

DIALOG FROM THE FIELD

Dyadic Intervention for Young Children Exposed to Interpersonal Violence

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Children aged five years and younger are more likely to be exposed to intimate partner violence than any other age group. Until recently, there was little literature devoted to the social and emotional needs of young children exposed to interpersonal violence in the home. However, research over the past two decades has found links between a number of stressful and traumatic events early in life and later social and emotional problems. This has led to increased clinical research on intervention for young children exposed to intimate partner violence. Because parents are so critical to young children's ability to cope with stress and trauma, intervention that targets the parent-child relationship holds the most promise for improving developmental outcomes for children birth through five years of age who have witnessed interpersonal violence. Research suggests that preschool personnel with more awareness of child mental health approaches feel more supported in their jobs and are more sensitive in their interactions with children. The purpose of this article is to raise awareness about how stress impacts early brain development and the developmental impact of witnessing interpersonal violence during early childhood.

Keywords: early childhood mental health, domestic violence, early intervention, preschool

As many as nine million children in the United States reside in households where intimate partner violence (IPV) is a recurrent pattern (McDonald et al., 2006). Children and adolescents are almost always present during IPV involving a parent (Fantuzzo & Fusco, 2007; Graham-Bermann et al., 2009). IPV is more likely to happen in homes with children five years and younger than in any other age group (Fantuzzo et al., 1991; Gjelsvik, Verhoek-Oftedahl, & Pearlman, 2003; Rennison, 2003). This age group is also more likely to be exposed to the most

physically violent forms of IPV, such as kicking, biting, hitting, choking, burning, or use of guns or knives (Centers for Disease Control & Prevention, 2012; McDonald et al., 2006). Women in minority, lower income, and immigrant families are more likely to experience domestic violence (Sokoloff & Dupont, 2005), meaning preschool programs that serve children from these families are more likely to encounter children with these experiences.

Over the past two decades, there has been a surge of interest and research regarding young children's responses to various other kinds of trauma. Most violence-related trauma research with young children has focused on the consequences of direct maltreatment; there has been less attention to the effects of IPV exposure to overall development (DeYoung, Kennardy, & Cobham, 2011; Lieberman & Knorr, 2007; Osofsky, 2004; Scheeringa et al., 2005). This is a concern for two reasons. First, there was evidence over a decade ago that many community-based mental health interventions are ineffective at preventing poor outcomes for young IPV-exposed children (see Scheeringa et al., 2005). Since that time, knowledge about mental health prevention and intervention models for this age group have been growing but has not been widely disseminated (DeYoung, Kennardy, & Cobham, 2011; Herman-Smith, 2013). Second, treatment that is effective for older children and adolescents is often not appropriate for use with very young children. Children between two and five do not have the verbal skills, memory recall, and non-contextual learning transfer skills that many trauma interventions for older children assume.

Dyadic interventions are mental health interventions that improve social and emotional skills of young children, not by focusing on the child exclusively, but by improving the parent-child relationship. Emerging evidence shows that dyadic interventions are more effective than individual treatment for children aged two to five who have experienced trauma, including IPV. The purpose of this article is to raise awareness about dyadic interventions among professionals who care for young children and their families, including teachers, family support specialists, social workers, nurses, mental health consultants, and program administrators. Better awareness of the dyadic intervention will help them better support to families. In addition, although child behavior management is one of the key concerns of preschool personnel, there are few systematic efforts to educate and support preschool personnel. This is unfortunate since research suggests that preschool staff who are knowledgeable about early childhood mental health approaches experience decreased job-related stress and feel more supported by their agencies (Green, Malsch, Kothari, Busse, & Brennan, 2012). More awareness of child mental health can also yield improvement in overall childcare quality (Brennan, Bradley, Allen, & Perry, 2008) and teacher sensitivity in interactions with children (Bleecker, Sherwood, & Chan-Sew, 2005).

THE IMPACT OF IPV ON YOUNG CHILDREN

Traditionally, research on brain development (neuroscience) and research on the importance of early-life relationships (ecological sciences) were two separate areas of science. Over the past two decades, advances in technology have begun to show how brain growth and caregiver-child relationships work together to form children's ability to regulate stress (Shonkoff et al., 2012). Infants and young children are attuned to distress and usually respond by crying or moving toward a primary caregiver to receive protection (Bernard & Dozier, 2010). Overall, their repertoire of coping and self-soothing strategies are much more limited than that of older children and adults, so younger children are more dependent on these external supports to help

them regulate stress and trauma. During distress, the brain experiences dramatic increases in levels of stress hormones, especially cortisol, norepinephrine, and adrenaline. These hormones, which are associated with the “fight or flight” response, protect humans by preparing us to respond to danger. With caregiver reassurance and comfort, young children usually experience lowered distress, with a concomitant drop in stress hormones. Over time, children learn to assess more realistically for threats and self-soothe once it is clear that a threat is not imminent.

When caregivers are persistently unavailable or unresponsive to the child’s need for reassurance, infants and young children become more agitated. Unresolved distress results in greater flooding of stress hormones into the brain. Infants and young children enter a state of hyperarousal. With hyperarousal, young children experience frequent bouts of hormonal flooding with stress hormones and can become reactive to relatively benign stressors. If there is continuous environmental stress or a succession of acutely stressful events, the nervous system can begin to deregulate and individuals succumb more easily to stress-related illnesses, psychological withdrawal, or hyperarousal (McEwen & Wingfield, 2010; Shonkoff et al., 2009; see van Ijzendoorn & Kroonenberg, 1988). Even as they become more mobile and self-sufficient, younger children cannot escape distressing situations by leaving the stress-inducing environment. They are in a sense “captives” of the immediate environment, including those in which IPV occurs.

The brain is particularly sensitive to neurochemical influences during the earliest years of life and, in large doses, stress hormones can alter brain development in children younger than three (Dawson & Ashman, 2000; DeBellis, Hooper, & Sapia, 2005; Fox, Almas, Degnan, Nelson, & Zeanah, 2011). During the first three years, neurons in the brain grow and connect to each other at a rapid pace. A denser network of neural connection is associated with increased cognitive skills, increased language skills, and emotional coping skills later in life (Shonkoff et al., 2012). Hormonal flooding interrupts this rapid neural connectivity, which in turn inhibits skill development. Neuronal growth and development continue into early adulthood, so children can overcome the impact of early trauma, but this becomes more difficult without intervention since high levels of stress early in life distort the foundation on which subsequent development rests.

Child Emotional Functioning and IPV

Two psychiatrists, Michael Scheeringa and Charles Zeanah (1995) were among the first researchers to assess the impact of traumatic stress on very young children. They were interested in children who had experienced a wide range of potentially traumatic experiences. However, through case reviews, observations, and parent interviews, they concluded that “perceived threat to a caregiver” was more likely than any other type of traumatic experiences to result in negative behavioral and emotional outcomes for young children. Within six months of being exposed to IPV in the home, preschool-aged children in their study exhibited hyperarousal, fearfulness, and increased aggression toward peers to the degree that treatment was warranted. In a later study, Scheeringa et al. (2005) followed a group of preschool-aged children three years after they had been exposed to IPV. Up to three years later, children who had been exposed to IPV still experienced significant impairment, which included anxiety, depression, oppositionality, and problems with impulse control that interfered with their daily lives. Unfortunately, these high levels of emotional and behavioral impairment were still observable among children in this

group who had received play therapy or other forms of individual therapy. There was no difference in these children and a control group of children who had received no treatment.

Additional research has shown that many children exposed to IPV experience significant effects within one year of exposure. Lieberman and Knorr (2007) found significantly higher levels of hyperarousal, aggressive behavior, fearfulness, withdrawn behavior, avoidant behavior, and developmental regression in preschool-aged children within six to 12 months after IPV exposure compared to a demographically matched comparison group. Spilsbury et al. (2007) reported that preschool-aged children exposed to IPV were more likely than non-exposed children to display symptoms of anxiety and depression within one year of exposure. Ybarra et al. (2007) found that preschool children experienced separation anxiety, sleep disturbances, changes in eating patterns, and toileting regression at clinically significant levels within one year of IPV exposure. Finally, Bogat et al. (2006) found that 37% of young children exposed to IPV exhibited at least one trauma symptom associated with Posttraumatic Stress Disorder (PTSD) within two months after exposure. Symptoms included hyperarousal, increased startle response, increased aggression, and inconsolability.

Parent-Child Relationships and IPV

Exposure to IPV during the preschool years can also have a negative impact on relationships between children and the victimized parent, which in most cases is the mother. Young children who are exposed to IPV make fewer verbal requests of their mothers. These children's verbal exchanges with their mothers are brief and less playful compared to other children of the same age who have not witnessed IPV (Ybarra et al., 2007). Preschool-aged children exposed to IPV are less likely to make eye contact with their mothers during conversation and less likely to follow through with their mothers' requests (Borrego et al., 2008; Levendosky et al., 2003). They exhibit less positive affect during interactions with their mothers and maintain greater physical distance from them during play (Borrego et al., 2008). Mothers who have experienced IPV self-report poor behavioral control of their preschool-aged children (Ybarra et al., 2007). In some cases, this leads mothers to be more authoritarian and punitive toward their children (Lieberman & Knorr, 2007).

Although there is a growing body of research documenting difficult relationships between young children who have been exposed to IPV and their mothers, the reasons for these relationship problems is still being debated (Huang, Wang, & Warrener, 2010). A review of the literature suggests a number of possible causes. Each of these is briefly outlined below.

Attachment. One possible cause of parent-child interaction problems following IPV is poor attachment. Attachment theory has yielded the most comprehensive, cross-cultural body of research on the emergence of the early parent-child relationship and its importance for the child's development. Attachment refers to the impulse to seek comfort and protection from a trusted, favored adult caregiver (Ainsworth et al., 1978; Bowlby, 1980; Lieberman & van Horn, 2008). Children with secure attachments feel free to explore their environments because they know the mother is a "secure base" to which they may return if they become frightened or uncertain. Secure attachment is associated with the ability to self-soothe when upset (Dozier et al., 2006; Southwick, Rasmussen, Barron, & Arnsten, 2005). Children with secure attachments have fewer behavior problems, higher levels of social competence, lower anxiety, better

language skills, and better school readiness skills at age three compared to children who have histories of insensitive or inconsistent parenting (Belsky & Fearon, 2002; Juffer & van IJzendoorn, 2005). Failure to develop secure attachments has been correlated with a number of chronic emotional and behavioral problems (Fox et al., 2011; Weinfield et al., 1999).

Approximately 70% of children between 12 and 24 months of age develop secure attachments (Ainsworth et al., 1978; Pollak et al., 2000; Schore, 2001). In one of the few studies that focused on infants and toddlers exposed to IPV, only one third displayed secure attachment with their mothers (Zeanah et al., 1999). Some studies have found that exposure to more severe forms of violence results in greater likelihood of insecure attachment (see Carpenter & Stacks, 2009; Zeanah et al., 1999); however, a particularly well-designed study of 100 mother-infant dyads by Belsky (1999) did not find attachment security related to violence severity.

The precise mechanisms by which IPV leads to parent-child relationship problems is unclear. Based on attachment theory, however, witnessing IPV could encourage young children to withdraw from the relationship with the victimized parent because the child thinks the parent is incapable of preventing harm to them. Young children, who think very concretely, might conclude that if the parent cannot protect herself from physical harm, then she is not a reliable source of protection; consequently, the parent-child relationship becomes a source of anxiety for the child.

Parenting stress. Mothers who have experienced IPV are more likely to use a harsh parenting style (Holden, Geffner, & Jouriles, 1998; Lieberman & Knorr, 2007; Osofsky, 2004). Huang, Wang, and Warriner (2010) reported that maternal use of spanking was associated with increased externalizing (opposition, defiance, high activity levels) and internalizing (depression, anxiety, withdrawal) child behaviors two years after IPV incidents in the home. Conversely, positive discipline was associated with decreases of externalizing and internalizing behaviors. Because the sample sizes in these studies were small, more research is needed before making definitive statements on this hypothesis.

Parental mental health. IPV victims are at higher risk of depression, anxiety, and posttraumatic stress disorder (Coker et al., 2002; Graham-Bermann & Levendosky, 1998; Levendosky et al., 2006). Lieberman and colleagues (2005) also showed that children's responses to IPV were mediated by their mothers' response to stress; mothers who better managed stress had children who also demonstrated less distress within one year of the last reported incident of IPV.

Economic stress. It has been long established that family economic stress is associated with less optimal parenting, which in turn is related to negative social-emotional outcomes for children (see Chazen-Cohen et al., 2009; Conger, Conger, & Elder, 1997). Family income both directly influences child outcomes and is mediated by other family factors. Lower income is associated with higher likelihood of IPV in the home. In addition, individuals with an abusive partner might find it more difficult to leave an abusive relationship due to financial concerns. Furthermore, leaving an abusive relationship might result in more financial hardship since the financial resources of an abusive partner will probably no longer be available. Individuals experiencing economic stress are more likely to experience parenting problems, at least in the short term.

Child stress. As stated previously, young children are prone to hyperarousal, non-compliance, and inconsolability in response to traumatic stress (Bogat et al., 2006). Young children's behavior might be more difficult to manage as a consequence of having witnessed IPV, especially if the child's exposure-related symptoms manifest as non-compliance or impulsive behaviors (Kitzmann et al., 2003; Osofsky, 2004). It is likely that a combination of these factors influence harsh parenting style after experiencing IPV.

It is important to understand that the link between each of these factors and relationships of children and post-IPV victimized parents is preliminary. None have sufficient scientific support to draw definitive conclusions about how IPV exposure during early childhood impacts child mental health and parent-child relationships. On the other hand, each of these factors will likely form the basis of the next generation of research in this area.

Despite the fact that more research is needed to establish causal links between the factors reviewed here and post-IPV child outcomes, the research so far offers two conclusions. First, relationships between children and parents who are victims of IPV are often in need of repair. Second, because preschool-aged children remain highly dependent on these parents for emotional development and overall well-being, children are much more likely to benefit from interventions that involve both the child and parent. In fact, an analysis of evidence-based interventions for young children exposed to IPV finds that parent involvement in treatment is usually a key component. Child care professionals, (e.g., teachers, family support specialists, social workers, nurses, mental health consultants, and program administrators) are often in a position to support, guide, and inform parents who are struggling with parenting after experiencing IPV. Professionals who work with young children and families should be aware of these interventions and the important role parents play in them so they can provide better information to parents.

INTERVENTION FOR YOUNG CHILDREN EXPOSED TO IPV

An overview of evidence-based clinical interventions for young children was completed using the following sites: the National Registry of Evidence-Based Programs and Practices (NREPP), Promising Practices Network, Child Trends, the National Child Traumatic Stress Network, the Department of Health and Human Services' Home Visiting Evidence of Effectiveness (HomVEE); and the databases Medline, PsycINFO, and Social Work Abstracts. The treatment models selected met three criteria. First, the model targeted children who were five years of age or younger. Second, each model addressed exposure to verbal assault, physical assault, or other types of violence in the home. Third, the model was associated with positive child social and emotional outcomes in at least one clinical trial. Inclusion reflects these criteria and is not meant to serve as a recommendation or endorsement of any particular treatment model. Table 1 provides a summary of each intervention with expected outcomes, strategies, participants, and time to complete.

TABLE 1
Summary of Interventions for Young Children Exposed of IPV

Intervention	Expected Outcomes	Strategies	Participants	Timeframe
<i>Child Parent Psychotherapy (CPP)</i>	Strengthened relationship between children and parents or other primary caregivers	Helping parent to understand how the child's past traumatic experiences may be affecting his/her behavior	Parent(s) and child 2-5 years of age	30–50 weekly sessions over one year
	Improvements in child aggressive behavior and maternal PTSD symptoms	Increasing parent awareness of how her own trauma affects interactions with the child	Foster parents	
		Teaching the parent basic traditional play therapy skills		
<i>Child FIRST</i>	Improved maternal health	Helping parent to understand how the child's past traumatic experiences may be affecting his/her behavior	Parent(s) and child 2-5 years of age	30–50 weekly sessions over one year
	Reductions in child maltreatment by parents	Increasing parent awareness of how her own trauma affects interactions with the child		
	Improved child school readiness	Problem-solving new parenting strategies		
		Educating parents about normal developmental challenges and learning		

<i>Parent Child Interaction Therapy (PCIT)</i>	<p>Improved child externalizing behavior (opposition, aggression)</p> <p>Improved parent-child relationships</p> <p>Reduced incidence of parental maltreatment</p> <p>Improvements maintained one to six years post-treatment</p>	<p>Modeling positive parenting providing</p> <p>Coaching parents on specific parenting behavior with the child</p> <p>Assigning family homework between sessions.</p>	<p>Parent(s) and child 2-6 years of age</p> <p>Foster parents</p>	<p>14-20 weekly sessions</p>
<i>Trauma Focused Cognitive Behavior Therapy (TF-CBT)</i>	<p>Improved child behavior problems</p> <p>Decreased symptoms of posttraumatic stress</p> <p>Decreased child shame</p> <p>Decreased child depression</p>	<p>Parenting skills education</p> <p>Teaching relaxation, coping, problem-solving, and safety skills to the child</p> <p>Completing a trauma narrative</p> <p>Occasionally conducting conjoint parent-child sessions</p>	<p>Child 3-17 years of age; occasional parent involvement</p>	<p>12-16 weekly sessions</p>

Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is the only empirically-supported intervention developed specifically for children two through five years of age who have experienced exposure to IPV (Cohen, Mannarino, Murray, & Igelman 2006; Lieberman & van Horn, 2005). The primary goal of CPP is to support and strengthen the relationship between children and their parents or other caregivers; this intervention has also been used successfully with children and their foster parents. Other goals include restoring the child's sense of safety and improving the child's cognitive, behavioral, and social functioning. CPP began as an adaptation of the parent-infant psychotherapy model developed by Selma Fraiberg and colleagues (Fraiberg, Adelson, & Shapiro, 1987). Based in attachment theory, that model focused on repairing the parent-infant relationship in an effort to forestall intergenerational transmission of trauma. CPP also draws on attachment theory but, as a dyadic intervention, also incorporates adult learning theory (Lieberman, Silverman, & Pawl, 2000; Lieberman & van Horn, 2008).

CPP uses three primary strategies. The first is helping the parent understand how the child's past traumatic experiences may be affecting the child's current development. The second is helping the parent become aware of how his or her own trauma history can affect her interactions with the child (Lieberman & van Horn, 2005). The third strategy uses traditional play techniques as a means of 1) facilitating communication between the child and parent, and 2) helping the parent interact with the child in new, more developmentally appropriate ways. A treatment manual called "Don't Hit My Mommy" (Lieberman & van Horn, 2005) is used to structure therapy, which usually consists of weekly sessions with mother-child dyads for 30 weeks to one year.

Two randomized controlled trials have been conducted with CPP, which is listed as a "proven and promising practice" by the National Child Traumatic Stress Network (Gerrity & Folcarelli, 2008) and "supported by research evidence" by the California Evidence-Based Clearinghouse for Child Welfare (2011). Clinical research samples have been relatively diverse, and the program has been specifically adapted for use with Latino immigrant mothers and their infants. Research has found that mothers attribute fewer negative behaviors to their children, children show fewer avoidance behaviors toward mothers, and the child shows more pro-social behaviors by the end of treatment (Lieberman, van Horn, & Ghosh Ippen, 2005; Toth et al., 2002; Toth, Rogosch, Manly, & Cicchetti, 2006). In each of these studies, mothers exhibited improved mental health or self-image; these improvements were not significant although improvements in parent-child relationships were significant.

Child FIRST

Child FIRST was developed for families with children birth to age six in which the child has emotional, behavioral, or developmental concerns or the family faces multiple barriers associated with poverty (Lowell et al., 2011). The primary focus of intervention is helping parents/caregivers understand normal developmental challenges; encouraging parental reflection on the meaning and feelings motivating a child's behavior; reframing the child's behavior; problem-solving new strategies; and reflecting on the relationship among parental feelings, trauma and violence history, and the parental response to the child (Crusto et al., 2008; Lowell et al., 2011). The Child FIRST model is based on the most current brain development research

showing that high-stress environments resulting from poverty, maternal depression, domestic violence exposure, abuse and neglect, substance abuse, and homelessness are “toxic” to the developing brain of the young child (see Shonkoff et al., 2012). Child FIRST is designed to strengthen the parent-child relationship, which serves as a protective buffer to unavoidable stress. The model is also designed to directly facilitate emotional, language, and cognitive growth.

Child FIRST operates as a team approach to treatment with the parent, a therapist, and a care coordinator. Services are provided in the home and continue for 30 weeks to one year. Intervention begins with a comprehensive assessment of child and family needs, both clinical and non-clinical. Assessment results are used to design parent-child mental health intervention, development of a child and family plan of care, and care coordination to address family needs for resource assistance. The Child FIRST team partners with the family to develop a comprehensive plan of intervention, supports, and community-based services. This plan reflects the parents’ goals, priorities, strengths, culture, and needs, and so it includes services for the child, parents, and other members of the family as needed. Parent-child mental health intervention incorporates elements of Lieberman and van Horn’s (2005) Child Parent Psychotherapy, as well as parent guidance. Child FIRST meets Department of Health and Human Services’ criteria for an “evidence-based early childhood home visiting service delivery model.” Child FIRST is associated with statistically significant improvement in children and parents, including children’s school readiness, maternal health, and reductions in child maltreatment by parents (Lowell et al., 2011).

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) was designed to address externalizing disorders in children from two through eight years of age (Eyberg, 1988; Eyberg et al., 2001; Hembree-Kigin & McNeil, 1995; Urquiza et al., 2009). Intervention targets problems in the parent-child relationship as well as disruptive behavioral problems in young children (Borrego et al., 2008). Like CPP, PCIT’s theoretical foundation draws from both attachment theory and social learning theory (Eyberg et al., 2001). From attachment theory, PCIT borrows the idea that sensitive parenting leads the child to assume her needs will be met by the parent. When this does not happen, the child becomes increasingly disorganized and difficult to comfort (Ainsworth et al., 1978). PCIT also uses Patterson’s (1982) idea of the “coercive interaction cycle.” During times of conflict, family members sometimes enter habitual, coercive attempts to control others members’ behaviors. For example, a parent might become frustrated when his children do not respond as expected to behavior management. Out of frustration, the parent uses more forceful, aggressive techniques. The child resists the parent’s growing forcefulness, which leads the parent to become even more aggressive, and the cycle continues. The aim of treatment is to interrupt the coercive interaction cycle. Social learning theory is used to structure interactions between parents and children in ways that halt this cycle, ostensibly through modeling and coaching by the therapist.

PCIT treatment lasts for 14 to 20 weeks and is delivered in two phases, Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI; Eyberg, 1988). CDI is the first phase of treatment and focuses on enhancing positive dyadic interactions. PDI, the second phase of treatment, focuses on improving child compliance. The therapist is supportive but directive throughout intervention, providing modeling, giving immediate feedback to parents on their

performance, and assigning family homework between sessions. During sessions, the therapist provides live coaching to the parent either in the same room with the parent and child or from behind a two-way mirror speaking to the parent through a wireless “ear bug” microphone.

Numerous studies have found PCIT to be an efficacious model for reducing child externalizing behavior and improving parent-child relationships, including reductions in parental maltreatment (Eyberg et al., 2001). Research has documented positive effects maintained for up to six years post-treatment (Hood & Eyberg, 2003). PCIT has been shown to be a highly effective intervention for families in which a child has experienced parental maltreatment (Chaffin et al., 2004; Gothard, Ryan, & Heinrich, 2000). Although not designed as an intervention for children exposed to IPV, one study found PCIT used with mother-child dyads exposed in which a child had been exposed to IPV resulted in significant improvement in young children’s oppositional behavior. Parenting stress also improved at the beginning of treatment; however, it did not change significantly over the course of treatment (Timmer et al., 2010).

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was designed for children three to 17 years of age who present with post-traumatic stress disorder, depression, anxiety, or externalizing behaviors subsequent to traumatic experiences (Cohen & Mannarino, 2008). It is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially, TF-CBT was developed to address the psychological trauma associated with child sexual abuse; however, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence exposure, traumatic loss, and the multiple psychological traumas often experienced by children prior to foster care placement. The aim of treatment is to reduce child behavior problems, depression, symptoms of posttraumatic stress disorder, and feelings of shame. Treatment also aims to improve parents’ emotional reactions to the child’s trauma experience. TF-CBT is a hybrid treatment model that integrates elements of cognitive-behavioral therapy and various family therapy principles with trauma sensitive interventions.

While designed to encourage model fidelity, TF-CBT also encourages a relatively high degree of therapist flexibility in adapting the model for specific families, and community setting (Cohen, Mannarino & Deblinger, 2006). Intervention is delivered by trained therapists. The acronym PRACTICE reflects the components of the treatment model: Psycho-education and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. Initially, treatment involves parallel individual sessions with children and their parents or guardians; however, conjoint parent-child sessions are increased as treatment progresses.

Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process. TF-CBT is considered a “proven and promising practice” by the National Child Traumatic Stress Network (Gerrity & Folcarelli, 2008) and “well-supported by research evidence” in the California Evidence-Based Clearinghouse for Child Welfare (2011). TF-CBT has been adapted by therapists across the United States and in Australia, Cambodia, Canada, China, Denmark, Germany, Japan, the Netherlands, Norway, Pakistan, Sweden, and Zambia. It has been used

with children in foster care and with those who have suffered multiple and diverse traumas. Research has found TF-CBT to be associated with improved child behavior problems, decreases symptoms of posttraumatic stress, decreased child shame, and decreased child depression (Cohen, & Mannarino, 1996; Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Lippmann, & Steer, 1996; Deblinger, Mannarino, Cohen, & Steer, 2006).

LIMITATIONS OF THE INTERVENTION RESEARCH

Research with young children exposed to IPV is still grappling with methodological problems. These problems are rarely mentioned in the clinical literature (Fantuzzo & Fusco, 2007; Jouriles et al., 2001), but they are important for practitioners to consider. The first major problem is lack of attention to “dosage” effects. Most studies have conceptualized IPV exposure as a dichotomous variable (exposure versus non-exposure). Dichotomous measures do not account for the impact of repeated exposure to highly stressful events over time, which is probably an important factor in assessing IPV exposure (Lieberman & Knorr, 2007; see National Scientific Council on the Developing Child, 2005). Dichotomous measures also fail to account for violence intensity; this is a special concern for younger children since research suggests they are more likely to be present during more severe IPV (Centers for Disease Control & Prevention, 2012; McDonald et al., 2006).

A second concern is that many studies of young children exposed to IPV have involved children living in domestic violence shelters with their mothers (Appel & Holden, 1998; Fantuzzo & Fusco, 2007). Living in a domestic violence shelter could mean children have been exposed to more severe violence than children not living in a shelter. Children living in shelters might differ from those who do not in other important ways as well, such as level of extended family or other social support, income, parent employment status, and degree of poverty (Fantuzzo et al., 1991; Peled, 1998). Families in shelters are probably not representative of all young children exposed to IPV (Fantuzzo & Fusco, 2007), though most of the current literature does not make this distinction.

A third concern is that the research on early childhood IPV exposure has focused almost exclusively on children who live with their mothers, to the exclusion of children living with fathers. Mothers are the most at risk of being the victim of violence (Centers for Disease Control & Prevention, 2012), and children in the United States are more likely to live with mothers instead of fathers in single parents homes. However, much could be learned by examining similarities and differences between mother-child and father-child dyads and by including children with parents in same-sex relationships.

A fourth concern is that the research on post-IPV child symptomatology relies heavily on parent report. This raises the possibility of parents over-reporting or under-reporting their children’s problems related to IPV exposure. The research so far suggests that parents who experience IPV underestimate their children’s violence exposure and its struggles. Perhaps they do so in an attempt to minimize their own trauma (Pynoos, Steinberg, & Piancentini, 1999) or to assuage feelings of guilt for “allowing” their children’s exposure to violence (Lieberman, 2004).

Finally, many studies of children exposed to IPV fail to account for how much family violence is aimed directly at children. Appel and Holden (1998) completed a meta-review of studies involving spousal violence and child maltreatment. They estimated the overall percentage of children experiencing both direct physical abuse and exposure to IPV at around

40%. Edleson et al. (2003) found that nearly a quarter of children were physically involved in IPV episodes, either as intended or unintended targets; the more severe the IPV, the greater chance that the child was physically involved.

CONCLUSION

Children aged five years and younger are more likely to be exposed to IPV than any other age group (Fantuzzo & Fusco, 2007; Graham-Bermann et al., 2009; Gjelsvik, Verhoek-Oftedahl, & Pearlman, 2003; Rennison, 2003), and families from minority, impoverished, or immigrant backgrounds are more likely to experience IPV; consequently, programs that target these families for services, such as Head Start, are likely to encounter families affected by IPV. Preschool personnel do not provide mental health services or domestic violence services, but they do provide support to children and parents who have experienced violence in their homes. This article is not intended to inform specific treatment recommendations for families struggling with current or past IPV but to inform staff about the impact of trauma on early brain development, the social-emotional outcomes associated with IPV, and the general types of treatment that are most effective.

Preschool staff who are knowledgeable about early childhood mental health approaches demonstrate improvements in overall childcare quality (Bleecker, Sherwood, & Chan-Sew, 2005; Brennan, Bradley, Allen, & Perry, 2008). Better awareness of mental health issues and of the potential outcomes related to IPV might also help preschool staff to respond more sensitively to parents who have experienced violence in their homes. IPV is a sensitive topic. Given that young children are more likely than older children to witness IPV, preschools should have discussions that lead to protocols for how to handle cases of IPV or suspected IPV. Having these discussions, perhaps facilitated by a trained mental health provider who has experience in IPV, can lead to a shared understanding of the preschool's vision for mental health care. Such discussions often lead to better use of mental health consultants to preschool programs by narrowing and refining teacher and program administrators' questions and concerns (Green, Malsch, Kothari, Busse, & Brennan, 2012).

The common theme among all empirically-supported trauma interventions for young children is that parent involvement in treatment is important to success. Children younger than five are highly dependent on their parents for cues about how to respond to distress (Beardslee, Versagem, & Gladstine, 1998; Carpenter & Stacks, 2009; DeWolff & van IJzendoorn, 1997; Pilowsky et al., 2006). The attachment literature has demonstrated the relationship between lost trust in one's preferred caretakers during early childhood and ongoing distress and psychopathology (Ainsworth et al., 1978; Juffer & van IJzendoorn, 2005; Weinfeld et al., 1999). So far, there is little evidence that individual therapy for younger children is effective or should be preferred to intervention that involves parents.

Early childhood mental health scholars often emphasize the need for treatment to begin for children as early as possible. Some parents might have clinical needs that are not addressed by any of the interventions covered here, for example, substance abuse, child maltreatment, maternal depression, or inadequate safety plans. In some cases, parents' needs will have to be addressed before they can be full participants in intervention for their children. This might delay when the child receives treatment, and in that way delay the support that is available to children.

If preschool staff understand that parents' needs must be addressed first, they are more likely to understand delays in starting treatment for the child.

Those who work directly with young children and those who advocate for them should continue working to ensure better access to comprehensive community services for families experiencing IPV. Better attention to the social and emotional needs of young children exposed to IPV should complement, not replace, efforts to ensure access to a variety of services that meet the varied needs of families experiencing IPV, including stronger enforcement of protections for parents and children. Preschool personnel should also continue to assist with referrals to community organizations familiar with IPV, referrals to housing, development of family safety plans, and supportive listening. Child advocates should also redouble their prevention work regarding IPV. In fact, preventing adult IPV is probably the most effective action that can be taken on behalf of young children who are at risk for experiencing it.

REFERENCES

- Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Oxford: Erlbaum.
- Appel, A., & Holden, G. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology, 12*, 578 – 599.
- Beardslee, W., Versagem, E., & Gladstone, T. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*(11), 1134–1141.
- Belsky, J. (1999). Interactional and contextual determinants of attachment security. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications*. New York, NY: Guilford Press.
- Belsky, J., & Fearon, R. M. (2002). Early attachment security, subsequent maternal sensitivity, and later child development: Does continuity in development depend on continuity of caregiving? *Attachment and Human Development, 4*(3), 361–387.
- Bernard, K., & Dozier, M. (2010). Examining infants' cortisol responses to laboratory tasks among children varying in attachment disorganization: Stress reactivity or return to baseline? *Developmental Psychology, 46*, 1771-1778.
- Bleecker, T., Sherwood, D., & Chan-Sew, S. L. (2005). *San Francisco high quality child care mental health consultation initiative*. San Francisco: Department of Public Health, Community Behavioral Health Services.
- Bogat, G. A., DeJonghe, E., Levendosky, A. A., Davidson, W. S., & Von Eye, A. (2006). Trauma symptoms among infants exposed to intimate partner violence. *Child Abuse & Neglect, 30*, 109-125.
- Borrego, J., Gutlow, M. R., Reicher, S. & Barker, C. (2008). Parent-Child Interaction Therapy with domestic violence populations. *Journal of Family Violence, 23*, 495-505.
- Bowlby, J. (1980). *Attachment and loss*. New York: Basic Books.
- Brennan, E. M., Bradley, J. R., Allen, M.D., & Perry, D. F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education and Development, 19*(6), 982–1022.
- California Evidence-Based Clearinghouse (2011). *Trauma-Focused Cognitive Behavioral Therapy*. Retrieved from <http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed>
- Carpenter, G., & Stacks, A. (2009). Developmental effects of exposure to intimate partner violence: A review of the literature. *Children and Youth Services Review, 31*, 831-839.
- Centers for Disease Control and Prevention (2012). *Intimate partner violence*. Retrieved from <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>
- Chaffin, M., Silovsky, J. F., Bunderburk, B., Valle, L. A., Breston, E. V., Balachova, T., Jackson, S., Lengraf, J., & Bonner, B. L. (2004). PCIT with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*, 491–499.

- Chazan-Cohen, R., Raikes, H., Brooks-Gunn, J., Ayoub, C., Pan, B. A., Kisker, E. E., Roggman, L., & Fuligni, A. S. (2009). Low-income children's school readiness: Parent contributions over the first five years, *Early Education and Development, 20*(6), 958-977.
- Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(4), 393-402.
- Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(1), 42-50.
- Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioral therapy for children and parents. *Child and Adolescent Mental Health, 13*, 158-162.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.
- Cohen, J. A., Mannarino, A. P., Murray, L. K., & Igelman, R. (2006). Psychosocial interventions for maltreated and violence-exposed children. *Journal of Social Issues, 62*, 737-766.
- Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., et al. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260.
- Conger, R. D., Conger, K. J., & Elder, G. H., Jr. (1997). Family economic hardship and adolescent adjustment: Mediating and moderating processes. In J. Brooks-Gunn & G. Duncan (Eds.), *Consequences of growing up poor* (pp. 288-310). New York: Russell Sage Foundation.
- Crusto, C. A., Lowell, D., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S. R., & Kaufman, J. S. (2008). Evaluation of the Child FIRST program services for children exposed to family violence. *Best Practices in Mental Health: An International Journal, 4*(1), 1-18.
- Dawson, G., & Ashman, D.B. (2000). On the origins of a vulnerability to depression: The influence of the early social environment on the development of psychobiological systems related to risk of affective disorder. In C.A. Nelson (Ed.), *The effects of early adversity on neurobehavioral development. Minnesota Symposia on Child Psychology, Vol. 31* (pp. 245-279). Mahwah, NJ: Erlbaum.
- DeBellis, M., Hooper, S. R., & Sapia, J. L. (2005). Early trauma exposure and the brain. In J. Vasterling, & C. R. Brewin (Eds.), *Neuropsychology of PTSD: Biological, cognitive, and clinical perspectives* (pp. 153-177). New York: Guilford Press.
- Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(12), 1474-1484.
- Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*(4), 310-321.
- DeWolff, M. S., & van Ijzendoorn, M. H. (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant-attachment. *Child Development, 68*, 571-591.
- DeYoung, A. C., Kennardy, J. A., & Cobham, V. E. (2011). Trauma in early childhood: A neglected population. *Clinical Child & Family Psychology Review, 14*, 231-250.
- Dozier, M., Peloso, E., Lindhiem, O., Gordon, M. K., Manni, M., Sepulveda, S., Ackerman, J., Bernier, A., & Levine, S. (2006). Preliminary evidence from a randomized clinical trial: Intervention effects on foster children's behavioral and biological regulation. *The Journal of Social Issues, 62*, 767-785.
- Edleson, J., Mbilinyi, L., Beeman, S., & Hagemeister, A. (2003). How children are involved in domestic violence. *Journal of Interpersonal Violence, 18*, 18-32.
- Eyberg, S. M. (1988). PCIT: Integration of traditional and behavioral concerns. *Child and Family Behavioral Therapy, 10*, 33-46.
- Eyberg, S., Funderburk, B., Hembree-Kigin, T., McNeil, C., Querido, J., & Hood, K. (2001). Parent-child interaction therapy with behavior problem children: One and two year maintenance of treatment effects in the family. *Child & Family Behavior Therapy, 23*, 1-20.
- Fantuzzo, J. W., DePaola, L. M., Lambert, L., Martino, T., Anderson, G., & Sutton, S. (1991). Effects of interpersonal violence on the psychological adjustment and competencies of young children. *Journal of Consulting and Clinical Psychology, 59*, 258-265.
- Fantuzzo, J. W., & Fusco, R. A. (2007). Children's direct exposure to types of domestic violence crime: A population-based investigation. *Journal of Family Violence, 22*, 543-552.

- Fox, N. A., Almas, A. N., Degnan, K. A., Nelson, C. A., & Zeanah, C. H. (2011). The effects of severe psychosocial deprivation and foster care intervention on cognitive development at 8 years of age: Findings from the Bucharest early intervention project. *The Journal of Child Psychology and Psychiatry*, 52(9), 919-928.
- Fraiberg, S., Adelson, E., & Shapiro, V. (1987). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. In S. Fraiberg & L. Fraiberg (Eds.), *Selected writings of Selma Fraiberg* (pp. 164-196). Columbus: Ohio State University Press.
- Gerrity, E., & Folcarelli, C. (2008). Child traumatic stress: What every policymaker should know. Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/nctsn_assets/pdfs/PolicyGuide_CTS2008.pdf
- Gjelsvik, A., Verhoek-Oftedahl, W., & Pearlman, D. N. (2003). Domestic violence incidents with children witnesses: Findings from Rhode Island surveillance data. *Women's Health Issues*, 13(2), 67-72.
- Gothard, S., Ryan, B., & Heinrich, T. (2000). Treatment outcome for a maltreated population: Benefits, procedural decisions, and challenges. *Child Abuse & Neglect*, 24, 1037-1045.
- Graham-Berman, S. A., Gruber, G., Howell, K. H., & Girz, L. (2009). Factors discriminating among profiles of resilience and psychopathology in children exposed to intimate partner violence (IPV). *Child Abuse & Neglect*, 33, 648-660.
- Graham-Bermann, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence*, 13(1), 111-128.
- Green, B. L., Malsch, A. M., Kothari, B. H., & Busse, J. (2012). An intervention to increase early childhood staff capacity for promoting children's social-emotional development in preschool settings. *Early Childhood Education Journal*, 40(2), 123-32.
- Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent-Child Interaction Therapy*. New York: Plenum Press.
- Herman-Smith, R. (2013). Intimate partner violence exposure in early childhood from an ecobiodevelopmental perspective. *Health & Social Work*, 38(4), 231-239.
- Holden, G. W., Geffner, R., Jouriles, E. N. (1998). Children exposed to marital violence: Theory, research, and applied issues. Washington, DC: American Psychological Association.
- Hood, K., & Eyberg, S. (2003). Outcomes of parent-child interaction therapy: Mothers' reports of maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology*, 32, 412-429.
- Huang, C. C., Wang, L. R., Warrenner, C. (2010). Effects of domestic violence on behavior problems of preschool-aged children: Do maternal mental health and parenting mediate the effects? *Children and Youth Services Review*, 32(10), 1317-1323.
- Jouriles, E. N., McDonald, R., Spiller, L., Norwood, W. D., Swank, P. R., Stephens, N., Ware, H., & Buzy, W. M. (2001). Reducing conduct problems among children of battered women. *Journal of Consulting and Clinical Psychology*, 69(5), 774-785.
- Juffer, F., & van IJzendoorn, M. H. (2005). Behavior problems and mental health referrals of international adoptees: A meta-analysis. *JAMA*, 293, 2501-2515.
- Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 71(2), 339-352.
- Levendosky, A. A., Huth-Bocks, A. C., Shapiro, D. L., & Semel, M. A. (2003). The impact of domestic violence on the maternal-child relationship and preschool-age children's functioning. *Journal of Family Psychology*, 17, 275-287.
- Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davison, W. S., & Von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology*, 20, 544-552.
- Lieberman, A. F. (2004). Traumatic stress and quality of attachment: Reality and internalization in disorders of infant mental health. *Infant Mental Health Journal*, 25, 336-351.
- Lieberman, A. F., & Knorr, K. (2007). The impact of trauma: A developmental framework for infancy and early childhood. *Psychiatric Annals*, 37, 416-422.
- Lieberman, A. F., Silverman, R., & Pawl, J. H. (2000). *Infant-parent psychotherapy: Core concepts and current approaches*. In C. H. Zeanah (Ed). *Handbook of infant mental health* (pp. 472-484). New York: Guilford.
- Lieberman A. F., & van Horn, P. (2005). *Don't hit my mommy*. Washington, DC: Zero to Three Press.
- Lieberman, A. F., & van Horn, P. (2007). *Assessment and treatment of young children exposed to traumatic events*. In J. Osofsky (Ed.). *Young children and trauma: Intervention and treatment* (118-138). New York: Guilford Press.
- Lieberman, A. F., & van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York: Guilford Press.

- Lieberman, A. F., van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*(12), 1241-1248.
- Lowell, D. I., Carter, A. S., Godoy, L., Paulicin, B., & Briggs-Gowan, M. J. (2011). A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice. *Child Development*, *82*(1), 193-208.
- McDonald, R., Jourlies, E. N., Ramisetty-Mikler, S., Caetano, R., & Green, C. E. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology*, *20*, 137-142.
- McEwen, B. S., & Wingfield, J. C. (2010). What is in a name? Integrating homeostasis, allostasis and stress. *Hormones and Behavior*, *57*(2), 105-111.
- National Scientific Council on the Developing Child (2005). *Excessive stress disrupts the architecture of the developing brain: Working Paper No. 3*. Updated Edition. Retrieved from www.developingchild.harvard.edu
- Osofsky, J. D. (2004). *Young children and trauma: Intervention and treatment*. New York, NY: Guilford Press.
- Patterson, G. R. (1982). *Coercive family process*. Eugene, OR: Castalia.
- Peled, E. (1998). The experience of living with violence for preadolescent witnesses of woman abuse. *Youth & Society*, *29*, 395-430.
- Pilowsky, D. J., Wickramaratne, P. J., Rush, D. J., Hughes, C. W., Garber, J., Malloy, E., et al. (2006). Children of currently depressed mothers: A STAR*D ancillary study. *Journal of Clinical Psychiatry*, *67*(1), 126-136.
- Pollak, S. D., Cicchetti, D., Hornung, K., & Reed, A. (2000). Recognizing emotions in faces: Developmental effects of child abuse and neglect. *Developmental Psychology*, *38*, 784-791.
- Pynoos, R. S., Steinberg, A. M., & Piacentini, J. C. (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biological Psychiatry*, *46*, 1542-1554.
- Rennison, C. M. (2003). *Intimate partner violence 1993-2001: Bureau of Justice Statistics crime data brief*. Washington: US Department of Justice.
- Scheeringa, M. S., & Zeanah, C. H. (1995). Symptom expression and trauma variables in children under 48 months of age. *Infant Mental Health Journal*, *16*, 259-270.
- Scheeringa, M. S., Zeanah, C. H., Myers, L., & Putnam, F. W. (2005). Predictive validity in a prospective follow-up of PTSD in preschool children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *44*, 899-906.
- Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, *22*(1-2), 201-269.
- Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. *JAMA: Journal of the American Medical Association*, *301*(21), 2252-2259.
- Shonkoff, J. P., Garner, A. S., & The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics (2012). *The lifelong effects of early childhood adversity and toxic stress*. Available at <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;129/1/e232>
- Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women*, *11*(1), 38-64.
- Southwick, S. M., Rasmusson, A., Barron, J., & Arnsten, A. (2005). Neurobiological and neurocognitive alterations in PTSD: A focus on norepinephrine, serotonin, and the hypothalamic-pituitary-adrenal axis. In J. Vasterling & C. R. Brewin (Eds.), *Neuropsychology of PTSD: Biological, Cognitive and Clinical Perspectives* (pp. 27-58). NY: The Guilford Press.
- Spilsbury, J. C., Bellinston, L., Drotar, D., Drinkard, A., Kretschmar, J., Creedon, R., Flannery, D. J., & Friedman, S. (2007). Clinically significant trauma symptoms and behavioral problems in a community-based sample of children exposed to domestic violence. *Journal of Family Violence*, *22*, 487-499.
- Timmer, S. G., Ware, L. M., Urquiza, A. J., & Zebell, N. M. (2010). The effectiveness of Parent Child Interaction Therapy for victims of interpersonal violence. *Violence and Victims*, *25*, 486-503.
- Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Development and Psychopathology*, *14*(4), 877-908.

- Toth, S. L., Rogosch, F. A., Manly, J. T., & Cicchetti, D. (2006). The efficacy of Toddler-Parent Psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology, 74*(6), 1006-1016.
- Urquiza, A. J., Zebell, N. M. & Blacker, D. (2009) Blending play therapy with cognitive behavioral therapy. In A. A. Drews (Ed.). *Innovation and integration: Parent-Child Interaction Therapy as play therapy* (pp. 199-218). Hoboken, NJ: John Wiley & Sons.
- van IJzendoorn, M. H., & Kroonenberg, P. M. (1988). Cross-cultural patterns of attachment: A meta-analysis of the strange situation. *Child Development, 59*(1), 147-156.
- Weinfeld, N. S., Sroufe, A. L., Egeland, B., & Carlson, E. A. (1999). The nature of individual differences in infant caregiver attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment* (pp. 68-88). New York: Guilford Press.
- Ybarra, G. J., Wilkens, S. L., & Lieberman, A. F. (2007). The influence of domestic violence on preschool behavior and functioning. *Journal of Family Violence, 22*, 33-42.
- Zeanah, C. H. (Ed.). (2009). *Handbook of infant mental health*. New York: Guilford Press.