these with caregivers. The third stage, again about attunement adds engagement in affect identification and expression, and involves reflecting observations and providing validation of children's experience in the moment. The fourth stage focuses on modulation, and involves practitioners assisting children in developing modulation skills so that they are better able to focus on the process of integration. Stage five of the process incorporates affect identification and expression with support from attunement and caregiver affect management and involves practitioners or caregivers in helping children identify how their present experiences are linked to their previous experiences. Stage six focuses on self-attunement and the goal is to help children connect to the function of their current response. Stage seven focuses on executive functioning and centers on children understanding the difference between the past and the present. Stage eight, focuses on

affect identification and assists children with becoming more aware of when their self-states shift in the moment due to thematic or fragmented responses. Stage nine focuses on practitioners helping children develop modulation strategies in the moments where they arousing or constricting. Finally, in stage ten, practitioners are encouraged to help children make choices and develop executive function through engaging them in processes of assessing the situations in which they realistically find themselves, and using this information to develop achievable goals and choose appropriate actions.

The Processing of Specific Events. To assist with helping children remain anchored in the present rather than being flooded by past experiences of trauma, Blaustein and Kinneburgh suggest that children should be encouraged to work on having mastery over their memories rather than being disconnected from them. To make this possible, they suggest that children be supported to safely explore the affective, physiological and cognitive experiences that are part of their memories of trauma, while using modulation skills to tolerate the impact of working with these memories. Blaustein and Kinniburgh point out that through this process, children can make observations about the trauma that can be integrated into their life stories and decrease the power and intensity of these experiences.

When working with children on processing specific memories Blaustein and Kinneburgh (2010) encourage practitioners to be aware of timing and consider if the level of functioning of the child can sustain the processing. They also suggest that practitioners continually assess how well children are able to engage in modulation and to continually assess if there is an appropriate level of safety in the therapeutic relationship and a stable environment for the child outside of therapy. Blaustein and Kinniburgh caution that some

processing may be spontaneous and encourage practitioners to attune to the child and be prepared to respond and use their clinical judgment to decide to process or contain the experience.

Blaustein and Kinniburgh (2010) outline areas to target in processing specific memories. They recommend that practitioners tune in to memories that appear to intrude on a daily basis, memories supported by multiple experiences (e.g., memories of domestic violence where a child is affected by the perpetrators voice, fear of hearing parents fighting or having to hide) and those memories that have a particularly high impact for individual children. These authors also define stages for processing specific memories. They encourage practitioners to support the child through continuous self-assessment by noting the child's degrees of feelings, subjective units of distress and his or her use of modulation skills or displacement. As well they encourage the practitioner guide the process of storytelling through play writing or drawing while continually being aware of the possibility of the child re-experiencing trauma rather than processing it. Additionally, practitioners should help children to appraise their stories and make connections between their experiences and their responses thus keeping the child engaged in modulation and in staying in the present. Finally, practitioners are encouraged to help children explore their memories in the present using skills, strength and resources and that will help them to create a positive sense of a future self.

As with other intervention areas, Blaustein and Kinniburgh (2010) also provide suggestions for how practitioners can assist caregivers to support their children with trauma experience integration. First, they recommend that practitioner educate them about the nature of trauma processing, possible behavioral dis-regulation, and some of the

goals that are hoped to be achieved; helping them to understand that the treatment is not just processing the trauma but also about learning and integrating skills that will support attachment, self-regulation and competency. They also suggest that practitioners assist caregivers in staying in tune with what their children are processing and how they can assist in helping their child modulate at home. To support this, caregivers can reflect on the themes that are developing in treatment with their children so that they can show empathy and understanding for the ways in which their children are impacted by these themes.

Blaustein and Kinniburgh (2010) provide some points around application of the trauma experience integration. First, the goal of the process is to help children create a narrative. They suggest activities such as writing a story (either written by themselves, dictated to a practitioner, or based on a collaboration between child and caregiver for younger children) or creating a narrative symbolically through things like poem or plays, drawing, or play. They also suggest other possible activities such as computer presentations, board games, using lyrics from music to build a collage, or developing raps or songs about their lives.

As with all the other areas of intervention mentioned thus far, Blaustein and Kinniburgh note that children's developmental ages and changes need to be kept in mind. Where trauma integration is concerned, they point out that while children in middle childhood have a greater ability to reflect verbally about their experiences, it is none-the-less, still important that practitioners are aware of where each child's individual capacity for reflection and readiness to proceed, and be willing to use displacement methods if needed, in order to ensure emotional safety. They also note that children in middle

childhood respond well to structure and suggest the use of worksheets or a list of questions to help exploration. Blaustein and Kinniburgh (2010) argue that this developmental stage is a key time for identity formation and therefore state that, "in working with children to reflect upon their historical experience, the role of psycho-education, an exploration of systems of meaning, and the development of realistic appraisal becomes increasing important" (p. 234). Finally, these authors suggest that trauma experience integration though typically done within individual and familial formats, can also be pursued in groups. They caution however that the groups focus on more general ideas (not specific individual experiences) and focus on foundational concepts through displacement activities such as film clips.

The Effectiveness of the ARC Framework. The ARC Framework (Kinniburgh et al., 2005) has been studied by several researchers who have found evidence of its efficacy for treating children who have been traumatized by experiences like abuse and intimate partner violence. Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Evans, Andres, Cohen and Blaustein (2011) studied this intervention with an ethnically diverse sample of preschool and school-aged children, involved in the child protection system due to maltreatment in their family. These children were found to have behavioural, relational, and mental health challenges. This study initially included ninety- three children three to twelve years old (average age of 7.5) attending an outpatient clinic program in Alaska. Due to attrition, only 26 children completed the ARC Framework treatment. According to Arvidson et al. the main reason for the attrition was based on the relocation of families to other communities. In these cases, services were transferred to the new community. Attrition also occurred when 14% of the initial participants dropped

out of the treatment and 8% were lost at the time of the follow-up for the study. In their analysis of the data, these researchers used those who ended treatment early as the comparison group and found that children who completed ARC treatment had a 19-point improvement on the Child Behavior Checklist (Achenbach, 2001) and a higher rate of permanent placement such as adoptive placement, placement with relatives or reunification with biological parents.

In another study, Hodgdon, Kinniburgh, Gabowitz, Blaustein and Spinazzola (2013) examined the use of the ARC Framework (Kinniburgh et al., 2005) in two residential treatment programs for 156 female children ages 12 to 22-years-old, who had experienced numerous difficulties including exposure to violence. According to Hodgdon et al. 90% of the participants were involved in protective services and had been out of their home numerous times due to difficulties with emotions. They also report that these participants had an average length of stay between six to nine months in the program. The comparison group consisted of those females attending other programs at the two residential treatment centres but were not included in the ARC Framework intervention. The workers and clinicians who conducted the intervention were trained in the attunement and consistent caregiver responses, attachment related elements of the ARC Framework, and focused on using positive reinforcement and effective communication skills. The participants received both group and individual session with both of the formats following a structured process including an opening mindfulness activity, an experiential activity, and ending with self- appraisals. Hodgdon et al. (2013) report that following treatment, participants involved with the ARC Framework, showed significant reductions in trauma related symptoms such as hyper-arousal and re-experiencing as well

as reductions in aggressive behaviours, anxiety and depression, cognitive problems and somatic complaints. In addition, they found that the use of physical restraint decreased significantly (by 50%) in the first six months through to the end of both residential treatment programs.

In a more recent study, Hodgdon, Blaustein, Kinniburgh, Peterson, and Spinazzola (2016) studied the application of the ARC Framework (Kinniburgh et al., 2005) to support resiliency and the well-being of families for children who have been adopted. According to the researchers, this study focused on 481 adopted children (49.1% male) ages six to twelve, and their caregivers in an outpatient program. Hodgdon et al. (2016) report that these children had experienced a variety of traumatic events with higher numbers of incidents related to physical abuse (48.4%), emotional abuse (50.1%), neglect (62.6%), parental substance abuse (51.8%), attachment disruption (99.4%), traumatic loss (47.8%) and family violence (37.4%). They also report that the average child had "three living transitions prior to adoptive placement; clinically significant post-traumatic stress symptoms; clinically significant parent-reported externalizing symptoms; and low levels of adaptive functioning" (p. 47). Hodgdon et al. report that the ARC Framework intervention offered consisted of a sixteen-week structured program that included sixteen individual sessions and six- group session with both children and caregivers together. Effectiveness was evaluated by using outcome data based on before treatment conditions and after treatment conditions of the participants. The practitioners who delivered the program were at the masters' degree level and received weekly clinical supervision from the treatment developers.

Hodgdon et al. (2016) report that improvement was shown for both the children in

the study and their caregivers. They report reductions in both internalizing and externalizing behaviours such as depression, anxiety, anger, and disassociation, as well as reduction at follow-up twelve months later. In addition, Hodgdon et al. report that there was significant improvement in the functioning for caregivers including reductions in stress and caregivers described fewer difficulties in their children's functioning. Finally, Hodgdon et al. share that caregivers reported improvement in their children's adaptability and their adaptive functioning meaning that they exhibited not only reductions in undesired behaviour but increases in desired behaviour.

Project Support

Project Support (Jouriles, McDonald, Stephens, Norwood, Spiller & Ware, 1998) is an evidence-based intervention for parents focusing on attachment, the parent-child relationship, and helping families address the impact of intimate partner violence. Minze, McDonald and Jouriles (2012) describe this program as a compilation of evidence-based interventions for child maltreatment and families at risk that is theoretically focused and intended to treat children, up to nine years old, who have developed conduct problems based on exposure to IPV and other kinds of child maltreatment. There are two central tenants associated with this program: providing mothers with social and instrumental support and supporting the development of parenting skills.

Social and Instrumental Support for Mothers. According to Minze et al., Social and instrumental support is a key need for families who have been affected by IPV. The authors argue that experiences of IPV often result in mothers and children facing instability with housing, finances, and connection to school and other resources.

Based on the premise that mother will struggle with their own experience of IPV, Minze et al. suggest that there is less likelihood that they will be able to focus on establishing and maintaining parenting skills. For these reasons, providing emotional and instrumental support related to the difficulties that have emerged as a result of the IPV experience is part of every Project Support Program (Jouriles et al., 1998) session. Parents are connected with resources such as food security, employment services, school support and childcare, especially at the beginning of the program when families are often dealing with the greatest level of material and emotional crisis.

Minze et al. (2012) suggest that providing social and instrumental support also allows practitioners to work with parents on developing self-confidence and self-esteem and in turn reducing hopelessness and distress. According to these authors, some parents, may have more abilities than others. Practitioners are therefore encouraged to be continually aware of times where parents may need assistance and times where they can establish resources and support for themselves. Also within the area of social and instrumental support, Minze et al. suggest that practitioners focus on assisting parents in developing social support networks to help them manage their lives with support from others. Finally, these authors suggest that practitioners work with parents on problem solving. They argue that because of their experience of IPV many families have had to make decisions while in crisis and may have become used to reactive decision making. Minze et al. therefore see potential through Project Support for practitioners to assist parents in developing problem solving skills to help them make decisions based on the long-term health and welfare of their family.

The Project Support (Jouriles et al., 1998) program is facilitated in families'

homes for a number of reasons. First is to decrease the barriers to attendance such as transportation and stress on the parent to bring children to in-house sessions and increase the rate of participation, Secondly, it enables the practitioner to observe and understand the family in context (Minze et al., 2012). Minze et al. suggest that sessions should be weekly however they encourage practitioners to use their clinical judgment and adjust the session frequency depending on how the families are functioning. These authors stipulate that Project Support master's level clinicians should provide therapeutic services to parents while undergraduate practitioners trained in behavioral approaches work with their children during simultaneous home-based sessions during which the same skills are taught to both parents and children so that everyone in the family is familiar with the approach.

Parenting Skills Development. As identified in the first section of the review, IPV can impact parenting often making it difficult for the victimized parent to be consistent and in tune with their children. Minze et al. (2012) believe that there is the potential within the Project Support Program (Jouriles et al., 1998) for practitioners to support the development of more positive parenting behaviours, thus helping parents more effectively deal with challenging behaviours of their children. Minze et al (2012) report that the Project Support intervention is aimed at improving behaviour outcomes of children by enhancing the ability of parents, building competence and skills as well as improving the quality of the relationship between parent and child. These authors outline twelve core skills of parenting, moving from positive reinforcement skills through to skills for dealing with misbehaviour.

The use of positive reinforcement skills. The first skill outlined by Minze et al.

(2012) is attending. Practitioners are encouraged to work with parents on paying attention and communicating to their children about their behaviour. Practitioners teach parents how to interact during playtime, describing what they observe about their child's behaviour (e.g., you are playing with the doll) followed by teaching parents to enthusiastically comment about parts of their child's behavior that they want to encourage (e.g., you are playing with the doll so nicely and gently). Minze et al. recommend that practitioners guide parents to overlook behaviours that are not desirable and to refrain from being critical, judgmental and asking lots of questions. These authors point out that attending will provide the basis for all other parenting skills.

The next positive reinforcement skills outlined by Minze et al. (2012) are praise and positive attention. Practitioners are encouraged to teach parents two reinforcement connected approaches: verbally (e.g., I like the way that you gave your brother that toy) and physically (e.g., high five or hug). As with attending, Minz et al. see praise and positive attention as a foundational skill that subsequent skills are built upon and suggest that suggest relationships between child and parent can become more positive when praise and positive attention are intentional, systematic and consistent.

Listening and comforting, are the next positive reinforcement skills described by Minze et al. (2012). These authors note that it is vital that practitioners help parents understand that listening to their children without acting, interrupting, or questioning is important so that they can understand their child's feelings as clearly as possible. To be effective, Minze et al. suggest that parents use short interest focused responses (e.g., tell me more) to encourage children to continue to express themselves and that they also reflect their children's feelings (e.g., you seem sad). These authors note that providing

comfort through hugs and soothing responses during these times is important so that children feel safe about talking about feelings.

Rewards and privileges are also positive reinforcement skills identified by Minze et al. (2012) as important to effective parenting. They suggest that rewards and privileges do not necessarily need to be in the form of material items but can include things like staying up later to play a game or choosing cereal at the grocery store. Minze et al. caution parents to be careful that they do not provide a reward for not engaging in a behaviour as this can result in reinforcing this unwanted behaviour. They recommend that rewards and privileges should be specific, immediate and consistent and directly connected to desired behaviours.

The final positive reinforcement skill that Minze et al. (2012) recommend is that of giving clear instructions. These authors suggest Project Support (Jouriles et al., 1998) practitioners should work with parents to help them give instructions that are not only clear but also age-appropriate. They suggest several points for working with clear instructions such as: encouraging parents to be prepared to follow-up with consequences, if instructions are not followed; making sure that parents have their child's attention when they are giving them information or instructions, speaking firmly but not harshly, and using statements not questions. Finally, these authors suggest that parents give instructions that tell their children what to do versus what not to do and to wait for about five seconds for them to comply. They recommend that praise be given for compliance and consequences for non-compliance as discussed next.

Dealing with Misbehavior. Reprimands and redirection are the first skills

identified by Minze et al. (2012) to help deal with misbehavior. These authors encourage parents to provide firm messages when particular behaviours are not acceptable and then give redirection to a more acceptable behaviour. They further suggest that parents use this skill before behaviour escalates and to do this consistently with all forms of misbehaviour.

Minze et al. (2012) encourage using time outs as a way of dealing with misbehavior but recommend that these be used only to deal with extreme misbehavior. They caution that if times out are used too often they can become ineffective. They also suggest that a warning be used following non-compliance to an instruction before a time out is invoked and caution that the amount of time out should be developmentally age appropriate (e.g., one minute per year of age). Minze et al. encourage parents to place children in the time out and not interact with them during that time unless they need to ensure compliance. Following the time out, these authors suggest that parents direct their children to comply with the original instruction.

Ignoring is also a skill that Minze et al. (2012) recommend for dealing with misbehaviour. They suggest that as with attending to desirable behavior, parents should be encouraged to ignore the undesirable behaviours of their children. When ignoring parents need to consistently target the specific behaviour, tell the child that they are not going to pay attention and turn their body away from the child with no further discussion. Minze et al. encourage parents to continue to do this until the child ceases the behaviour. Practitioners are advised to help parents identify ways to tolerate these moments especially if the behaviours are overly irritating. Minze et al. caution however, that ignoring should not be used for any behaviours that are overly aggressive, destructive or

unsafe.

According to Minze et al. (2012), withdrawing rewards and privileges is also a way to reduce misbehavioor. They encourage parents to strategically withdraw privileges such as not allowing children to watch television or play video games for a period of time that is long enough to motivate the child to change their behaviour, and suggest that these consequences match the degree of the misbehaviour and occur immediately. Finally, Minze et al. encourage practitioners to work with parents on rule setting. They suggest that parents develop house rules based on behaviours that are not acceptable (e.g., aggression or destruction) and will result in consequences. Parents are encouraged to give children reminders about the rules, and use praise for compliance, especially if it occurs without a reminder.

Guidance for Practitioners. Minze et al. (2012) provide a number of suggestions for practitioners when implementing the Project Support (Jouriles et al., 1998) approach. First, they encourage practitioners to have flexibility by focusing directly on the needs of individual families, their perspectives, their most significant challenges, and their particular philosophical and cultural perspectives. Secondly, based on assessment, these authors recommend that practitioners initially use standardized assessments to comprehensive collect information about the child's behaviour and at the same time inform themselves about parents', current parenting practices including their challenges and strengths and about the families' the levels of violence and any needs related to social and instrumental supports. Minze et al. encourage practitioners pursue continuing assessment throughout the sessions through the use of "discussion, a sequence of role plays, mastery checks and homework" (p. 172).

Minze et al., also provide directions for the practitioners who are teaching skills to parents. They recommend that practitioners approach skills building with a process that includes an introduction to the skill followed by a skills teaching and practice sessions that include understanding the parent's familiarity and ability to use the skill and assessment of the parent's feeling about how effective the skills would be in helping them with their child. Minze et al. recommend the initial teaching of the skill be through role-plays. They see role-plays as an effective way for practitioners to demonstrate the skill (with the parent as the child, allowing the practitioner to assess the parent's perception of their child's thoughts feeling and behaviours and for the parent to gain insight about their child) and to have parents practice the skills with the guidance of the practitioner. Minze et al. also suggest switching roles (parent as parent; practitioner as child) thus allowing the practitioner to assess the learning of skills and the ability of parent to apply the skills. Role-playing can also help to build competence and confidence in the parent. Following this process, Minze et al. (2012) recommend that the child be brought into the session (mainly around the skills of attending and positive reinforcement) so that the parent can work with the child on the skill for five minutes, allowing the practitioner to observe the interaction and give feedback.

Minze et al. explain that mastery checks are important and can be implemented in two ways: observing the parents use of skill with the child and observing how the child responds when a certain skill is used. If there is a positive response from the child, this often will reinforce a parent to continue using the skill. The process of assessing and checking allows the practitioner and the parent to fine tune the skills so that the family can experience success. Minze et al. also encourage practitioners to complete mastery

checks for skills in dealing with misbehavior by observing parents discussing rules with their children including warnings and consequences for not complying. As a final recommendation for practitioners, these authors reinforce the use of homework to encourage parents to practice skills between sessions reinforcing the integration of these into successful ways to interact with their children.

The Effectiveness of Project Support

Jouriles, McDonald, Rosenfield, Spiller, Corbitt-Shindler, Norwood, Stephens and Ehresaft (2010) have studied the Project Support (Jouriloes et al., 1998) intervention. The sample for their study consisted of families with children, ages three to eight that had been identified by child protection services as having witnessed abuse and where the children were remaining with the victimized parent. These researchers report that they screened seventy-six families for eligibility and included forty-nine in the study. With further assessment, eleven of the forty-nine were found to have an untreated maternal mental health issues or changes were imminent for the family and therefore were offered other services. This resulted in a treatment sample of thirty-five families. Also included in the study was a comparison group of fourteen families that were offered another type of parenting intervention, while the treatment sample received the Project Support intervention in the format as described in the above sections.

Jouriles et al. report that the Project Support (Jouriles et al., 1998) intervention had a significant, positive effect on mother's ability to parent their children. They found that mothers in the Project Support treatment group showed a significant decrease in feeling unable to manage the behaviours of their children as well as a self-reported

decrease in using harsh and ineffective parenting. Jouriles et al. also found that the greatest improvements happened during the time that the families were in the program and improvements were maintained at follow-up. Jouriles et al. (2010) report continued maltreatment in both the treatment group and the comparison group however the treatment group had only 5.9 % new reports to child protection services while the comparison sample had 27.7 % new reports. Based on these findings, these researchers suggest that the Project Support intervention may lead to a reduced risk of child maltreatment and with that, reduce costs associated with child protection intervention. Finally, Jouriles et al. report that mother's self-report of harsh and ineffective parenting decreased in the treatment group where the comparison group self-reported an increase in ineffective and harsh parenting.

McDonald, Dodson, Rosenfield and Jouriles (2011) also have assessed the effectiveness of the Project Support (Jouriles et al., 1998) intervention. They conducted a study using secondary data from a clinical trial looking at the effects of the Project Support program with sixty-six families. The children in these families were between the ages of four and nine and all families were in shelters seeking refuge from domestic violence. Each one of these families had at least one experience of IPV in the last twelve months, perpetrated by a male, and one child of the family met the criteria for a diagnosis for oppositional defiance (ODD) or conduct disorder (CD). These participants were matched with a comparison group that consisted of 34 families who received some mental health and parenting support but not to the degree of the Project Support intervention.

Results of this study showed that the children in those families who received the

Project Support (Jouriles et al., 1998) treatment experienced a steady decrease in their diagnosed ODD or CD symptoms during the intervention that were maintained at follow-up. The comparison group on the other hand showed no substantial change during the study and at follow-up, symptoms had worsened. McDonald et al. (2011) argue that: "these findings are the first from a randomized controlled trial to demonstrate that a parenting intervention can alter the course of the development of features of psychopathy in young children with conduct problems" (p. 1023). They also found that a substantial part (35%) of the demonstrated change was due to a decrease in harsh and inconsistent parenting and therefore argue that their results show that using interventions that address harsh relationships between parent and child and replacing these with firm but positive discipline strategies can help to reduce the psychopathy of children.

Trauma Focused Cognitive Behaviour Therapy (TF-CBT)

Rubin (2012) focuses on the application of TF-CBT (Cohen, Deblinger & Manarino, 2006) for children who experienced maltreatment, and reflects on the structure of this approach as outlined by Cohen, Deblinger and Manarino (2006). Rubin notes that the TF-CBT approach is a component-based intervention, building skill in a progressive manner. Skills are provided in a fashion that meets the needs of the client and respects diversity by taking into consideration cultural, family and community values of the individual. According to Rubin, this intervention requires the practitioner to adapt and be flexible in its delivery while still respecting the protocol and process of the intervention. He outlines that this intervention is also intended to support the family and incorporates caregivers into the treatment process and, at times, other people in a child's ecological system. He highlights the importance of practitioners developing relationships with

clients and their families based on trust, empathy, acceptance and validation. Finally, Rubin states that the main goal for TF-CBT is to move client towards self-efficacy through using therapeutic relationships, assisting children and families in building trust, hope and self-esteem and increasing their ability to cope and stay safe.

The Process and Components of TF-CBT. Rubin (2012) explains that TF-CBT involves prolonged exposure to therapy that is adapted to the developmental abilities of children and youth. He states that, "prolonged exposure therapy involves clients gradually and incrementally recalling and narrating the traumatic event … or gradually and incrementally having contact with something feared in real life by clients that is associated with the trauma…" (p. 124). Rubin points out that the intention of gradual exposure is to habituate children to their fears by confronting memories or stimuli that are feared and working to alleviate trauma related symptoms. He also notes that the key piece of the process is that the habituation occurs in a safe and trusting environment so the child sees that confronting the memories is not a dangerous event, which helps with extinguishing the connection between the memories and state of fear. Rubin states that this process can eventually lead to children feeling control and mastery over the feared stimuli and memories so that they can experience life differently and have a more realistic perception of other people and themselves.

Rubin (2012) describes the process of TF-CBT (Cohen et al., 2006) as a "directive approach" (p. 125), beginning with the acknowledgement of the traumatic experience in the first session. The course of treatment is typically twelve sessions long and is divided into a beginning phase, middle phase and final phase of treatment. According to Rubin, the beginning phase of treatment focuses mainly on providing

psycho-education about TF-CBT, parenting skills, relaxation, expressing and regulating affect as well as working on cognitive coping. The middle phase of treatment focuses on developing and processing the trauma narrative as well as engaging in-vivo gradual exposure. The final phase focuses on working with parent and child together as well as enhancing the family's ability for safety and future development.

Rubin (2012) also makes suggestions for how to conduct a comprehensive assessment focusing on both treatment planning and treatment evaluation. According to Rubin, areas that are important to assess are the child's cognitive and emotional states, relationship dynamics, attachment, conflict and behavioural difficulties, and the child's trauma, somatic and PTSD symptoms. Rubin also recommends that practitioners obtain both a narrative from the child that is neutral for example one that focuses on feelings, thoughts and sensation about a recent event such as a holiday or an outing and a narrative that gives the practitioner a baseline understanding of the trauma experience. Obtaining the trauma narrative helps to open communication about the trauma and give the practitioner an idea how comfortable the child is with communicating about their experiences.

Psycho-Education and Parenting Skills. The psycho-education and parenting skills component that is the focus of the first phase of TF-CBT (Cohen et al., 2006), is intended to provide practitioners with the opportunity to educate both children and caregivers about the psychological and social impacts of trauma, discuss information about the assessment and teach them about the TF-CBT process at the appropriate developmental level (Rubin, 2012). This part of the TF-CBT process also allows practitioners to establish that the child is the focus of treatment not the caregiver while

also directing the caregiver to resources that may be needed. This helps to set the stage for discussing trauma in a manageable way that inspires hope and to starts to introduce behaviour management skills by focusing on what is going well and teaching caregivers to praise these behaviours. Rubin also suggests that in this stage of the process, practitioners should start to focus on other parenting skills such as providing attention, time outs and reinforcement.

Teaching Relaxation. Rubin encourages teaching relaxation techniques such as breathing, visualization, mindfulness, muscle relaxation and physical exercise to both children and caregivers at this stage of the TF-CBT (Cohen et al., 2006) process in order to support their learning about how to manage the stress and arousal that is connected to their traumatic experiences. In addition, he states that learning relaxation skills helps to prepare both the child and the caregiver to manage the gradual exposure to the past trauma experience that will come later in the process.

Working on Affect Regulation and Expression. The TF-CBT (Cohen et al., 2006) intervention, like the ARC Framework (Kinniburgh et al., 2005), has a component of treatment that focuses on identifying, regulating and expressing emotions. Rubin (2012) notes that during the assessment phase practitioners should work to understand how children, who have experienced a traumatic event such as intimate partner violence, tolerate the often difficult and painful emotions that are a part of such experiences. The first step according to this author is for practitioners to help children create a list of emotions connected to the traumatic event both positive (e.g., proud that they can talk about it) and negative (e.g., sad or scared), as well as helping them understand that they can have mixed or contradictory feelings about the same event (e.g., feeling scared of

having to move but happy to get away from the violence).

In the TF-CBT (Cohen et al., 2006) process, as with the ARC Framework (Kinniburgh et al., 2005), Rubin points out that part of the treatment plan requires the practitioner to work simultaneously with the caregiver on affect regulation and expression. In this regard, the primary goal is to provide the caregiver with a comfortable environment (through building empathy and trust) where they feel validated allowing for discussion of the more difficult and challenging feelings (e.g., being upset by their child). The second goal, is to teach caregivers how to engage in reflective listening in preparation for supporting their children in their recovery. Finally, both caregiver and child are taught about skills such as: “thought interruption and positive imagery, positive self-talk, enhancing the child’s sense of safety, problem solving and social skills” (Rubin, 2012, p. 130).

Teaching Cognitive Coping and Processing. In this component of TF-CBT (Cohen et al., 2006), Rubin encourages practitioners to take an opportunity to teach children and their caregivers about the connection between thoughts, emotions and behavior and how to shift their thinking and elicit different feelings and responses to events. In starting the process of cognitive reframing, Rubin, suggests that the first step involves helping children express thoughts verbally (e.g., “I don’t want to go to bed because I don’t want to be alone). Secondly, Rubin (2012) suggests that practitioners help the child understand additional, more specific thoughts that are behind the challenges they are having (e.g., I don’t want to go to bed, I don’t want to be alone because I hear footsteps and I think there are monsters in my room) and how they influence feelings (e.g., I don’t want to go to bed, I don’t want to be alone because I hear

footsteps and I think there are monsters in my room and this scares me). Rubin points out that the process of working with thoughts and feelings can be followed by helping the child look at other possibilities related to the situation (e.g., the footsteps are someone walking down the hallway by their bedroom). Rubin (2012) further recommends working with children on the connection between thoughts, feelings and behaviours using potentially difficult situations they may face that at home, school or in the community.

Ideally, according to Rubin (2012), engaging children in cognitive processing about situations early in treatment, will assist them with improving self-esteem, creating safety in their lives and increasing hope that their lives can be different from what they have previously experienced. He also highlights that cognitive processing will be an important process as treatment moves into trauma narrative processing where practitioner and child will work together to redefine and integrate their past experiences of trauma. Finally, Rubin encourages practitioners to follow the same cognitive coping and processing skills development with caregivers.

Developing Narratives and Processing Trauma. At this point Rubin (2012) suggests that the child needs to be able to talk, make meaning and process their traumatic experiences specifically. He therefore outlines the stages related to developing a trauma narrative with a child and suggests that the caregiver become comfortable with the process and be able to talk specifically about the trauma. As mentioned earlier, caregivers will need to have been educated on the impacts of trauma early on so that they may use this understanding in supporting their child in developing a narrative and processing the trauma. Rubin recommends that practitioners and children can use activities such as books and games to initiate the process of building a trauma narrative.

Based on suggestions from Cohen (2006) and Hoch (2009) Rubin encourages practitioners to use stories about other children and their traumatic experiences as a way to encourage children to engage in the development of their own narrative. Rubin notes that Hoch cautions practitioners to be aware of the level of anxiety of the child and to proceed gradually when beginning a narrative assisting them in using coping skills taught earlier in treatment.

When developing a trauma narrative through the TF-CBT (Cohen et al., 2006) treatment process, Rubin (2012) suggests that practitioners guide their clients in "developing a hierarchy of chapters" (p. 132) through which children can organize their knowledge of the trauma. Although children should have as much control over the narrative as possible, Rubin suggests that practitioners may need to guide younger children in developing the chapters whereas with older children, the process may become more collaborative. He provides a general outline of chapters suggest by Hoch (2009) that include a chapter of specific events related to the trauma (e.g., times when my father yelled and hit my mother; mother going to the hospital; the police coming to my house; talking with the police; leaving my house; moving to a new house). Rubin then suggests that the practitioner work with the child to identify which chapter to begin with; usually the one that is easiest for the child to communicate. Practitioners should record the narrative in writing as the child talks about the experiences prompting for additional information about the thoughts and feelings and sensations related to the situation. To begin the process of exposure, according to Rubin, the narrative of the chapter is read out loud by either the child or the practitioner. Also, at this stage it is suggested that the child create a title for the chapter and decide where in the hierarchy the chapter belongs.

Narratives can differ in length and can be in various formats (e.g., plays, books, or poems). He stresses that regardless of the format, the story needs to be relatable to the child and encourage the greatest amount of processing.

Finally, when developing the chapters of the trauma narrative, Rubin cautions practitioners not to fall into cognitive processing and make sure that they are focusing on attending to the children through listening and validating their experiences. He points out that the final chapter is where the cognitive processing can begin. In this final chapter, children discuss what they have learned from the experience, how their perspectives about the trauma are now different, and which strengths they have identified to help them in the future. Rubin states that each child will relate to the development of the trauma narrative differently and highlights Hoch (2009) who points out that one child may be able to understand or make meaning through writing the narrative and move quickly into writing the last chapter, where other children who are struggling with distorted thoughts about the trauma may need to spend more time in the cognitive processing stage of the TF-CBT treatment.

When entering into the cognitive processing of a child's trauma narrative, Rubin notes that it is important that the caregivers are able to talk about their own version of the trauma story as well as feelings that they have about the impact of the trauma on their children. Rubin (2012) states that, "common caregiver cognitions that may need to be processed include notions that their child's life has been ruined, self-blame for not preventing the abuse, not being able to trust anyone again and not being a competent parent" (p. 133). With that in mind, he suggests that practitioners work with caregivers to normalize and validate their negative thoughts and feelings and help them to do cognitive

restructuring (i.e. processing evidence supporting or disputing the negative thoughts) before entering into processing their child's narrative.

Cognitive processing of the trauma narrative for children, according to Rubin (2012), can also include cognitive restructuring once thoughts, feelings and physical reactions and sensations have been identified. He suggests that practitioners begin this process by choosing what issues to focus on with restructuring and if the child describes the experience in the past, practitioners take responsibility to encourage the child to talk about whether or not they are having the same feelings now. If not, he suggests that the process of narrating the final chapter can begin with allowing the child to capture the new perspectives. If the child is still overwhelmed with negative thoughts and feelings, Rubin suggests that the practitioner and the child engage in the process of cognitive restructuring. He outlines some suggestions offered by Hoch (2009) for cognitive restructuring: 1) devising an experiment and gathering evidence that disputes the inaccurate or negative thinking; 2) asking children questions to help them look at their issues from a new perspective; or, 3) practitioners and children engaging in role plays where the child plays the role of a friend or practitioner and try to convince practitioners (who are playing the child) that their thoughts and feelings about the issues are inaccurate or distorted.

Gradual In Vivo Exposure. Rubin (2012) outlines gradual narrative-based in vivo exposure of children to the trauma as the second part of the TF-CBT (Cohen et al., 2006) treatment process. He indicates that the gradual in vivo exposure process encourages children to overcome their trauma related behaviours and improve their daily lives. He suggests that this process start with a feared situation, one that the child feels ready to

confront. The child is reminded to employ relaxation and coping strategies that have already been taught. Rubin encourages practitioners to ensure that children not expose themselves to situations that remain unsafe (e.g., visiting the home of a relative that still may be abusing them) and firmly reminds practitioners that safety is the priority when engaging in exposure.

Rubin (2012) reiterates that gradual in vivo exposure is based on desensitization and encourages practitioners to collaborate with the child and the child's caregiver to develop a plan for exposure. He suggests that the plan needs to be based on a hierarchy of feared but non-threatening situations starting from the least anxiety provoking situations to the most anxiety provoking situations. Rubin (2012) clearly outlines that this should occur "one step at a time, moving on to the next level only after mastering the previous one" (p. 136). Using guidance from Hoch (2009) Rubin shows that it is helpful for children to experience exposure for shorter periods of time working up to longer periods as they are able to tolerate situations, use their newly developed skills and receive positive reinforcement from their caregivers and practitioners. Rubin also highlights Cohen (2006) who suggests that overcoming feared situations can increase feelings of self-competence and mastery for children.

Joint Sessions with Children and their Caregivers. Rubin (2012) points out that in working with both children and their caregivers joint work is an important part of the treatment process. He suggests that joint sessions should occur in three stages following the cognitive processing stage for both child and caregiver. Rubin indicates that the sessions themselves are to be carefully structured, as for example, one quarter of the first session involves working with only the child, the second quarter of the session focuses on

working only with the caregiver. The last half then involves working with both the child and the caregiver. In sessions with the child, the focus should be on reviewing the material that will be presented in the joint session, discussing the potential worries or fears for the child about the joint session and how they may be able to manage those worries or fears. He specifically recommends role-playing with the child in these circumstances especially when helping the child prepare to present the trauma narrative to the caregiver. In working with caregivers in the second quarter, Rubin encourages practitioners to work with fears and worries and how to manage their responses when the child's narrative is presented.

In preparation for the joint part of the session, Rubin (2012) suggests practitioners may need to coach parents on how to respond to their children with support and how to ask the child questions that do not infer blame or inadequacy. Rubin provides an outline of goals for the first session developed by Hoch (2009). These goals consist of creating a comfortable environment in the counseling room and assisting the child to establish a safe place and to counteract negative feelings that child might be having. The second goal is to help both the child and parent communicate effectively about the trauma allowing the child to understand that the caregiver can cope with hearing and discussing the traumatic story. According to Rubin, the overall objective is to have the child read the trauma narrative while the caregiver listens, with the practitioner assisting the caregiver in praising the child's ability to talk about the trauma and offering supportive comments. Once the traumatic story is shared, Rubin encourages practitioners to provide time for the child and caregiver to ask question of each other. He highlights the importance of previously discussing these questions with the child and caregiver in their individual

portion of the session. At the end of the first session, Rubin encourages the practitioner to work with the child and caregiver to plan the discussion for the next joint session. He suggests that other topics such as safety, relationships, anger and managing conflict can be focused on in subsequent joint sessions.

According to Rubin (2012), a minimum of three joint sessions should be facilitated as part of the TF-CBT (Cohen et al., 2006) treatment and aspects of fun, happiness, enjoyment and laughter should be included through activities such as games or play to allow their emotional experiences of the trauma to be different from their previous emotions of fear, sadness or shame. In the final joint sessions, Rubin encourages practitioners to work with the child and caregiver to learn how to maintain the progress in treatment and to use role-plays or other activities to practice how to handle potentially unsafe experiences in the future.

Key Points and Areas of Caution When using TF-CBT. Rubin (2012) provides practitioners with some key points and areas of caution when providing TF-CBT (Cohen et al., 2006) treatment. First, the trauma needs to be acknowledged in the first session and be substantiated as a form of child maltreatment assessed by child protection workers, medical staff or legal professionals. Rubin makes it clear that the TF-CBT practitioner should not be involved in the verification or substantiation of the trauma. He suggests, that if the abuse is suspected or unsubstantiated, the child be referred to a professional who specializes in investigating child abuse. In addition, Rubin cautions that even if the abuse or exposure is substantiated but the memories or details are vague or unclear, TF-CBT may not be the most effective treatment because this approach is based first on a clear acknowledgment and recollection that abuse or exposure has taken place, followed

by gradual exposure to the details of the trauma along with coping strategies that are intended to reduce symptoms of anxiety and avoidance. Such a process must not be undertaken if the abuse or exposure is, as yet, not in the child's conscious experience.

Effectiveness of the TF-CBT Intervention. Cohen, Mannarino and Iyengar (2011), completed a controlled random trial examining the effectiveness of TF-CBT (Cohen et al., 2006) in treating post-traumatic stress disorder, in a community setting for children who were exposed to intimate partner violence. One hundred and twenty-four children between the ages of 7 and 14 were included in this study. These children received eight TF-CBT sessions. The study included a computer generated random assignment to either TF-CBT treatment protocol (64 children) or child-centered therapy (60 children). Attrition for this study included 18 of the children assigned to the TF-CBT treatment who did not attend the initial session and 31 who did not return after the initial session, resulting in 75 children completing the trial.

According to Cohen et al. (2011) this study is one of the first studies to show "significant improvement of children's and adolescent's IPV related PTSD and anxiety symptoms using brief community TF-CBT (Cohen et al., 2006) compared with usual community treatment¨ (p.20). They found that for the children in the TF-CBT treatment group, there were greater reductions in symptoms of hyper-arousal and avoidance than in children who received child-centered therapy. In particular, Cohen et al. found that the TF-CBT treatment model was helpful in reducing vigilance, irritability, difficulties with sleeping, issues with anger and increasing the ability of children to talk with their caregivers about that trauma.

In a systematic review of evidence based treatments for children with trauma-related psychopathology related to childhood maltreatment, Leenarts, Diehle, Doreleijers, Jansma and Lindauer (2013) reviewed treatments for maltreatment of children based on both randomized and non-randomized clinical trials conducted between 2001 and 2013. Studies included children aged 6-18 years who had been exposed to childhood maltreatment and who had been treated with psychotherapeutic approaches involving CBT. Additionally, these studies included a comparison group comprised of either a waitlist group, delayed treatment group, treatment as usual group, groups receiving other psychotherapeutic treatments or no treatment. Five studies were included in the review (Cohen, Deblinger & Steer, 2004; Cohen, Mannarino, Knudsen, 2005; Cohen, Mannarino & Iyengar, 2011; Deblinger, Mannarino, Cohen, Runyon & Steer, 2011; Weiner Schneider & Lyons, 2009). Leenarts et al. (2013) found that “the five studies confirm the evidence supporting the efficacy of TF-CBT treatment” (p. 278). In particular, these researchers highlight the findings of Deblinger et al. (2011) who found that TF-CBT (Cohen et al., 2006) treatment eight sessions in length, with the inclusion of a trauma narrative process, were shown to be the most effective and efficient for reducing fear and anxiety related to a child’s experience of abuse and was helpful in improving children’s safety skills and caregiver’s parenting skills.

Chapter 3

Conclusions and Recommendations

From the evidence presented in this review, it is clear that IPV exposure exerts a significant negative impact on children. IPV exposure is now recognized as one of the most significant forms of child maltreatment (Trocme et al., 2008) and can establish a lifelong challenge for children, impacting them in different ways at different stages. The impact of IPV can be two-fold: there are the immediate consequences for children in witnessing IPV, like threats to their safety and feelings of instability. More profound are the cascading impacts that many IPV exposed children face where consequences in earlier developmental stages can influence more serious and rooted problems in later developmental stages (Smith et al., 2010, Graham-Bermann& Levendosky, 2011 & Artz et al., 2014).

Given that there is significant impact of IPV on children, is there a difference in the degree of impact between boys and girls? As the literature reviewed here shows, the research on gender specific impacts has produced mixed results. Some studies find that there are no differences in impact between boys and girls (Olaya et al., 2010; Bayarri et al., 2011 & Georggson et al., 2011), while other studies have discovered that girls are more at risk for externalizing difficulties (Calvete & Orue, 2013 & Bair-Merritt et al., 2015). A greater number of studies have however found that males show more externalizing behaviour difficulties, whereas girls show more internalizing behaviour difficulties (Graham-Bermann & Perkins, 2010; Moylan et al., 2010; Wood & Sommers, 2011; Calvete & Orue, 2012; Knous-Westfall et al., 2012; Maliken et al., 2012; Calvete

and Orue, 2013 & Blair-Merritt et al., 2015). Interestingly, the impact literature identifies these gender differences, however, the treatment literature shows very little differences when it comes to the treatment of IPV exposed boys and girls.

Knowing that IPV can have a cascading effect and can influence a developmental trajectory of compounding issues, this review has focused on understanding the impact of IPV from the earliest point of development. Research evidence shows that when children are exposed to IPV in-utero there can be neurobiological impacts related to hypothalamic-pituitary-adrenal axis functioning with resulting high or low cortisol levels which have been shown to be connected to both internalizing and externalizing behaviours later on in development (Sturge-Apple et al. 2012; Artz et al., 2014; Hibel et al., 2014 & Martinez-Torteya et al., 2016). Further, development of the autonomic-nervous-system functioning is also a significant concern related to the impact of IPV on early in development. Findings in relation to an imbalance between the sympathetic and parasympathetic nervous system, caused by chronic exposure to experiences such as IPV, can influence either over-arousal or under-arousal leading to adaptations in functioning that can be connected to delinquency and other behavioral problems in later development stages (Howell and Graham-Bermann, 2011; El-Sheikh, Hinnant, & Erath, 2011).

The relationship between parent and child and how this influences the degree of IPV impact on children through development, also emerged as significant in the research evidence reviewed here. Focused mainly on mothers as the primary caregivers, findings related to the early stages of life and IPV exposure suggest that insecure attachments between mother and child can develop even when a child is in-utero and can add to difficulties in functioning for children (Bogat et al., 2011 & Sturge-Apple et al., 2012).

Overall, relationships between parent and child, within the context of IPV, can contribute to children's difficulties at any developmental stage. Studies have found that in many cases, the experience of IPV on a child can be more impactful if children are unable to receive positive guidance and support or perceive a sense of insecurity from their primary caregivers (Kennedy et al., 2010; Margolin and Vickerman, 2011; Sousa et al., 2011; Hungerford et al., 2012; Turner et al., 2012; Brunette, 2013; Latzman et al., 2015; Katz et al., 2016 & Telman et al., 2016).

As development moves along through the preschool and school-age years, evidence shows the impact of IPV exposure on the cognitive and emotional functioning of children. Findings related to cognitive functioning indicate that the degree of impact of IPV exposure can be higher based on negative or distorted thoughts that children have about the IPV experience, their parents and themselves within that experience (Howell & Graham-Bermann, 2011). In much of the literature it appears that IPV exposed children can be impacted by perceptions that children have about threat (Jouriles et al., 2014; Miller et al., 2014 & Blair et al., 2014), self-blame (DeBoard-Lucas and Grych, 2011; Hungerford et al., 2012 & Miller et al., 2014), handling conflict (El-Sheikh et al., 2011; Georgsson, et al., 2011 & Howell and Graham-Bermann, 2011) and responsibility for the IPV (DeBoard-Lucas and Grych, 2011).

Emotional functioning for children is also impacted by IPV as shown in the research evidence. Findings indicate that the primary concern for children who witness IPV is how these experiences and the threat of future experiences impact a child's ability to understand, regulate and express their emotions effectively (DeBoard-Lucas and Grych, 2011 & Jourilles et al., 2014). Also, critical to this area is the role that caregivers

play in the emotional development of their children. Often with IPV exposure, it can be difficult for children to experience emotional security and healthy emotional development within a family where IPV occurs. Findings suggest that when emotional security within the family unit is reduced due to IPV, it can be difficult for caregivers to function at a level needed to support their children and children are often left to cope with their emotional experience alone (Hungerford et al., 2012).

The building of social competence through developmental stages and a child's physical health can also be negatively impacted by IPV exposure. There is evidence in the literature connecting IPV exposure to diminished levels of social competence in school-aged children. Hungerford, Wait, Fritz and Clements (2012) recognizes that there has been less focus on the impact of IPV on social competence than on other impacts but research has revealed that children who experience IPV can have difficulties with peers at school (Georgsson et al., 2011; Hungerford et al., 2012 & Koutselini and Valandiou, 2014) and dealing with conflict; and their functioning in the classroom (Grip et al., 2014 & Koutselini and Valanidou, 2014). Health-wise, the evidence shows that IPV exposed children can experience a higher degree of health-related issues such as allergies and asthma (Olofsson et al., 2011); sleeping and eating difficulties as well as being more at risk for physically harming themselves (Lamers-Winkleman et al., 2012).

Most notable within the range of outcomes for IPV exposed children are internalizing and externalizing behavioural difficulties and traumatic responses. The research evidence details the development of cumulative difficulties starting in toddlerhood that then grow into greater concerns as children move into the school-age, adolescent and early adult years. Research on IPV affected children has shown

connections between exposure to IPV and mental health challenges such as depression (Kennedy et al., 2010; Bayarri et al., 2011; Voith et al., 2014 & Fainsibler Katz et al, 2016), oppositional defiance (Burnette, 2013), hyperactivity/attention (Georgsson et al., 2011 & Towe-Goodman, 2011) and other internalizing difficulties with self-esteem (Clements et al., 2014 & Koutselini and Valanidou, 2014). There is also documented evidence between IPV exposure and externalizing issues such as aggression (Schermerhorn et al., 2011; Towe-Goodman, 2011; Holmes, 2013 & Koutselini and Valanidou, 2014) and delinquency (El-Sheikh et al., 2011 & Huang et al., 2015).

IPV exposure and traumatic stress have also been clearly documented in the research literature. Findings from a number of studies indicate that IPV exposed children show significant symptoms related to post traumatic stress (Georgsson et al., 2011; Graham-Bermann, 2011; Margolin and Vickerman, 2011; Lieberman et al., 2011; Levendosky et al., 2013 & Telman et al., 2016). In addition to direct exposure, the research suggests that the functioning of the caregiver can also impact the level of traumatic stress that an IPV exposed child experiences, especially if the caregiver has difficulty understanding, accepting and working on the impact of IPV on their children and themselves (Lieberman et al., 2011; Turner et al., 2012; Katz et al., 2016 & Telman et al., 2016). Poly-victimization, the experiencing of IPV exposure as well as direct abuse, has been shown by some studies in this review to also add to the traumatic stress on exposed children (Voith et al., 2014 & Telman et al., 2016).

Assessing for the developmental impact of IPV exposure on children would not complete without considering outcomes for these children in adolescence. The evidence in the literature shows strong connections between IPV exposure and a host of

consequences. A number of studies have found evidence connecting IPV exposure and violence in dating relationships (Calvete and Orue, 2011; Luz McNaughton Reyes, 2012; Temple et al., 2013; Latzman et al., 2015 & Foshee et al., 2016), aggression in peer relationships (Moylan et al., 2010; Calvete and Orue, 2011; Voisin and Hong, 2012; Calvete and Orue, 2013 & Foshee et al., 2016), substance use (Fagan and Wright, 2011; Howard et al., 2012 & Wright et al., 2013), depression and anxiety (Moylan et al., 2010 & Mrug and Windle, 2010), psychosomatic issues (Moylan et al., 2010), delinquency (Moylan et al., 2010; Sousa et al., 2011; Howard et al., 2012 & Park et al., 2012) and sexual delinquency (Teten Tharp et al.,2012 & Foshee et al., 2016).

Recommendations for Treatment

From a thorough review of four select treatment approaches: The Kid's Club (Graham-Bermann, 1992) and Mother's Parenting Empowerment Program (Graham-Bermann and Levendosky, 1994), The ARC Framework (Kinniburgh et al., 2005), Project Support (Jouriles et al., 1998) and Trauma Focused CBT (Cohen et al., 2006), Chapter Two of this review sought to present interventions that most comprehensively addressed the developmental impacts brought forth from Chapter One. To move away from the one-size fits all approach and create a well- informed base of knowledge for program development, these interventions were chosen based on their versatility and flexibility in working within both group and individual modalities and providing integrated support for caregivers. The following section will highlight themes related to treating IPV exposure in children and provide recommendations for FRA as this agency moves forward on developing an innovative approach for school-aged children who have witnessed intimate partner violence.

From the review of the Kid's Club (Graham-Bermann, 1992) and Mother's Parenting Empowerment (Graham-Bermann & Levendosky, 1994) Program; the ARC Framework (Kinnibrugh et al., 2005); Project Support (Jouriles et al., 1998) and Trauma-Focused Cognitive Behavioral Therapy (Cohen et al., 2006) the following outlines themes and recommendations for program development:

1) Supporting Parent/Caregivers: All interventions include an outline for providing support to the non-offending parent. The purpose of support is to assist parents with understanding the impact and providing support for their children as they deal with the challenges related to IPV exposure. The interventions did not include direct treatment of parent/caregivers, but do focus on educating them about the impact of IPV and on coaching them on how to use positive strategies with their children (Blaustein and Kinniburgh, 2010, Graham-Bermann, 2011; Minze et al., 2012 & Rubin, 2010). The interventions support the following:
    a. Helping parent/caregivers understand the impact of IPV on children: providing psycho-education around the impact on children's thinking and emotions, emotions, competence, coping and communication (Blaustein and Kinniburgh, 2010; Graham-Bermann, 2011 & Rubin, 2012).
    b. Empowering and building competence and confidence in the parent/caregiver: focusing on skills to assist parent/caregivers with tuning into their children through learning and understanding how to focus on thinking, emotions, and triggers rather than specifically on behavior (Blaustein and Kinniburgh, 2010 & Rubin, 2012) as well as educating and coaching on child development (Graham-Bermann, 2011) and parenting

skills such as reflective listening (Blaustein and Kinniburgh, 2010 & Minze et al., 2012); clear instructions (Minze et al.); praise and positive reinforcement (Blaustein and Kinniburg, 2010; Minze et al., 2012 & Rubin, 2012); rule setting, rewards and privileges (Minze et al., 2012), routines and rituals (Blaustein and Kinniburgh); rule setting, time outs and ignoring misbehavior (Blaustein and Kinniburgh & Minze et al.).

c. Encouraging self-care and providing practical support for parent/caregivers: assisting parent/caregivers to regulate their own emotions through teaching how to emotionally self-monitor (Blaustein and Kinniburgh, 2010) and employ cognitive coping (Rubin, 2012) as well as modulation and relaxation skills (Blaustein and Kinnibrugh & Rubin), self-care strategies (Graham-Bremann, 2011; Minze et al., 2012) and supporting caregivers around more pragmatic issues such as housing, food resources and child care that will help to provide stability (Minze et al, 2012).

d. Helping parent/caregiver build support networks: establishing support networks outside of counselling (Blaustein and Kinniburgh, 2010; Graham-Bermann, 2011 & Minze et al., 2012). Parents' groups are one of the best ways to assist the building of natural support networks (Graham-Bermann, 2011).

2) Providing professional, ethical and client-centered services for children and parent/caregivers: using master's level therapists who are well supervised (Blaustein and Kinniburgh, 2010; Minze et al, 2012 & Rubin, 2011) Practitioners

are recommended to be empathetic, validating and flexible; culturally sensitive (Blaustien and Kinniburgh, 2010; Graham-Bermann, 2011; Minze et al., 2012 & Rubin, 2012) and most importantly be able to monitor emotions and self-regulate (Blaustein and Kinniburgh, 2010).

3) Employing a variety of modalities and mediums:

    a. School-aged children are able to talk more successfully about their experiences (Blaustein and Kinniburgh, 2012). Interventions recommend that practitioners be developmentally aware as well as aware of the individual abilities of those being treated to account for factors such as resilience (Blaustein and Kinniburgh, 2010 & Rubin, 2011).

    b. Use of displacement activities that allow practitioners to work with children without focusing directly on their own IPV experience if they are not ready. Displacement activities like reading books, using movies, doing plays or role-plays, art or puppet shows (Blaustein and Kiniiburgh, 2010; Graham-Bermann, 2011 & Rubin, 2012).

4) Providing programs that are phase-oriented (Graham-Bermann, 2011) or component-based (Blaustien and Kinniburgh, 2010 & Rubin, 2012) to provide building blocks or stepping stones strategies to educate and work with children on their thinking, feelings and behavior, moving towards a more healthy and beneficial present life:

    a. The systematic design of interventions: treating both the cognitive and emotional impact of IPV (Blaustien and Kinniburgh, 2010; Graham-Bermann, 2011 & Rubin, 2012). It is recommended that treatment start

focusing on affect regulation and cognitive coping moving later into building competence, self-confidence and trauma processing ((Blaustein and Kinniburgh, 2010 & Rubin, 2012). All interventions recommend that practitioners work on the building of safety and comfort, regardless if it is group or individual treatment (Blaustein and Kinniburgh, 2010; Graham-Bermann, 2011; Minze et al., 2012 & Rubin, 2012).

b. Creating a sense of safety: Practitioners are recommended to consistently assess children's sense of safety, being in tune with children's level of energy and comfort; proceeding carefully and conscientiously when introducing new concepts being sure not to get too far ahead of where/how a child is functioning (Blaustein and Kinniburgh, 2010 & Rubin, 2012). Practitioners are also encouraged to take the same approach when working with parent/caregivers (Blaustien and Kinniburgh, 2010; Graham-Bermann, 2011 & Minze 2012).

c. Working with children on affect regulation: understanding, regulating and expressing emotions can be a challenge for children who have lived with IPV and therefore the following are recommended to practitioners when working with school-aged children:

   i. Helping children to identify emotions: practitioners are encouraged to validate a children's difficulty with emotions and be willing to work with children from where they are at with their emotional understanding (Blaustein and Kinniburgh, 2010; Arvidson et al., 2011; Graham Bermann, 2011 & Rubin 2012).

Creating feelings lists, or talking about how a character is feeling in a book can be effective ways to assess children's level of emotional understanding. Helping children to increase their emotional vocabulary, understanding levels of emotion and emotions in context are key. Using check-ins, opening and closing activities, plays and role-plays in groups and individual settings can be prime opportunities to focus on emotions (Blaustein and Kinniburgh, 2010).

ii. Working towards affect regulation: It is recommended that practitioners work with children on regulating emotions (Blaustein and Kinniburgh, 2010; Arvidson et al., 2011; Graham-Bermann, 201l; Rubin, 2012m & Hodgdon et al., 2016). The intention is to assist children in developing safe strategies to manage emotions through being in-tune with different emotional states and triggers; understanding the connection between emotions and their physiological states in their body and how their danger response functions; learning strategies for regulation such as muscle relaxation, breathing, using grounding objects, movement or imagery and helping children be aware of how their states change with these strategies. Regulation strategies can be embedded in opening and closing activities and check-ins for both individual and group work (Blaustein and Kinniburgh, 2010).

iii. Assisting children with affect expression: working with children to effectively express emotions (Blaustien and Kinniburgh, 2010; Arvidson et al., 2011; Graham-Bermann, 2011 & Rubin, 2012. It is recommended that practitioners work with children to determine the people in their life with whom it is safe to practice emotional expression; picking the right moments to express themselves; developing skills on how to initiate conversations; helping children be aware of non-verbal skills and practicing boundaries with others. Group settings or individual sessions with parent or caregivers are prime opportunities for children to practice skills with coaching from practitioners (Blaustein and Kinniburgh, 2010).

d. Cognitive Coping

i. Based on the interventions reviewed it is recommended that practitioners work with children to identify perspectives about themselves, the non-offending parent and the aggressor as it relates to the IPV experience (Graham-Bermann, 2011 & Rubin 2012).

ii. Assessing thinking patterns: practitioners are encouraged to assess for levels of guilt, responsibility for the violence, self-blame, shame and distorted thoughts about aggression (Graham-Bermann 2011 & Rubin, 2012).

iii. Helping children name fears and worries: practitioners should

develop an understanding of children's levels of vulnerability and assess for anxiety and depression (Graham-Berman, 2011 & Rubin, 2012).

iv. Helping children to shift their thinking: working with children to understand thoughts about their experience and how they connect to feelings and choices that they made as well as helping them to look at other possibilities to explain/understand the situation (Rubin, 2012).

v. Empowering children through gaining control over their experience: helping children to normalize their experience and develop more realistic perceptions about the event, lowering the impact of the experience and allowing them to experience more control (Graham-Bermann, 2011 & Rubin, 2012)

e. Supporting the development of competence and self-confidence: As a result of experiencing IPV, it can be difficult for children to understand their strengths or qualities outside of the behaviours used to survive. The interventions reviewed recommend that practitioners focus on the following areas of skills development:

i. Developing problem solving skills: helping children identify a problem, generate possible solutions and evaluate solutions to determine the best course of actions (Blaustein and Kinniburgh, 2010, Arvidson et al., 2011; Graham-Bermann et al., 2011; Rubin, 2012 & Hodgdon et al., 2016).

ii. Learning and using conflict resolution skills: developing ways to deal with problems based on evaluating situations and making choices around response versus reacting to situations (Blaustein and Kinniburgh, 2010, Arvidson et al., 2011; Graham-Bermann et al., 2011; Rubin, 2012 & Hodgdon et al., 2016).

iii. Identifying and naming strengths: practitioners are recommended to help children build their self-confidence and self-identity by focusing on personal strengths that can be used in the present and the future to assist in positive growth and development and allow them to experience mastery (Blaustein and Kinniburgh, 2010).

iv. Developing a sense of self: using different activities to help children define themselves as a whole. Recommended activities include all about me books, power books, pride walls, life books or writing about their future selves (Blaustien and Kinniburgh, 2010).

f. Assisting children in processing IPV as a traumatic event: there are several findings related to IPV exposure and traumatic stress, especially in cases of poly-victimization where children are IPV exposed and also experience direct abuse. Built on skills and strategies learned through cognitive coping and affect regulation recommendations regarding trauma processing is as follows:

i. Acknowledging the trauma: It is recommended that practitioners work with children to acknowledge the traumatic events and be

able to talk about the experience (Rubin, 2012). If this is difficult, it is recommended that practitioners work with cognitive coping and affect regulation until children are in a space to effectively communicate about the experiences (Rubin, 2012). Practitioners are encouraged to use attending and validation skills as they move through this process with children (Blaustein and Kinnibrugh, 2010).

ii. Building an integrated idea of self: supporting children in moving from a fragmented idea of self to a more integrated idea of self that incorporates the experiences of IPV, but does not define them (Balustein and Kinniburgh, 2010 & Rubin, 2012).

iii. Developing a trauma narrative: practitioners are recommended to assist children in developing narratives about their experiences, highlight specific and difficult events (how they think and feel about those events); processing them using strategies and skills related to cognitive coping using cognitive restructuring techniques like role-plays, doing experiments based on alternate perspectives and exposure techniques (Rubin, 2012) and affect based skills such as identifying, regulation and expressing emotions about the experiences (Blaustein and Kinniburgh, 2010). Narratives can take the form of writing a book with different chapters about different events related to the IPV experience (Rubin, 2012) or writing poems, making a board

game or power point presentation (Blaustein and Kinniburgh, 2010).

iv. Connecting past experiences to present: narratives can help practitioners assist children to connect their present functioning to past experiences and how they can work with fears, worries and threat to understand their situation differently in the present (Blaustein and Kinniburgh, 2010 & Rubin, 2012). It is recommended that practitioners proceed with trauma processing gradually keeping in tune with the child. It is also recommended that practitioners help children understand how their physiological states change when they think differently and are able to regulate their emotions (Blaustein and Kinniburgh, 2010).

v. Developing mastery over their experience: the goal of trauma processing as it relates to events such as IPV is to help children understand that they can experience mastery over feared stimuli and recognize their strength and capacity to set goals and make choices around behavior as opposed to acting or reacting in the moment to survive (Blaustein and Kinniburgh, 2010 & Rubin, 2012).

5) Working with parent/caregivers and children together in session: Sessions with parent/caregivers and children allow for practitioners to coach and mentor parents in supporting their child, assess how well parents/caregivers are able to coach their children and provide extra support in areas where there is difficulty. Having

the opportunity to coach parents/caregivers to ensure understanding of aforementioned concepts is important as parent/caregivers will be supporting their child's developing skills at home between sessions and long-term beyond treatment (Blaustein and Kinniburgh, 2010; Minze et al., 2012 & Rubin, 2012).

Limitations of the Review

This review has extensively investigated the current literature related to the impact of intimate partner violence across development. In addition, treatments that have been shown through evidence to be effective in treating IPV have also provided key recommendations for developing a comprehensive program for school-aged children. There are however some limitations to the review. First, despite reviewing the impact across development for children and youth who are exposed to IPV, treatments recommendations for pre-natal to preschool children and their parents as well as adolescents were not included in this review. The area of program development for FRA for this project is specifically around school-aged children. Future reviews may want to add to this piece of work by focusing on treatment options for other developmental stages.

Secondly, this review is limited in offering recommendations for treating the family as a whole. This project has focused more on the treatment of children. There is very little focus on the impact and treatment of the victimized parent/caregiver helping them to address the personal impact of the traumatic experience other than how it relates to the welfare of their children. Also, this project does not focus on the treatment of offenders. It would be ideal for future

research or reviews to focus on this area and develop program recommendations to create a program for victimized parent or caregiver and offender that could become part of a greater treatment option for treating IPV exposed families as a whole.

References

Achenbach, T. (2001). *Child behavior checklist for ages 6–18. Burlington*, VT: University of Vermont.

Artz, S., Jackson, M., Rossiter, K., Nijdam-Jones, A., Geczy, I., & Porteous, S. (2014). A comprehensive review of the literature on the impact of exposure to intimate partner violence for children and youth. *International Journal of Child, Youth, and Family Studies,* 5(4), 493-587.

Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., Andres, B., Cohen, C., & Blaustein, M.E. (2011). Treatment of complex trauma in young children: Developmental and cultural considerations in application of the ARC intervention model. *Journal of Child and Adolescent Trauma,* 4(1), 34-41. doi:10.1080/19361521.2011.545046

Bair-Merritt, M.H., Ghazarian, S.R., Burrell, L., Crowne, S.S., McFarlane, & Duggan, A.K. (2015). Understanding how intimate partner violence impacts school age children's internalizing and externalizing problem behaviors: A secondary analysis of Hawaii healthy start program evaluation data. *Journal of Child and Adolescent Trauma,* 8(4), 245-251. doi:10,1007/s40653-015-0066-8

Baldry, A. C. (2003). Bullying in schools and exposure to domestic violence. *Child Abuse & Neglect,* 27(7), 713-732. doi.org/10.1016/S0145-2134(13)00114-5

Bayarri, E, Ezpeleta, L., & Granero, R. (2011). Exposure to intimate partner violence, psychopathology, and functional impairment in children and adolescents:

Moderator effect of sex and age. *Journal of Family Violence,* 26(7), 535-543. doi:10.1007/s10896-011-9390-4

BC Association of Specialized Victim Assistance and Counselling Programs (2006). *Best practices manual for stopping the violence counselling programs in British Columbia.* Vancouver: M. McEvoy & M. Zielger.

BC Yukon Society of Transition Houses (2009). *Best practices for the children who witness abuse program.* Vancouver: E. Barbeau.

Beaupre, P. (2015). *Family violence in Canada: A statistical profile, 2013.* Ottawa: Canadian Centre for Justice Statistics.

Benavides, L. E. (2015). Protective factors in children and adolescents exposed to Intimate partner violence: An empirical research review. *Children & Adolescent Social Work Journal,* 32(2), 93-107. doi:10.1007/s10560-014-0339-3

Blair, F., McFarlane, J., Nava, A., Gilroy, H., & Maddoux, J. (2015). Child witness to domestic abuse: Baseline data analysis for a seven-year prospective study. *Pediatric Nursing,* 41(1), 23-29. Retrieved from http://content.ebscohost.com/

Blaustein, M. E., & Kinniburgh, K. M. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency.* New York: The Guildford Press.

Bogat, G. A., Levendosky, A. A., von Eye, A., & Davidson II, W. S. (2011). The effects of intimate partner violence on the attachment relationship between mother and child: Data from a longitudinal study beginning during pregnancy. In S. Graham-

Bermann & A. Levendosky (Eds.). *How intimate partner violence affects children: Developmental research, case studies, and evidence-based intervention* (pp. 19-46). Washington, D.C.: American Psychological Association.

Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.

Browning, K., Thornberry, T. P., & Porter, P. K. US Department of Justice, Office of Juvenile Justice and Delinquency Prevention (1999). *Highlights of findings from the Rochester Youth Development Study (*OJJDP Fact Sheet # 103). Albany, NY: Juvenile Justice Clearinghouse. Retrieved from https://www.ncjrs.gov/pdffiles1/fs99103.pdf

Burnette, M. L. (2013). Gender and the development of oppositional defiant disorder: Contributions of physical abuse and early family environment. *Child Maltreatment,* 18(3), 195-204. doi:10.1177/1077559513478144

Calvete, E., & Orue, I. (2011). The impact of violence exposure on aggressive behaviour through social information processing in adolescents. *American Journal of Orthopsychiatry,* 81(1), 38-50. doi:10.1111/j.1939-0025.2010.01070.x

Calvete, E., & Orue, I. (2012). Social information processing as a mediator between cognitive schemas and aggressive behavior in adolescents. *Journal of Abnormal Child Psychology,* 40(1), 105-117. doi:10.1007/s10802-011-9546-y

Calvete, E. & Orue, I. (2013). Cognitive mechanisms of the transmission of violence: Exploring gender differences among adolescents exposed to family violence. *Journal of Family Violence,* 28(1), 73-84. doi:10.1007/s10896-012-9472-y

Carbonell, D. M., Reinherz, H. Z., Giaconia, R. M., Stashwick, C. K., Paradis, A. D., & Beardslee, W. R. (2002). Adolescent protective factors promoting resilience in young adults at risk for depression. *Child and Adolescent Social Work Journal*, 19(5), 393–412. https://doi-org.ezproxy.library.uvic.ca/10.1023/A:1020274531345

Clements, M. L., Martin, S. E., Randall, D. W., & Kane, K. L. (2014). Child and parent perceptions of interparental relationship conflict predict preschool children's adjustment. *Couple and Family Psychology: Research and Practice,* 3(2), 110-125. doi:10.1037/cfp0000017

Chandy, J. M., Blum, R. W., & Resnick, M. D. (1996). History of sexual abuse and parental alcohol misuse: Risk, outcomes, and protective factors in adolescents. *Child and Adolescent Social Work Journal*, 13(5), 411–432.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York, NY: Guilford Press.

Cohen, J. A., Mannarino, A.P. & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: A randomized controlled trial. *Archives of Pediatric Adolescent Medicine,* 165(1), 16-21. Retrieved from http://archpedi.jamanetwork.com

Crick, N. R., & Dodge, K. A. (1994). A review and reformulation of social information-processing mechanisms in children's social adjustment. *Psychological Bulletin*, 115(1), 74–101. doi: 10.1037/0033-2909.115.1.74

Criss, M. M., Pettit, G. S., Bates, J. E., Dodge, K. A., & Lapp, A. L. (2002). Family adversity, positive peer relationships, and children's externalizing behavior: A longitudinal perspective on risk and resilience. *Child Development*, 73(4), 1220–1237. Retrieved from http://www.jstor.org/stable/3696281

Cross, D., Barnes, A., Papageorgiou, A., Hadwen, K., Hearn, L., & Lester, L. (2015). A social-ecological framework for understanding and reducing cyberbullying behaviours. *Aggression and Violent Behavior.* Advance online publication.dx.doi.org/10.1016/j.avb.2015.05.016

DeBoard-Lucas, R. L., & Grych, J. H. (2011). Children's perceptions of intimate partner violence: Causes, consequences, and coping. *Journal of Family Violence,* 26(5), 343-354. doi:10.1007/s10896-011-9368-2

Dodge, K. A. (1986). A social information processing model of social competence in children. In M. Perlmutter (Ed.), *The Minnesota Symposia on Child Psychology: Vol. 18. Cognitive perspectives on children's social and behavioral development* (pp. 77–125). Hillsdale, NJ: Erlbaum

El-Sheikh, M., Hinnant, J. B., & Erath, S. (2011). Developmental trajectories of delinquency symptoms in childhood: The role of marital conflict and autonomic nervous system activity. *Journal of Abnormal Psychology,* 120(1), 16-32. doi:10.1037/a0020626

Enlow, M.B., Blood, E. & Egeland, B. (2013). Sociodemographic risk, developmental competence, and PTSD symptoms in young children exposed to interpersonal trauma in early life. *Journal of Traumatic Stress,* 26(6), 686-694, doi:10.1002/jts.21866

Fagan, A. A., & Wright, E.M. (2011). Gender differences in the effects of exposure to intimate partner violence and drug use. *Child Abuse & Neglect,* 35(7), 543-550. doi:10.1016/j.chiabu.2011.05.001

Fainsilber Katz, L., Stettler, N., & Gurtovenko, K. (2016). Traumatic stress symptoms in children exposed to intimate partner violence: The role of parent emotion socialization and children's emotion regulation abilities. *Social Development,* 25(1), 47-65. doi:10.1111/sode.12151

Finkelhor, D., Shattuck, A., Turner, H. A., Ormrod, R., & Hamby, S. L. (2011). Polyvictimization in developmental context. *Journal of Child and Adolescent Trauma,* 4(4), 291-300. doi:10.1080/19361521.2011.610432

Fosco, G. M., DeBoard, R. L., & Grych, J. H. (2007). Making sense of family violence: Implications of children's appraisals of interparental aggression for their short and longterm functioning. *European Psychologist*, 12, 6–16. doi:10.1027/1016-9040.12.1.6

Foshee, V. A., McNaughton Reyes, H., Chen, M. S., Ennett, S. T., Basile, K. C., DeGue, S., Vivolo-Kantor, A. M., Moracco, K. E., & Bowling, J. M. (2016). Shared risk factors for the perpetration of physical dating violence, bullying and sexual harassment among adolescents exposed to domestic violence. *Journal of Youth*

and Adolescence, 45(4), 672-686. doi:10.1007/s10964-015-0404-z

Georgsson, A., Almqvist, K., & Broberg, A. G. (2011). Naming the unmentionable: How children exposed to intimate partner violence articulate their experiences. *Journal of Family Violence,* 26(2), 117-129. doi:10.1007/s10896-010-9349-x

Georgsson, A., Almqvist, K., & Broberg, A. G. (2011). Dissimilarity in vulnerability: Self-reported symptoms among children with experiences of intimate partner violence. *Child Psychiatry and Human Development,* 42(5), 539-556. doi:10.1007/s10578-011-0231-8

Graham-Bermann, S. A. (1992). *The Kids' Club: A preventative program for children of battered women.* Ann Arbor, MI: University of Michigan, Department of Psychology.

Graham-Bermann, S. A. (2011). Evidence-based practices for school-age children exposed to intimate partner violence and evaluation of the kids' club program. In S. Graham-Bermann & A. Levendosky (Eds.). *How intimate partner violence affects children: Developmental research, case studies, and evidence-based intervention* (pp. 179-206). Washington, D.C.: American Psychological Association.

Graham-Bermann, S. A, Castor, L. E., Miller, L. E., & Howell, K. H. (2012). The impact of intimate partner violence and additional traumatic events on trauma symptoms and PTSD in preschool-aged children. *Journal of Traumatic Stress,* 25(4), 393-400. doi:10.1002/jts

Graham-Bermann, S. A., Howell. K. H., Lilly, M., & DeVoe, E. (2011). Mediators and moderators of change in adjustment following intervention for children exposed to intimate partner violence. *Journal of Intepersonal Violence,* 26(9) 1815-1833. doi:10.1177/08686260510372931

Graham-Bermann, S. A., Howell, K. H., Miller, L. E., Kwek, J. & Lilly, M. M. (2010). Traumatic events and maternal education as predictors of verbal ability for preschool children exposed to intimate partner violence (IPV). *Journal of Family Violence,* 25(4), 383-392. doi:10.1007/s10896-009-9299-3

Graham-Bermann, S. A. & Levendosky, A. A. (1994). *The Mom's Group: A parenting support and intervention program for battered women who are mothers.* Ann Arbor, MI: University of Michigan, Department of Psychology.

Graham-Bermann, S. A., & Levendosky A. A. (2011). Introduction. In S. Graham-Bermann & A. Levendosky (Eds.). *How intimate partner violence affects children: Developmental research, case studies, and evidence-based intervention* (pp. 3-16). Washington, D.C.: American Psychological Association.

Graham-Bermann. S. A., Miller-Graff, L. E., Howell, K. H., & Gorgan-Kaylor, A. (2015). An efficacy trial of an intervention program for children exposed to intimate partner violence. *Child Psychiatry & Human Development,* 46(6), 928-939. doi:10.1007/s10578-015-0532-4

Graham-Bermann, S. A., & Miller-Graff, L. (2015). Community-based intervention for women exposed to intimate partner violence: A randomized control trial. *Journal*

of Family Psychology, 29(4), 537-547. doi:10.1037/fam0000091

Graham-Berman, S. A., & Perkins, S. (2010). Effects of early exposure and lifetime exposure to intimate partner violence (IPV) on child adjustment. *Violence and Victims,* 25(4), 427-439. doi:10-1891/0886-6708.25.4.427

Glover, V., O'Connor, T. G., & O'Donnell, K. (2010). Prenatal stress and the programming of the HPA axis. *Neuroscience & Biobehavioral Reviews,* 35(1), 17-22. doi:10.1016/j.neubiorev.2009.11.008

Gottman, J. M., Katz, L. F., & Hooven, C. (1997). *Meta-emotion: How families communicate emotionally*. Mahwah, NJ: Lawrence Erlbaum Associates Inc.

Grip, K. K., Almqvist, K., Axberg, U., & Broberg, A. G. (2014). Perceived quality of life and health complaints in children exposed to intimate partner violence. *Journal of Family Violence,* 29(6), 681-692. doi:10.1007/s10896-014-9622-5

Grossman, F. K., Beinashowitz, J., Anderson, L., Sakurai, M., Finnin, L., & Flaherty, M. (1992). Risk and resilience in young adolescents. *Journal of Youth and Adolescents*, 21(5), 529–550. https://doi.org.ezproxy.library.uvic.ca/10.1007/BF01537394

Harding, H.G., Morelen, D., Thomassin, Bradbury, L. & Shaffer, A. (2013). Exposure to maternal-and-parental-perpetrated intimate partner violence, emotion regulation and child outcomes. *Journal of Family Violence,* 28(1), 63-72. doi:10.1007/s10896-012-9487-4

Herman-Smith, R. (2013). Intimate partner violence exposure in early childhood: An ecobiodevelopmental perspective. *Health and Social Work,* 38(4), 231-239. doi:10.1093/hsw/hlt018

Herrenkohl, T. I., Hill, K. G., Chung, I. J., Guo, J., Abbott, R. D., & Hawkins, J. D. (2003). Protective factors against serious violent behavior in adolescence: A prospective study of aggressive children. *Social Work Research*, 27(3), 179–191. Retrieved from: http://www.jstor.org/stable/42659530

Hibel, L. C., Granger, D. A., Blair, C., Cox, M.J., & The Family Life Project Key Investigators. (2011). Maternal sensitivity buffers the adrenocortical implications of intimate partner violence exposure during early childhood. *Development & Psychology,* 23(2), 689-701. doi:10.1017/S0954579411000010

Hoch, A. L. (2009). Trauma focused cognitive behavioral therapy for children. In A. Rubin & D. W. Springer (Eds.), *Treatment of traumatized adults and children* (pp. 179-253). Hoboken, NJ: John Wiley and Sons.

Hodgdon, H. B., Blaustein, M., Kinniburgh, K., Peterson, M.L., & Spinazzola, J. (2016). Application of the ARC model with adopted children: supporting resiliency and family well being. *Journal of Child and Adolescent Trauma,* 9(1), 43-53. doi:10.1007/s40653-015-0050-3

Hodgdon, H. B., Kinniburgh, K., Gabowitz, D., Blaustein, M. E., & Spinazzola (2013). Development and implementation of trauma-informed programming in youth residential treatment centers using the ARC framework. *Journal of Family*

Violence, 28(7), 679-692. doi:10,1007/s10896-013-9531-z

Holmes, M. R. (2013). Aggressive behavior of children exposed to intimate partner violence: An examination of maternal mental health, maternal warmth and child maltreatment. *Child, Abuse and Neglect,* 37(8), 520- 530. dx.doi.org/10.1016/j.chiabu.2012.12.006

Howard, A. L., Kimonis, E. R., Munoz, L. C., & Frick, P. J. (2012). Violence exposure mediates the relation between callous-unemotional traits and offending patterns in adolescents. *Journal of Abnormal Child Psychology,* 40(6), 1237-1247. doi:10.1007/s10802-012-9647-2

Howard, S., Dryden, J., & Johnson, B. (1999). Childhood resilience: Review and critique of literature. *Oxford Review of Education*, 25(3), 307–323. http://dx.doi.org/10.1080/030549899104008

Howell, K. H., & Graham-Bermann, S. A. (2011). The multiple impacts of intimate partner violence on preschool children. In S. Graham-Bermann & A. Levendosky (Eds.). *How intimate partner violence affects children: Developmental research, case studies, and evidence-based intervention* (pp. 87-107). Washington, D.C.: American Psychological Association.

Howell, K. H., Miller. L. E., Lilly, M. M., Burlaka, V., Grogan-Kaylor, A. C., & Graham-Bermann, S. A. (2015). Strenghtening positive parenting through intervention: Evaluating the mom's empowerment program for women experiencing intimate partner violence. *Journal of Interpersonal Violence,* 30(2),

232-252. doi:10.1177/0886260514533155

Huang, C., Viske, J. H., Lu, S., & Yi, S. (2015). Children's exposure to intimate partner violence and early delinquency. *Journal of Family Violence,* 30(8), 953-965. doi:10.1007/s10896-015-9727-5

Hungerford, A., Ogle, R. L., & Clements, C. M. (2010). Children's exposure to intimate partner violence: Relations between parent-child concordance and children's adjustment. *Violence & Victims,* 25(2), 185-201. doi:10.1891/0886-6708.25.2.185

Hungerford, A., Wait, S. K., Fritz, A. M., & Clements, C. M. (2012). Exposure to intimate partner violence and children's psychological adjustment, cognitive functioning and social competence: A review. *Aggression and Violent Behavior,* 17(4), 373-382. doi:10.1016/j.avb.2012.04.002

Hunter, E. C. & Graham-Bermann, S. A. (2013). Intimate partner violence and child adjustment: Moderation by father contact? *Journal of Family Violence,* 28(5), 435-444. doi:10.1007/s10896-013-9517-x

Jackson, Y. (2005). Testing the compensatory and immunity models of children's adaptive behaviors: The role of appraisal. *American Journal of Orthopsychiatry*, 75(3), 369–380. doi: 10.1037/0002-9432.75.3.369

Jouriles, E. N., & McDonald, R. (2015). Intimate partner violence, coercive control and child adjustment problems. *Journal of Interpersonal Violence,* 30(3), 459-474. doi:10.1177/0886260514535099

Jouriles, E. N., Rosenfield, D., McDonald, R., Mueller, V. (2014). Child involvement in interparental conflict and child adjustment problems: A longitudinal study of violent families. *Journal of Abnormal Child Psychology,* 42(5), 693-704. doi:10.1007/s10802-013-9821-1

Jouriles, E. N., Vu, N. L., McDonald, R., & Rosenfield, D. (2014). Children's appraisals of conflict, beliefs about aggression, and externalizing problems in families characterized by severe intimate partner violence. *Journal of Family Psychology,* 28(6), 915-924. doi:10.1037/a0037921

Jouriles, E.N., McDonald, R., Rosenfield, D., Spiller, L., Corbitt-Shindler, D., Norwood, W.D., Stephens, N., & Ehrensaft, M. (2010). Improving parenting in families referred for child maltreatment: A randomized controlled trial examining the effects of project support. *Journal of Family Psychology,* 24(3), 238-338. doi:10.1037/a0019281

Jouriles, E. N., McDonald, R., Stephens, N., Norwood, W., Spiller, L. C., & Ware, H. S. (1998). Breaking the cycle of violence: Helping families departing from battered women's shelters. In G. Holden, R. Geffner, & E. N. Jouriles (Eds.), *Children exposed to marital violence: Theory, research, and applied issues* (pp. 185-221). Washington, DC: American Psychological Association.

Katz, L. F., Hessler, D. M., & Annest, A. (2007). Domestic violence, emotional competence, and child adjustment. *Social Development,* 16(3), 513–538. doi:10.1111/j.1467- 9507.2007.00401.x.

Kennedy, A. C., Bybee, D. Sullivan, C. C., & Greeson, G. (2010). The impact of family and community violence on Children's depression trajectories: Examining the interactions of violence exposure, family social support and gender. *Journal of Family Psychology,* 24(2), 197-207. doi:10.1037/a0018787

Kinniburgh, K., Blaustein, M., Spinazzola, J., van der Kolk, B. (2005). Attachment, self-regulation and competency: A comprehensive intervention framework for children with complex trauma. *Psychiatric Annals,* 35(5), 424-430. Retrieved from http://psychrights.org/research/Digest/CriticalThinkRxCites/kinniburgh.pdf

Kliewer, W., et al. (2004). Violence exposure and adjustment in inner-city youth: Child and caregiver emotion regulation skill, caregiver-child relationship quality, and neighborhood cohesion as protective factors. *Journal of Clinical Child and Adolescent Psychology*, 33(3), 477–487. http://dx.doi.org/10.1207/s15374424jccp3303_5

Koutselini, M., & Valanidou, F. (2014). Children living with violence against their mothers: The side effects on their behavior, self-image and school performance. *Pedagogy, Culture & Society,* 22(2), 213-231.

Knous-Westfall, H. M., Ehrensaft, M. K., Watson MacDonell, K., & Cohen, P. (2012). Parental intimate partner violence, parenting practices, and adolescent peer bullying: A prospective study. *Journal of Child and Family Studies,* 21(5), 754-766. doi:10.1007/s10826-011-9528-2

Koss, K. J., George, M. R. W., Davies, P. T., Cicchetti, D., Cummings, E. M. & Sturge-Apple, M. L. (2013). Patterns of children's andrenocortical reactivity to interparental conflict and associations with child adjustment: A growth mixture modeling approach. *Developmental Psychology*, 49(2), 317-326. doi:10.1037/a0028246

Lamers-Winkelman, F., Willemen, A. M., & Visser, M. (2012). Adverse childhood experiences of referred children exposed to intimate partner violence: Consequences for their wellbeing. *Child Abuse & Neglect,* 36(2), 166-179. doi:10.1016/j.chiabu.2011.07.006

Lamers-Winkelman, F., De Schipper, J. C., Oosterman, M. (2012). Children's physical health complaints after exposure to intimate partner violence. *British Journal of Health Psychology,* 17(4), 771-784. doi:10.1111/j.2044-8287.2012.02072.x

Latzman, N. E., Vivolo-Kantor, A. M., Holditch Niolon, P., & Ghazarian, S. R. (2015). Predicting adolescent dating violence perpetration: Role of exposure to intimate partner violence and parenting practices. *American Journal of Preventative Medicine,* 49(3). Retrieved from http://www.ajpmonline.org

Leenarts, L. E.W., Diehle, J., Doreleijers, T.A.H., Jansma, E.P. & Lindauer, R.J.L. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child & Adolescent Psychiatry,* 22(5), 269-283. doi:10.1007/s00787-012-0367-5

Levendosky, A. A., Bogat, G. A., & Martinez-Torteya, C. (2013). PTSD symptoms in young children exposed to intimate partner violence. *Violence Against Women,* 19(2), 187-201. doi:10.1177/1077801213476458

Lieberman, A. F., Chu, A., Van Horn, P., & Harris, W. W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology,* 23(2), 397-410. doi:10.1017/S0954579411000137

McCabe, K. M., Clark, R., & Barnett, D. (1999). Family protective factors among urban African American youth. *Journal of Clinical Child Psychology*, 28(2), 137–150. http://dx.doi.org/10.1207/s15374424jccp2802_2

McCloskey, L.A., & Stuewig, J. (2001). The quality of peer relationships among children exposed to family violence. *Development and Psychopathology*, 13(1), 83–96. Retrieved from http://0-journals.cambridge.org.uncclc.coast.uncwil.edu/action/displayJournal?jid=DPP

McDonald, R., Dodson, M. C., Rosenfield. R., & Jouriles, E.N. (2011). Effectd of a parenting intervemtion on features of psychopathology in children. *Journal of Abnormal Child Psychology,* 39(7), 1013-1023. doi:10.1007/s10802-011-9512-8

McNaughton Reyes, H., Foshee, V. A., Bauer, D. J., & Ennett, S. T. (2012) Heavy alcohol use and dating violence perpetration during adolescence: Family, peer and neighborhood violence as moderators. *Preventative Science,* 13(4), 340-349. doi:10.1007/s11121-011-0215-8

Maliken, A. C., & Fainsilber Katz, L. (2012). Fathers' emotional awareness and children's empathy and externalizing problems: The role of intimate partner violence. *Journal of Interpersonal Violence,* 28(4), 718-734. doi:10.1177/0886260512455866

Margolin, S. (2006). African American youths with internalizing difficulties: Relation to social support and activity involvement. *Children and Schools*, 28(3), 135–144.

Margolin, G., & Vickerman, K. A. (2011). Post-traumatic stress in children and adolescents exposed to family violence: I. overview and issues. *Couple and Family Psychology,* 1(S), 63-73. doi:10.1037/2160-4096.1.S.63

Martinez-Torteya, C., Bogat, G. A., Levendosky, A. A., & von Eye, A. (2016). The influence of prenatal intimate partner violence exposure on hypothalamic-pituitary-adrenal axis reactivity and childhood internalizing and externalizing symptoms. *Development & Psychopathology,* 28(1), 55-72. doi:10.1017/S0954579415000280

Miller, L. E., Howell, K. H., & Graham-Bermann, S. A. (2014) Potential mediators of adjustment for preschool children exposed to intimate partner violence. *Child Abuse & Neglect,* 36(9), 671-675. doi:10.1016/j.chiabu.2012.07.005

Minze, L., McDonald, R., & Jouriles, E.N. (2012). Project support: Reducing conduct problems of children in violent families. In A. Rubin (Ed.). *Programs and interventions for maltreated children and families at risk: Clinicians guide to evidence-based practice* (pp. 163-175). Hoeboken, NJ: John Wiley & Sons, Inc.

Moylan, C.A., Herrenkohl. T. I., Sousa, C., Tajima, E. A., Herrenkohl, R. C., & Russo, M.J. (2010). The effects of child abuse and exposure to domestic violence on adolescent internalizing and externalizing behavior problems. *Journal of Family Violence,* 25(1), 53-63. doi:10.1007/s10896-009-9269-9

Mrug, S., & Windle, M. (2010). Prospective effects of violence exposure across multiple contexts on early adolescents' internalizing and externalizing problems. *Journal of Child Psychology & Psychiatry,* 51(8), 953-961. doi:10-1111/j.1469-7610.2010.02222.x

Olaya, B., Ezpeleta, L., de la Osa, N., Granero, R., & Domenech, J.M. (2010). Mental health needs of children exposed to intimate partner violence seeking help from mental health services. *Children and Youth Services Review,* 32(7), 1004-1011. doi:10.1016/j.childyouth.2010.03.028

Olofsson, N., Lindqvist, K., Gadin, K. G., Braback, L. & Danielsson, I. (2011). Physical and psychological symptoms and learning difficulties in children of women exposed and non-exposed to violence: A population-based study. *International Journal of Public Health,* 56(1), 89-96. doi:10.1007/s00038-010-0165-0

Overbeek, M.M., de Schipper, J.C., Lamers-Winkelman, F., & Schuengel, C. (2014). Risk factors as moderators of recovery during and after interventions for children exposed to interparental violence. *American Journal of Orthopsychiatry,* 84(3), 295-306. doi:10.1037/ort0000007

Park, A., Smith, C., & Ireland. T. (2012) Equivalent harm?; the relative roles of maltreatment and exposure to intimate partner violence in antisocial outcomes for young adults. *Children and Youth Services Review,* 34(5), 962-972. doi:10.1016/j.childyouth.2012.01.029

Rahim, M. (2014). Developmental trauma: an attachment-based perspective. *Clinical Child Psychology,* 19(4), 548-560. doi:10.1177/1359104514534947

Rak, C. F., & Patterson, L. E. (1996). Promoting resilience in at-risk children. *Journal of Counseling and Development*, 74(4), 368–373. doi**:** 10.1002/j.1556-6676.1996.tb01881.x

Renner, L. M., & Boel-Studt, S. (2013). The relation between intimate partner violence, parenting stress and child behavior problems. *Journal of Family Violence,* 28(2), 201-212. doi:10.1007/s10896-01209477-6

Rubin, A. (2012). Trauma-focused cognitive behavioral therapy for children. In A. Rubin (Ed.). *Programs and interventions for maltreated children and families at risk: Clinicians guide to evidence-based practice* (pp. 123-140). Hoeboken, NJ: John Wiley & Sons, Inc.

Schermerhorn, A. C., Chow, S. & Cummings, E. M. (2010). Developmental family processes and interparental conflict: Patterns of microlevel influences. *Developmental Psychology,* 46(4), 869-885. doi:10.1037/a0019662

Sinha, M. (2013). *Family violence in Canada: A statistical profile, 2011.* Ottawa: Canadian Centre for Justice Statistics.

Smith, C.A., Elwyn, L.J., Ireland, T.O, & Thornberry, T.P. (2010). Impact of adolescent exposure to intimate partner violence on substance use in early adulthood. *Journal of Studies on Alcohol and Drugs,* 71(2), 219—230. Retrieved from http://www.jsad.com/

Sousa, C., Herrenkohl, T.I., Moylan, C. A., Tajima, E. A., Klika, J. B., Herrenkohl, R. C., & Russo, M. J. (2011). Longitudinal study on the effects of child abuse and children's exposure to domestic violence, parent-child attachments and antisocial behavior in adolescence. *Journal of Interpersonal Violence,* 26(1), 111-136. doi:10.1177/0886260510362883

Spaccarelli, S., Coatsworth, J. D., & Bowden, B. S. (1995). Exposure to serious family violence among incarcerated boys: its association with violent offending and potential mediating variables. *Violence and Victims*, 10(3), 163–182.

Sroufe, L.A. (1997). Psychopathology as an outcome of development. *Development and Psychology,* 9, 251-268. doi:10.1017/S0954579497002046

Sturge-Apple, M. L., Davies, P. T., Cicchetti, D., & Manning, L. G. (2012). Interparental violence, maternal emotional unavailability and children's cortisol functioning in family contexts. *Developmental Psychology,* 48(1), 237-249. doi:10.1037/a0025419

Telman, M. D., Overbeek, M.M., de Schipper, J. C., Lamers-Winkelman, F., Finkenauer, C., & Schuengel, C. (2016). Family functioning and children's post-traumatic stress symptoms in a referred sample exposed to interparental violence. *Journal of*

Family Violence, 31(1), 127-136. doi:10.1007/s10896-015-9769-8

Temple, J. R., Shorey, R. C., Tortolero, S. R., Wolfe, D. A. & Stuart, G. L. (2013). Importance of gender and attitudes about violence in the relationship between exposure to interparental violence and the perpetration of teen dating violence. *Child Abuse & Neglect,* 37(5), 343-352. doi:10.1016/j.chiabu.2013.02.001

Teten Tharp, A., DeGue, S., Valle, L. A., Brookmeyer, K. A., Massetti, G. M., & Matjasko, J. L. (2012). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma, Violence & Abuse,* 14(2), 133-167. doi:10.1177/1524838012470031

Towe-Goodman, N. R., Stifter, C. A., Coccia, M. A., Cox, M. J., & The Family Life Project Key Investigators. Interparental aggression, attention skills, and early childhood behaviour problems. *Development and Psychopathology,* 23(2), 563-576. doi:10.1017/S0954579411000216

Trocme, N., Fallon, B., McLaurin, B., Sinha, V., Black, T., Fast, E., Felstiner, C., Helie, S., Turcotte, D., Weightman, P., Douglas, J., & Holroyd, J. (2008). *Canadian Incidence Study of Reported Child Abuse and Neglect, 2008.* Ottawa: Public Health Agency of Canada.

Turner, H. A., Finkelhor, D., Ormrod, R., Hamby, S., Leeb, R. T., Mercy, J. A., & Holt, M. (2012). Family context, victimization, and child trauma symptoms: Variations in safe, stable, and nurturing relationships during early and middle childhood. *American Journal of Orthopsychiatry,* 82(2), 209-219. doi:10.1111/j.1939-

0025.2012.01147.x

Voisin, D. R., & Hong, J. S. (2012). A meditational model linking witnessing intimate partner violence and bullying behaviors and victimization among youth. *Educational Psychology Review,* 24(4), 479-498. doi:10.1007/s10648-012-9197-8

Voith, L. A., Gromoske, A. N., & Holmes, M. R. (2014). Effects of cumulative violence exposure on children's trauma and depression symptoms: A sociological examination using fixed regression. *Journal of Child Adolescent Trauma,* 7(4), 207-216. doi:10.1007/s40653-014-0026-8

Wathen, C. N., & MacMillan, H. L. (2013). Children's exposure to intimate partner violence: Impacts and interventions [review article]. *Paediatrics & Child Health*, 18(8), 419-422.

Wood, S. L., & Sommers, M. S. (2011). Consequences of intimate partner violence on child witnesses: A systematic review of the literature. *Journal of Child and Adolescent Psychiatric Nursing,* 24(4), 223-236. doi:10.1111/j.1744-6171.2011.00302.x

World Health Organization. (2012). *Understanding and addressing violence against women*: *Intimate partner violence.* Retrieved from http://www.http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf

Wright, E. M., Fagan, A. A., & Pinchevsky, G. M. (2013). The effects of exposure to violence and victimization across life domains on adolescent substance use. *Child Abuse & Neglect,* 37(11), 899-909. doi:10.1016/j.chiabu.2013.04.010

Ybarra, G. J., Wilkens, S. L., & Lieberman, A. F. (2007). The influence of domestic violence on preschooler behavior and functioning. *Journal of Family Violence*, 22 (1), 33–42. doi:10.1007/s10896-006-9054-y.