

The Link between Boys' Victimization & Adult Perpetration of Intimate Partner Violence:

Opportunities for Prevention across the Life Course





The Learning Network is a provincial knowledge translation and exchange initiative at the Centre for Research & Education on Violence Against Women & Children funded by the Government of Ontario through the Ontario Women's Directorate. With the guidance of its Provincial Resource Group, the Learning Network's mandate is to build knowledge on gender-based violence, including the enhancement of supports for survivors, training for professionals, public education, and evaluation.

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Suggested Citation:

Etherington, Nicole A. & Baker, Linda L. (2016).
The Link between Boys' Victimization and Adult
Perpetration of Intimate Partner Violence:
Opportunities for Prevention across the Life
Course. London, Ontario: Centre for Research &
Education on Violence Against Women & Children.
ISBN 978-0-9688655-4-5

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Introduction


Intimate partner violence (IPV) is a significant violation of human rights with profound consequences for health and well-being that affect individuals of all genders across the life course (Minerson, Carolo, & Jones, 2011).

In fact, IPV is associated with 8 out of 10 leading health indicators; namely, smoking, high risk alcohol use, injuries and homicide, mental health problems, risky sexual behaviour and sexually-transmitted infections, access to health care (e.g. increased risk of late entry into prenatal care), immunizations (e.g. children of abused women are less likely to get immunizations), and obesity or weight gain (U.S. Department of Health and Social Services, 2011). Further, groups who generally experience pronounced health disparities relative to the general Canadian population (e.g. Indigenous peoples, low socioeconomic status groups, persons with disabilities), are also at a significantly greater risk of IPV (Canadian Institute for Health Information, 2015; Health Council of Canada, 2013; Vecova Centre for Disability, 2011; WHO, 2010). Accordingly, violence is impacted by and influences many social determinants of health beyond its direct adverse impact on health itself.

IPV is a serious, pressing, and preventable public health issue that, while not gender-specific, is overwhelmingly perpetrated against women by men (Sinha, 2013; World Health Organization, 2014). In fact, one in every four violent crimes reported to police in Canada involves IPV, with women accounting for approximately 80% of IPV victims and men comprising 83% of perpetrators

of violence against women (Sinha, 2013). One risk factor for men's IPV perpetration is the experience of maltreatment in childhood; that is, neglect, abuse, or exposure to IPV (Smith et al., 2011; Renner & Whitney, 2012; Millett et al., 2013). While not all boys who experience violence as children become perpetrators of IPV, and not all men will use or condone gender-based violence, prevention efforts cannot overlook increasing evidence of an association between the two (e.g. Ireland & Smith, 2009; Gil-Gonzalez et al., 2007; Guedes & Mikton, 2013), or the high proportion of IPV perpetrators who are men.

Pathways to IPV perpetration are certainly complex and characterized by a myriad of factors, necessitating a multilevel and integrated response as part of a wider set of strategies aimed to improve health and well-being (Patel, 2011; Baker, Cunningham & Harris, 2011; Hill & Thies, 2010; Murphy, 2010; WHO, 2006). A public health approach to prevention emphasizes strategies that target known risk factors, intervene at optimal times or life stages, and involve multidisciplinary approaches (Lutzker & Wyatt, 2006; Spivak et al., 2014). In light of growing recognition of child maltreatment as a risk factor for IPV perpetration, the need to build and summarize evidence with specific implications for prevention and intervention efforts at different life stages has been identified (Gil-Gonzalez et al., 2007; Reed et al., 2008).



While it is important to recognize the wide range of factors involved in IPV perpetration, this discussion paper draws attention to the ways in which IPV prevention can be enhanced through identifying men at risk of becoming perpetrators at earlier points in their lives and mitigating the impact of experiences of violence through age-specific intervention programs (Carr & Vandeußen, 2002; Lutzker & Wyatt, 2006; Baker et al., 2011; Pepler, 2012; Teten Tharp, 2012; Langhinrichsen-Rohling & Capaldi, 2012).

Specifically, the aim of this paper is to identify pathways from childhood maltreatment to IPV perpetration in order to highlight these two forms of violence as intricately linked public health issues with implications for prevention across the life course.

Family Violence as a Public Health Issue across the Life Course

Describing Intimate Partner Violence, Child Maltreatment, and the Overlap

Intimate partner violence (IPV) is defined as violence committed by married, separated, divorced, common-law, dating, or other intimate partners (Statistics Canada, 2015). IPV can involve a range of abusive behaviours, including but not limited to physical, sexual, and psychological harm. It is distinguished from other forms of violence in the nature of the relationship between victims and abusers, which is generally ongoing, with potential emotional attachment and economic dependence (Statistics Canada, 2012). In addition, there tend to be multiple incidents of violence over time rather than single or isolated events.

The impact of violence in the context of IPV can extend beyond the direct victim to children who are exposed to the violence (Statistics Canada, 2012). Exposure to IPV, for the purposes of this paper, is included in the term child maltreatment along with neglect, emotional/psychological abuse, physical abuse, and sexual abuse. These various forms of maltreatment are defined in Table 1 and are in accordance with the Canadian Incidence Study (Public Health Agency of Canada, 2010). Typically, children are considered those individuals under 18 years of age (Murray & Graves, 2013).

While the majority of individuals who experience maltreatment in childhood do not engage in IPV, a large portion of men who perpetrate violence against their female partners were abused or exposed to family violence as a child (Baker & Stith, 2008; Holt, Buckley & Whelan, 2008; Vezina & Hebert, 2007). Furthermore, just as child maltreatment is a risk factor for future IPV perpetration, the presence of IPV is a risk factor for child maltreatment (Alhusen et al., 2014; Public

Health Agency of Canada, 2010). In fact, the co-occurrence of child maltreatment and IPV within families is well-documented in the literature, with prevalence estimates ranging from 30 to 60% (Edleson, 1999; Jouriles et al., 2008; Hamby et al., 2010).

Evidence from one large, representative survey indicates that over one third of children with exposure to IPV in the past year also experienced maltreatment, compared to just 9% of children with no IPV exposure (Hamby et al., 2010).

Not surprisingly, there are many common risk factors between IPV perpetration and child maltreatment perpetration, which exist at the individual, relationship, community, and societal level (bolded in Table 2; see also: Appendix A). The identified factors tend to be shared by abusers; however, it is also important to acknowledge diversity among men (see “Abusive Men” in Part II for more information). Understanding men’s pathways to IPV perpetration, then, involves further exploration of the maltreatment they may have experienced as boys, and preventing child maltreatment also involves working with perpetrators of IPV.

Table 1. Forms of child maltreatment and definitions

Physical Abuse	Any act of physical aggression directed toward a child (e.g. shaking, pushing, hitting with object, biting, choking).
Sexual Abuse	Sexual molestation or exploitation of a child by an adult or older child within or outside the family (e.g. penetration, fondling, pornography).
Emotional/psychological abuse	Terrorizing or threat of violence (e.g. threats against child's cherished objects), verbal abuse or belittling (e.g. name-calling), isolation or confinement (e.g. purposely cutting child off from other children), inadequate nurturing or affection (e.g. lack of parental interaction), exploiting or corrupting behaviour (e.g. encouraging involvement in criminal behaviour).
Neglect	Failure to provide for child's basic needs, adequate protection, and adequate supervision (e.g. inadequate nutrition, failure to provide medical treatment).
Exposure to intimate partner violence	Child is present during physical or verbal violence between intimate partners and can see and/or hear the violence (direct); child not present during violence but suffers consequences, hears about it, or experiences changes in his/her life as a result (indirect); child is exposed to emotional violence between intimate partners.

See: Public Health Agency of Canada, 2010.

Table 2. Risk factors for IPV perpetration

Individual Risk Factors	Relationship Risk Factors	Community Risk Factors	Societal Risk Factors
Low self-esteem Low academic achievement Young age Social isolation Low income Unemployment Alcohol/drug abuse Anger/hostility Insecurity/emotional dependence Depression Strict gender role beliefs Antisocial or borderline personality traits Aggressive behaviour or delinquency in adolescence Prior use of physical abuse or psychological aggression Prior experience of childhood physical or psychological abuse or neglect Exposure to IPV in childhood Experience of physical discipline in childhood	Financial stress Divorce/Separation Marital conflict Dominance/control by one partner Unhealthy family relationships	Poverty and related factors, such as overcrowding Lack of institutions, relationships, and norms that influence community's social interactions Weak sanctions by community (e.g. neighbours unwilling to intervene if witness IPV)	Traditional gender norms Gender inequality

Adapted from CDC, 2015. Bolded and italicized factors are also risk factors for child maltreatment.

Understanding Violence and Health from a Life Course Perspective

The life course perspective (see Bengtson, Elder, & Putney, 2012) provides a useful framework for understanding the impact of early experiences of victimization on later life perpetration of violence in its attention to long-term processes of human development and the context in which it occurs. Important concepts from the life course perspective include the interdependency of human lives, the importance of timing in the impact of certain events, and the link between early life events and later life outcomes. Accordingly, children's lives can be understood as inextricably linked to those of their parents or caregivers, with an emphasis on the potential importance of prevention and intervention efforts targeted at particular life stages. Early life circumstances and processes influence both health outcomes and risk for IPV perpetration across the life course.

In its emphasis on context, the life course perspective highlights the influence of such conditions as culture and access to resources. Factors such as unemployment and poverty can exacerbate the association between child maltreatment and subsequent IPV perpetration. Thus, interventions to support children and youth who have experienced or been exposed to violence require consideration of the larger surrounding context (e.g. family, community, culture) (Gerwitz & Edleson, 2007).

Finally, the life course perspective recognizes that early risk factors do not completely determine an individual's subsequent experiences given the potential for "turning points", or changes in the direction of one's life trajectory (Laub et al., 1998). In the case of breaking the link between child maltreatment and IPV, the capacity for successful prevention and intervention is critical.

Both child maltreatment and IPV are associated

with a number of adverse health outcomes across the life course, situating these forms of violence as public health issues requiring concentrated prevention efforts. The impact of these experiences of violence on health can result in both short- and long-term effects on health and well-being (see Figure 1). The impacts of violence can vary by developmental stage and accumulate over time, beginning in early life. Early childhood experiences in particular can significantly impact physical, cognitive, emotional, and social development as individuals age (Harvey et al., 2007).

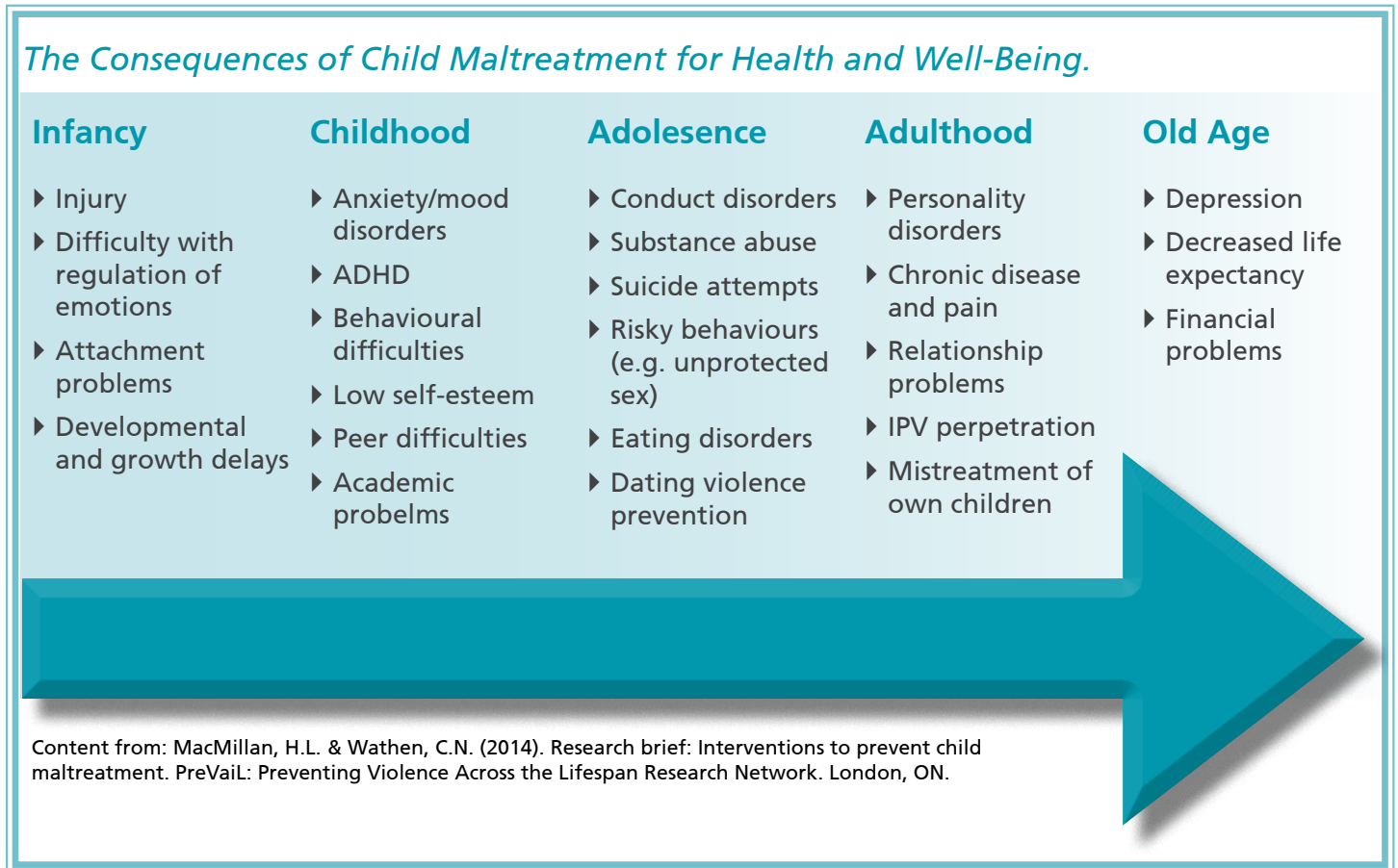
Child maltreatment is associated with such mental health outcomes as depression, anxiety, post-traumatic stress disorder (PTSD), psychopathy, oppositional-defiant disorder, conduct problems, attachment difficulties, difficulty in regulation of emotions, low self-esteem, eating disorders, substance abuse, and risky sexual behaviour (for reviews, see Widom, 2014; Hashima, 2014; Murray & Graves, 2013; Tscholl & Scribano, 2010; Sikes & Hays 2010; Gilbert et al., 2009). Dissociative disorders and personality disorders can also occur but are less common.



Taking a Life Course Perspective

- Human development is a lifelong process.
- Children's lives are intricately linked to those of their parents or caregivers.
- Early life experiences influence subsequent life outcomes.
- Context matters (e.g. culture, access to resources).
- "Turning points" are possible.

Figure 1. Associated consequences of family violence across the life course



Attempted suicide in adolescence and adulthood is linked to child maltreatment (Fergusson et al., 2008; Gilbert et al., 2009), and is particularly high among boys with victimization experiences (Murray & Graves, 2013). In later stages of the life course, the various forms of child maltreatment are predictive of physical difficulties, sleeping problems, head/brain injuries, eczema, central nervous system damage, learning and speech disorders, digestive problems, and increased risk of obesity, diabetes, poor lung functioning, liver disease, chronic pain, vision problems, kidney disease, oral health problems, chronic obstructive pulmonary disease (COPD), and ischemic heart disease (see Widom, 2014; Hashima, 2014; Murray & Graves, 2013; Tscholl & Scribano, 2010; Thackeray, Hibbard & Dowd, 2010).

Similar to child maltreatment, IPV has profound health consequences for adult survivors, including physical injury, disfigurement, permanent disability, and death. It is also associated with an increased risk of depression, anxiety, PTSD, hypertension, stroke, chronic pain, cardiovascular disease, irritable bowel syndrome, sexually transmitted infections, and adverse pregnancy outcomes such as low birth weight, premature labor, and neonatal/fetal death (for a review see Wathen, 2012; Black, 2011; Tscholl & Scribano, 2010). Table 3 summarizes the health consequences and risk behaviours associated with IPV with regard to adult survivors. Overall, childhood maltreatment and IPV reduce the health-related quality of life for those who experience or are exposed to these types of violence.

Table 3. Health impacts and health risk behaviours associated with intimate partner violence: Potential consequences for adult survivors

Brain and Nervous System	Cardiovascular System	Chronic Pain	Gastrointestinal System	Reproductive System	Genitourinary System	Mental Health Outcomes
Fainting Memory problems Speech difficulties Seizures Traumatic brain injury	Chest pain Hypertension High cholesterol Angina Cardiovascular disease Stroke Chronic obstructive pulmonary disease (COPD) Ischemic heart disease	Back pain Headaches Migraines Chronic fatigue Temporomandibular disorder Fibromyalgia	Decreased appetite Frequent indigestion Eating disorders Irritable bowel syndrome Constipation Diarrhea Spastic colon Inflammatory bowel syndrome Gastric reflux Functional gastrointestinal disorder Stomach ulcers	Adverse Pregnancy/ Child Outcomes Sexually transmitted infections Sexual dysfunction Pelvic pain Genital injuries Lack of sexual pleasure Hysterectomy Painful intercourse Painful menstruation Pelvic inflammatory disease Vaginal bleeding Gynecological disorders Interference with contraception Unintended pregnancy Forced/multiple induced abortions Unsafe abortions Pregnancy complications/ Miscarriage Delayed prenatal care Low birth weight Neonatal/fetal death Preterm delivery Premature labor	Genitourinary problems Bladder/kidney infections	Depression Anxiety/panic disorders Post-traumatic stress disorder Alcohol/drug abuse Psychosomatic disorders Phobias Insomnia Sleep disturbance Suicidal thoughts/behaviour and self-harm Psychological distress Nonaffective psychosis Social dysfunction Risk-taking/health risk behaviours (e.g. unsafe sexual behaviour, smoking, physical inactivity)

Adapted from Black, 2011.

Summary

Child maltreatment (neglect, abuse, or exposure to IPV) and intimate partner violence are important and overlapping public health issues with the capacity to negatively impact health and well-being from early to late life. A useful framework for understanding the relationship between these forms of family violence is that of the life course perspective, which situates violence and its perpetration in the context of its antecedents and consequences rather than focusing on a single point in time. With regard to health outcomes, it is apparent that violence has consequences for health at all life stages and that these impacts can accumulate over time. The link between early and late life will be increasingly apparent as this paper next turns to the association between childhood maltreatment and subsequent IPV perpetration, and later, risk and prevention across life stages.

Part I:

Connecting IPV Perpetration as an Adult & Victimization as a Boy



Part I: Connecting IPV Perpetration as an Adult and Victimization as a Boy

Men's childhood experiences with abuse, neglect, and exposure to IPV are often under-recognized and subsequently remain untreated (Haegerich & Hall, 2011). Acknowledging the victimization experiences of perpetrators of IPV, however, is important given the association between the two.

Recent Canadian statistics indicate annual investigation of 119, 336 cases of child maltreatment (abuse, neglect, IPV exposure) involving boys under the age of 15 (Public Health Agency of Canada, 2010). The experience of maltreatment in childhood appears to be linked to violent behaviour in general, with abused and/or

neglected children having an increased likelihood of arrest for violent crime in adolescence and adulthood (English et al., 2001). Boys exposed to IPV are also more likely to "approve of violence, to believe that violence improves one's reputation, and to justify their own violent behaviour" (Roberts et al., 2010, p.2). Finally, a history of violence in childhood is a significant predictor of IPV perpetration and male perpetrators from violent backgrounds have been found to have greater hostility and negative attitudes toward women (Ehrensaft et al., 2003; Lee et al., 2013).

Not surprisingly, the association of childhood maltreatment with an increased risk of future IPV perpetration has been highlighted as one of the most important findings in the field of IPV and a critical direction for future research and policy endeavours (Langhinrichsen-Rohling, 2005). It follows that prevention of IPV should address childhood experiences and should also include the prevention of child maltreatment.

1.1 Theoretical Explanations

There are many proposed explanations for the intergenerational transmission of violence including: trauma theory, social learning theory, attachment theory, power theory, neurophysiological models, and social information processing. These perspectives are reviewed briefly below and summarized in Table 4.

i. Trauma Theory

While not all individuals develop traumatic reactions to experiences of violence, abuse, neglect, and IPV exposure in childhood are related to the onset of post-traumatic stress symptoms (PTSS) and disorder (PTSD). PTSS/D and traumatic stress increase the risk of other internalizing and externalizing symptoms, poor cognitive functioning, aggression, depression, and poor long-term adjustment, for example (Katz et al., 2015). Unresolved trauma surrounding maltreatment in childhood – whether due to abuse or IPV exposure – is also associated with IPV perpetration (Marshall et al., 2011; Howard, 2012; Reingle et al., 2014; Maguire et al., 2015).

According to a trauma perspective, children who experience severe, early, and chronic violence may come to detach from emotion and compassion as a survival mechanism (Garbarino, 1999). This detachment can facilitate the intergenerational transmission of violence through inhibiting empathic engagement, rationalizing aggressive behaviours, and minimizing the impact of violence on the victim. “Survival mode” functioning can also be triggered by perceived environmental threats, activating a cognitive, behavioural, and psychological response process that stimulates anger structures (Bell & Orcutt, 2009). This stimulation results in heightened arousal and hostile appraisal which can prevent reappraisals

of threat and the evaluation of alternative ways of responding. In addition, experiences of trauma can cause dysregulation of anger and arousal, which are risk factors in themselves for future IPV perpetration. Research stemming from the neurobiological perspective supports these processes, demonstrating that an overactive fight or flight response can inhibit emotional regulation and self-soothing (van der Kolk & Greenberg, 1987; see also, Graham-Berman et al., 2012; Graham-Berman & Seng, 2005). Specifically, individuals may interpret social interactions as more threatening, resulting in an elevation of negative emotions. Coupled with poor emotional regulation skills, this elevation can contribute to aggressive responses (Marshall et al., 2011).

ii. Social Learning Theory

According to social learning theory, children develop attitudes and behaviours that they carry into their adult intimate relationships through imitation and internalization of principles learned in the family environment (Bandura, 1977). Children learn behaviours through modeling the behaviour of others, especially parents, and come to learn what is considered acceptable behaviour and effective ways to solve problems. Exposure to family violence, then, increases the risk that children will endorse violent behaviour in their own relationships (Ireland & Smith, 2009; Eriksson & Mazerolle, 2015). Violence, in essence, is normalized and legitimized. It is also hypothesized that violence is maintained in adulthood if it has been reinforced by positive outcomes or has served a purpose (Mihalic & Elliott, 1997; Riggs & O’Leary, 1989); that is, a person comes to expect similar outcomes from future violence, and continues their use of physical aggression. Reinforcement does not need to be direct as simply observing positive

outcomes of violence can be enough to determine a person's future engagement in similar behaviours (Riggs & O'Leary, 1989).

iii. Attachment Theory

Attachment, or the early bond formed between infants and their primary caregiver(s), is postulated to serve as the basis of children's orientation toward the world, shaping subsequent interpersonal interactions (Bowlby, 1969).

Secure attachment develops through responsive caregiving, such as soothing an infant when they are crying or feeding them when they are hungry. Attachment theory suggests that when this security is disrupted, as is the case in instances of child maltreatment, children come to view the world and others with hostility and respond with aggression, which can turn into violent behavior in adulthood (Ainsworth, 1989; Egeland, 1993; see also, Levendosky et al., 2011, 2012). Experiences of violence in early childhood provide an understanding of relationships as unpredictable and dangerous. Attachment can also continue to play a role as children get older, with research demonstrating that children who experience maltreatment (abuse or IPV exposure) tend to be less attached to their parents in adolescence (Sousa et al., 2011). Attachment to parents during this critical life stage can be an important protective factor against violent behaviour.

iv. Power Theory

This perspective locates the roots of violence in both culture and the family structure (Straus, Geilles, & Steinmetz, 1980). Social acceptance of violence, gender inequality, and family conflict are thought to interact and shape partner abuse in addition to increases in family tension. Tension within a family can rise as a result of economic hardships, power imbalances between partners,

and high levels of stress (Sagrestano, Heavey, & Christensen, 1999). Like social learning theory, power theory hypothesizes that children learn to use violence to address conflict through witnessing abuse or experiencing it themselves (Straus et al., 1980).

v. Neurophysiological Models

Repeated exposure to child maltreatment can trigger a physiological stress response in children that adversely affects neurological development (De Bellis, 2001). As a result, children's abilities to cope with stress, plan, manage emotional arousal, and make decisions are compromised. Multiple physiological systems (e.g. sympathetic nervous system, catecholamine system) are involved in the body's response to stress. Dysregulation of these systems through chronic exposure to stress can create an elevated stress response, which may cause individuals to become aggressive in stressful situations. Empirical evidence from animal studies supports this neurobiological model (see, for example, Sanchez & Pollack, 2009; Grace et al., 2011), but further examination among children is required. Nevertheless, evidence does exist regarding the substantial and damaging impacts of chronic stress on individuals' mental and physical health (see Thoits, 2010, for a review).

vi. Social Information Processing

Severe physical abuse before age 5 has been posited to result in social information processing deficiencies, whereby children interpret ambiguous or harmless interactions as hostile and react aggressively (Dodge, Bates, & Pettit, 1990). These patterns of social information processing are associated with chronic aggressive behaviour.

Table 4. Intergenerational cycle of violence: Theoretical perspectives

Theory	Central Tenets
Trauma Theory	<ul style="list-style-type: none">• Onset of post-traumatic stress symptoms/ disorder related to child maltreatment.• Dysregulated experience and expression of anger leads to heightened perception of threats.• Aggressive behaviours result from cognitive, behavioural, psychological responses.
Social Learning Theory	<ul style="list-style-type: none">• Attitudes and behaviours learned in family environment.• Violence learned, normalized and legitimized.
Attachment Theory	<ul style="list-style-type: none">• Violence disrupts secure attachment.• Relationships viewed as unpredictable/ dangerous.• Hostile orientation toward others.
Power Theory	<ul style="list-style-type: none">• Violence rooted in power imbalances and inequalities, which can create tension in families.• Violence learned as an effective way to address conflict.
Neurophysiological Models	<ul style="list-style-type: none">• Violence viewed as a chronic stressor.• Repeated exposure can result in dysregulation of biological systems.• Elevated stress response can cause individuals to respond to stressful situations with aggression.
Social Information Processing	<ul style="list-style-type: none">• Abuse creates deficiencies in ability to process social information.• Ambiguous/harmless interactions interpreted as hostile, resulting in aggressive reaction.

1.2 Reviewing the Evidence

It is important to remember that not all perpetrators of intimate partner violence (IPV) have experienced child maltreatment (abuse, neglect, IPV exposure) and that there can be many different pathways leading to IPV perpetration. Additionally, child maltreatment is not always the only factor in the intergenerational transmission of violence as it can interact with or be shaped by many other contextual factors or individual characteristics (see Bell & Naugle, 2008).

It is also important to note that there can be various experiences of transmission. Full transmission refers to the high probability of perpetration of physical and severe psychological violence. Psychological transmission is the high probability of perpetrating minor psychological aggression only. No transmission means that a

parent's use of violence was not passed on to the next generation (Rivera & Fincham, 2015). Indeed, some research finds child maltreatment is no longer predictive of subsequent IPV perpetration once other risk factors for IPV are taken into account; some report only a moderate rather than strong association, while other research finds a stronger link between child maltreatment and IPV perpetration for women than men; and some evidence indicates that it may actually be specific experiences of abuse rather than all forms of child maltreatment that are related to future involvement in IPV (e.g Fergusson, Boden, & Horwood, 2006; Maas, Herrenkohl, & Sousa, 2008; Jennings et al., 2013; Trabold et al., 2015; Tomsich et al., 2015).

Nevertheless, the relationship between experiencing maltreatment in childhood and perpetrating IPV in adulthood is generally supported by cross-sectional and longitudinal evidence from a large number of rigorous studies spanning across many populations (see Tables 5 and 6) as well as theoretical plausibility (Roberts et al., 2010). In other words, the theoretical frameworks discussed previously provide credible explanations for the link between childhood maltreatment and future IPV perpetration, in addition to being supported by empirical studies.

i. Cross-sectional Studies

Much of what is known about the link between child maltreatment and future IPV perpetration stems from cross-sectional, retrospective studies. In general, boys who have experienced maltreatment have a higher risk for perpetrating violence against women as they grow older than boys with no such experiences (Ehrensaft et al., 2003; White & Widom, 2003; McKinney et al., 2008; Widom, Czaja, & Dutton, 2014). Studies based on samples of abusive men also find that many perpetrators of IPV were exposed to family violence or experienced some form of violent victimization as children (Murrell, Christoff, & Henning, 2007; Stover, Meadows, & Kaufman, 2009; Adams, 2009). In a recent study, 60% of male perpetrators experienced some form of violent victimization in childhood (Asleland et al., 2010).

Research using the Adverse Childhood Experiences (ACE) Study, a large US-based survey, indicates that the experience of physical abuse, sexual abuse, or exposure to IPV in childhood approximately doubles the risk of IPV perpetration for men (Whitfield et al., 2003). When all three types of maltreatment are present, this risk appears to increase by four times. Research using high-

risk samples, such as individuals arrested for a range of offences, finds that men who observed IPV as children are significantly more likely to use violence in their intimate relationships than men without any exposure to IPV in childhood (Eriksson & Mazerolle, 2015).

Other representative cross-sectional surveys based on the US general population also find that serious child maltreatment increases the risk of future IPV perpetration (McMahon et al., 2015; Franklin & Kercher, 2012), and that this risk becomes further elevated when combined with recent adult stressors (Roberts et al., 2010; Roberts et al., 2011). Finally, US studies based on representative samples of couples as well as undergraduate students find associations between physical abuse or exposure to IPV in childhood and men's perpetration of IPV against female partners in young adulthood (Caetano & Field, 2005; Holt & Gillespie, 2008).

A summary of cross-sectional evidence for the relationship between childhood maltreatment and subsequent IPV perpetration is provided in Table 5. Perpetration outcomes are highlighted for boys/ men only.

Table 5. Summary of cross-sectional evidence for the association between child maltreatment and future IPV perpetration by men

Citation	Sample	Type and Timing of Maltreatment	Mediators	Moderators	Other Covariates	Significant Outcomes & Life Stage
Eriksson & Mazerolle, 2015	Male arrestees (N=303)	Physical abuse (PA) IPV exposure (E) Childhood	Attitudes justifying partner abuse	N/A	Age Education Race/ethnicity Alcohol/drug use	Physical IPV perpetration (E) ** Adulthood
McMahon et al. 2015	11850 men 13928 women	Sexual abuse (SA) Physical abuse (PA) Emotional abuse (EA) Emotional Neglect (EN) Physical Neglect (PN) Child maltreatment (shared effect of above) (CM) Prior to age 17	N/A	Gender	Age Personal income Education Race/ethnicity	IPV perpetration*** (CM) Reciprocal violence • CM*** • SA*** • EN*** • PN*** Adulthood
Franklin & Kercher, 2012b	189 men 360 women	IPV exposure (E) Physical punishment (e.g. spanking) (PP) Childhood	Acceptance of use of violence in relationship General alcohol consumption Masculine gender orientation	N/A	Gender Age Race/ethnicity Education Employment status Religiosity Relationship status	IPV perpetration (any) (E,PP)* Psychological IPV perpetration (E,PP)* Adulthood
Roberts et al., 2011	14564 men 20089 women	Physical abuse (PA) Emotional abuse (EA) Sexual abuse (SA) Emotional neglect (EN) Physical neglect (PN) IPV exposure (E) Prior to age 18	Adulthood stressors: financial, relationship, crime and violence, other (e.g. illness)	Gender	Family dysfunction (e.g. divorce) and adversity (e.g. poverty) Traumatic childhood events	IPV perpetration • PA* • E** • EA** • SA** Adulthood

Table 5. Summary of cross-sectional evidence for the association between child maltreatment and future IPV perpetration by men

Roberts et al., 2010	14564 men	IPV exposure Prior to age 18	N/A	N/A	Neglect Psychological abuse Physical abuse Sexual abuse Family structure Parental characteristics Traumatic childhood events Family history (e.g. antisocial personality disorder) Race/ethnicity Age Immigrant status Childhood poverty Childhood family emotional support	IPV perpetration* Adulthood
Asleland et al., 2010	480 men	Physical abuse (PA) Sexual abuse (SA) Psychological abuse (PSA) IPV exposure (E) Childhood/ adolescence	N/A	N/A	Age Ethnicity Marital status Occupation First contact (treatment) Type of therapy When terminated therapy Cause of terminating	Adulthood IPV perpetration: • sexual violence (SA)** • psychological violence (PA)**
Holt & Gillespie, 2008	147 men 276 women	IPV exposure Childhood	N/A	Gender	Self-esteem Narcissistic features	IPV perpetration* Adulthood
McKinney et al., 2008	1615 heterosexual couples (50% of sample = men)	Moderate/severe physical abuse (PA) IPV exposure (E) Prior to age 18.	Alcohol consumption	Gender	Ethnicity Age Household income Employment status Education Drug use Attitudes approving IPV	Nonreciprocal male-to-female partner violence (PA)* Reciprocal IPV (PA/E)* Adulthood
Murrell, Christoff, & Henning, 2007	1099 abusive men	IPV exposure (E) Abuse (A) Exposure/abuse prior to age 16	N/A	N/A	Psychopathology of offender (antisocial, borderline, dependent, depressive, narcissistic) Age Race Education	IPV perpetration (E, A)** Adulthood

Table 5. Summary of cross-sectional evidence for the association between child maltreatment and future IPV perpetration by men

Banyard et al., 2006	N=980 (48% male)	Physical abuse Sexual abuse Childhood	N/A	Gender	Alcohol/drug use Depressed mood/worries Parental divorce Parental monitoring Neighbourhood monitoring Neighbourhood support School attachment Sense of social responsibility	Dating violence perpetration *** Adolescence
Caetano & Field, 2005	1635 heterosexual couples (50% male)	Physical abuse (PA) IPV exposure (E) Childhood	N/A	Race/ethnicity Gender	Alcohol consumption Alcohol problems Approval of marital aggression Age Income Marital status Education	IPV perpetration (PA)* Adulthood
Whitfield et al., 2003	3955 men 4674 women	Physical abuse (PA) Sexual abuse (SA) IPV exposure (E) Prior to age 18	N/A	Gender	Age Gender Education level Race	IPV perpetration (SA, PA, E) ** Adulthood
Wolf & Foshee, 2003	675 men 687 women	Physical abuse (PA) IPV exposure (E) Prior to age 14	Anger expression style	Gender	Race/ethnicity	Dating violence perpetration* Adolescence
Carr & Vandeußen, 2002	99 men	Physical abuse (PA) IPV exposure (E) Childhood	Sexual experiences Hostility toward women Adversarial sexual beliefs scale Acceptance of interpersonal violence Rape myth acceptance scale	N/A	N/A	IPV perpetration (E)*** Adulthood

^a Child maltreatment includes abuse, neglect, and IPV exposure (PHAC, 2010).

^b This study did not separate effects on perpetration by gender.

* p<0.05 ** p<0.01 *** p<0.001

ii. Longitudinal Studies

Longitudinal research reflects that young adulthood appears to be a key timeframe for the emerging effects of child maltreatment and is predictive of the association between child maltreatment and later IPV perpetration as men get older.

Many studies link child maltreatment to dating or intimate partner violence in adolescence and young adulthood (Carr & Vandusen, 2002; Wolf & Foshee, 2003; Banyard et al., 2006; Widom et al., 2006; Wolfe, Crooks, Chiodo, & Jaffe, 2009; Fang & Corso, 2008; White & Smith, 2009; Cui et al., 2010, 2013; Gomez, 2010; Whitaker, Lee, & Niolon, 2010; Smith et al., 2011; Renner & Whitney, 2012; Jouriles et al., 2012; Narayan, Englund, & Egeland, 2013) as well as violent delinquency (e.g. Fergusson et al., 2006; Crooks et al., 2007; Millett et al., 2013).

Involvement in violence as an adolescent or young adult is often a mediator in the relationship between child maltreatment and later IPV. For

example, childhood neglect and physical abuse has been found to have an indirect effect on IPV perpetration through youth violence, while childhood sexual abuse strongly and directly predicts IPV perpetration (Fang & Corso, 2008). Similarly, Smith and colleagues (2011) find exposure to IPV in adolescence to increase the risk of IPV perpetration in early adulthood (age 21-23), and an indirect effect on later adult IPV perpetration mediated through involvement in relationship violence as a young adult. Prospective longitudinal studies such as these provide support to findings from the cross-sectional research discussed previously.

A summary of longitudinal evidence for the relationship between childhood maltreatment and IPV perpetration is provided in Table 6. Perpetration outcomes are highlighted for boys/men only.

Table 6. Summary of longitudinal evidence for the association between child maltreatment and future IPV perpetration by men

Citation	Sample	Type and Timing of maltreatment	Mediators	Moderators	Other Covariates	Significant Outcomes and Life Stage
Widom, Cjaza, & Dutton, 2014	586 men 610 women	Physical abuse (PA) Sexual abuse (SA) Neglect (N) Abuse/neglect occurring 0-11 years of age	N/A	Gender	Age Race	IPV perpetration (N)* Adulthood
Narayan, Englund, & Egeland, 2013 ^b	87 men 81 women	IPV exposure Early (0-64 months) and middle childhood (grades 1-3)	Externalizing behaviour Teen dating violence	N/A	Maternal age Family SES (prenatal) Child abuse/neglect Adult life stress	IPV perpetration** Early Adulthood
Cui et al., 2013 ^b	1548 men 1972 women	Physical abuse Prior to 6th grade	Relationship violence in young adulthood	N/A	General aggression Relationship type Race/ethnicity Family structure Parents' education	IPV perpetration** Young adulthood
Renner & Whitney, 2012	4950 men 5237 women	Physical abuse (PA) Sexual abuse (SA) Neglect (N) Prior to 6th grade	Youth violence perpetration and victimization	Gender	Self-esteem Depressive symptoms Prior suicide attempts Education Age Relationship status Alcohol problems	IPV perpetration Young adulthood - N** - SA***
Jouriles et al., 2012	43 men 45 women Juvenile justice system	IPV exposure Childhood	Trauma symptoms	Gender	Race/ethnicity Family income	Dating violence perpetration* Adolescence
Smith et al., 2011	730 men 270 women	IPV exposure Adolescence	IPV perpetration in early adulthood	Gender	Child physical abuse Race/ethnicity Family poverty Family transitions Parental education	IPV perpetration** Adulthood
Cui et al., 2010 ^b	102 men 111 women	IPV exposure Physical abuse Psychological abuse Adolescence	N/A	N/A	Parental education Gender Marital status Relationship duration	IPV perpetration** Adulthood

Table 6. Summary of longitudinal evidence for the association between child maltreatment and future IPV perpetration by men

Gomez, 2010	2179 men 2012 women	Abuse Prior to sixth grade	N/A	Gender	Adolescent dating violence victimization Parents' income Family structure Education Relationship status Immigrant status Race/ethnicity	IPV perpetration*** Young adulthood
Whitaker, Lee, & Niolon, 2010 ^b	2986 men 3550 women	Abuse/neglect Adolescence	Relationship aggression	N/A	Age Race/ethnicity Education Relationship characteristics (e.g. ever had sex, age difference)	IPV perpetration* Young adulthood
White & Smith, 2009	851 men	Physical abuse (PA) Sexual abuse (SA) IPV exposure (E) Prior to age 14	N/A	N/A	Relationship status Number of dating and sexual partners	Perpetration of physical/sexual aggression against intimate partner (E)* Young adulthood
Ireland & Smith, 2009 ^b	730 men 270 women	IPV exposure Adolescence	Adolescent antisocial behaviour (e.g. violent crime)	N/A	Race/ethnicity Gender Family poverty Family transitions Physical abuse	IPV perpetration* Young adulthood
Fang & Corso, 2008	4162 men 5190 women	Physical abuse (PA) Sexual abuse (SA) Neglect (N) Prior to sixth grade	Youth violence perpetration	Gender	Family background Adolescent individual factors Adolescent community factors	IPV perpetration - N** - SA*** Adulthood
Fergusson et al., 2008	391 men 437 women	Sexual abuse (SA) Physical abuse (PA) IPV exposure (E) Prior to age 18	Early aggressive behaviour Child conduct problems Conduct disorder Adolescent violent offending Mental disorders	Gender	Parental education Family living standards Family socioeconomic status Family functioning (e.g. parental drug use, parental criminality)	IPV perpetration - SA** - PA* - E** Young adulthood
Linder & Collins, 2005 ^b	58 men 63 women	Physical abuse (PA) IPV exposure (E) 2 to 6 years old	Parent-child interaction quality Negative affect Adolescent friendship quality	N/A	Age Race/Ethnicity Family background	IPV perpetration - PA** - E* Young adulthood

Table 6. Summary of longitudinal evidence for the association between child maltreatment and future IPV perpetration by men

Ehrensaft et al., 2003 ^b	243 men 298 women	Physical abuse (A) Neglect (N) IPV exposure (E) Prior to 18 years of age	N/A	N/A	Parental socioeconomic status ODD Conduct disorder Alcohol/drug abuse Parenting practices	IPV perpetration - PA* - N** Adulthood
White & Widom, 2003	446 men 493 women	Abuse/neglect Substantiated cases of abuse/neglect where children were less than 12 years of age	Early aggressive behaviour Adult antisocial personality disorder Hostility Problem drinking	Gender	Race/ethnicity	Physical IPV perpetration* Adulthood

^aChild maltreatment includes abuse, neglect, and IPV exposure (PHAC, 2010).

^bThis study did not separate effects on perpetration by gender.

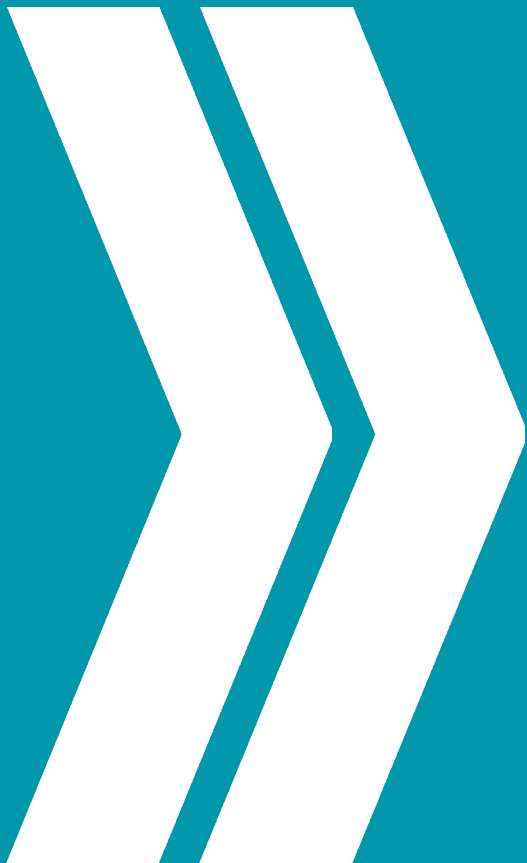
*p<0.05 **p<0.01 ***p<0.001

Summary: Part I

Research in the area of IPV has increasingly drawn attention to the importance of examining the link between maltreatment experienced by boys and future perpetration of violence against their intimate partners. Both cross-sectional and longitudinal studies have found support for this association, with various experiences of maltreatment — neglect, sexual abuse, physical abuse, emotional/psychological abuse, and IPV exposure — significantly predicting IPV perpetration in adulthood. These studies provide support for the various theoretical frameworks that have been used to explain potential mechanisms behind the intergenerational transmission of violence, including trauma theory, social learning theory, attachment theory, power theory, neurophysiological models, and social information processing. Of course, not all research finds support for the link between childhood victimization and IPV perpetration and there are many pathways to violence, affected by co-existing adversities such as poverty and life stress. Nevertheless, a substantial and growing body of evidence points to the importance of understanding the victimization experiences of men and boys as a critical avenue for prevention and intervention.

Part II:

IPV Prevention across the Life Course



Part II: IPV Prevention across the Life Course

2.1 Situating Violence and Prevention

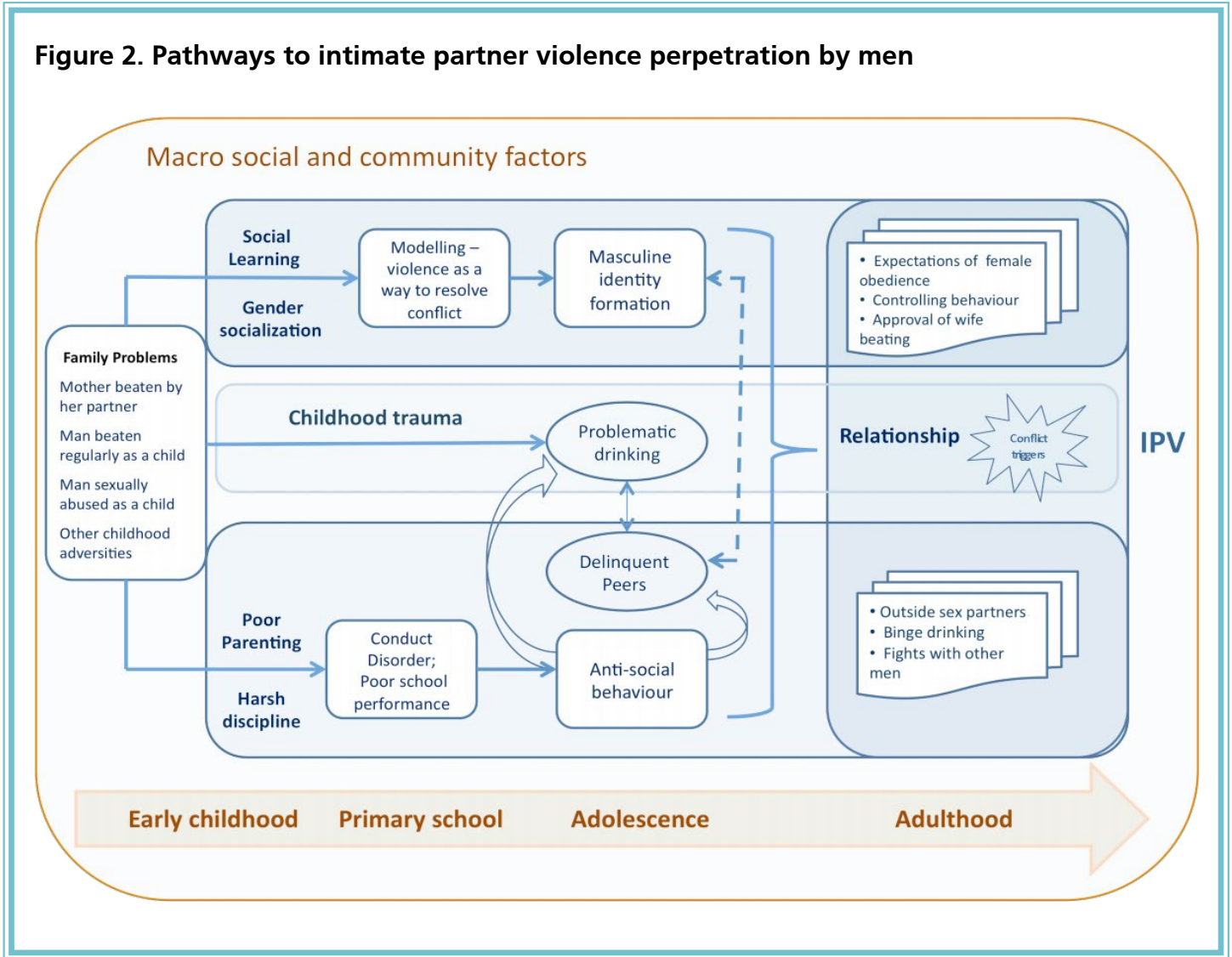
Pathways to IPV perpetration are complex and require a multifaceted approach to prevention. This paper focuses on one specific pathway; namely, childhood maltreatment — neglect, abuse, or IPV exposure — and subsequent perpetration of IPV among adolescent boys and men. Prior to examining the implications of this link for primary, secondary, and tertiary prevention efforts across the life course, it is first necessary to highlight some of the complexities of violence in terms of the various contextual factors that can be at play as well as heterogeneity among men. While an in-depth exploration of these factors is beyond the scope of this paper, it is important to recognize their influence on pathways to violence and their potential implications for prevention initiatives for boys and men.

When examining each life stage and corresponding models of prevention in the section to follow, it is important to consider co-existing and contextual risk factors such as poverty, the age of parents, the presence of disabilities among children, socioeconomic conditions, and parental substance abuse (see Murray & Graves, 2013 for a review). Many of these factors and other adversities can exacerbate the link between child maltreatment


and IPV (e.g. Foshee et al., 2005; Fergusson et al., 2006; Herrenkohl et al., 2008; Roberts et al., 2011). The intergenerational cycle of violence is situated within a larger system of stressors, such as poverty and racism, which can also be experienced across generations (Eckhardt et al., 2013). Prevention programs should therefore include initiatives developed for particular at-risk groups and communities, with culturally-sensitive applications (Jain et al., 2010; Foshee et al., 2007). In fact, attending to a family's social, economic and cultural context is considered essential for successful intervention (Gewirtz & Edleson, 2007).

Also, what it means to “be a man” and masculinities vary among and within different cultural and ethnic groups of men (Flood, 2013). Attitudes toward women, behaviours, and beliefs are also shaped by these and other factors, such as education level (e.g. Welland & Ribner, 2010). These attitudes, behaviours, and beliefs toward women and about masculinity play key roles in men's pathways to violence (Heise, 2011). The complexity of the aforementioned and other factors in men's perpetration of violence across the life course is summarized in Figure 2.

Figure 2. Pathways to intimate partner violence perpetration by men



Source: Heise, 2011.



Beyond factors such as race/ethnicity, employment, and education, there are many other dimensions that can influence men's treatment needs. Men who engage in IPV are a heterogeneous group and efforts have been made to develop typologies, which may guide differential responses and influence treatment outcomes (Cantos & O'Leary, 2014).

While the usefulness of such typologies has been debated, there is increased attention to customized intervention.

First, approaches to treatment can differ depending on the life stage of the perpetrator and the stage of the relationship (Cantos & O'Leary, 2014). For example, dating violence in teen years, a man in his early twenties in the first year of his marriage, and a middle-aged man who has been abusing his partner for fifteen years, are situations with different issues to be addressed.

Second, the timing, type and severity of the abusive behaviour can vary by perpetrator (Cantos & O'Leary, 2014) and may warrant differential responses (e.g. early intervention, more comprehensive programs).

Third, abusive men can vary in regards to the presence or absence of alcohol and drug abuse, a history of attachment difficulties, and their motivations for treatment/readiness for change that require a range of sequential and/or concomitant intervention.

Lastly, whether violent victimization or exposure to family violence in childhood occurred must be considered, as these experiences can be relevant to intervention for some offenders, though never justification for abusive behaviour (Cantos & O'Leary, 2014).

2.2 Primary, Secondary and Tertiary Prevention

It is clear that early experiences of violence can be precursors of later violence perpetration, which has important implications for primary, secondary, and tertiary prevention efforts.

Primary prevention aims to intervene before the occurrence of IPV by preventing the development of associated risk factors, such as child maltreatment (Perlson & Greene, 2014). Secondary prevention is targeted to individuals at high risk of experiencing or perpetrating child maltreatment or IPV, with the goal of preventing its occurrence or progression. Tertiary prevention occurs after child maltreatment or IPV has been identified, with interventions designed to minimize its impact for survivors and decrease the risk of recurring abusive behaviour by perpetrators (Perlson & Greene, 2014). At each point of prevention, the objective is to increase the effectiveness of strategies designed to prevent IPV or child maltreatment perpetration in the first place, their reoccurrence, and their associated negative impacts.

While there are many existing prevention strategies, this paper focuses on those that are evidence-based in that they are based on results from randomized control trials¹, and to a lesser extent, strategies with emerging evidence that are considered promising. Accordingly, this paper reviews a sample of strategies for primary, secondary, and tertiary prevention with existing evaluations. The list provided is not meant to be exhaustive. Attention is also given to life stage as a public health/life course approach to prevention emphasizes optimal times for intervention (Lutzker & Wyatt, 2006), and the timing of prevention

programs has been found to be important in program efficacy (Langinrichsen-Rohling & Capaldi, 2012). Finally, while women do perpetrate child maltreatment and this may also be important in looking at the link between maltreatment and IPV prevention, for the purposes of this paper, the focus is on boys and men.

Prevention programs specific to life stage will be reviewed first, with programs focused on multiple life stages (e.g. infancy/pre-school and school-age) reviewed in a later section.

1 For the purposes of this paper, we defined "evidence-based" as studies which used randomized control trials; however, we recognize that there are many other forms of evidence that can be used to inform policies and practice.



Levels of Prevention

Primary prevention: aims to intervene before the occurrence of IPV by preventing the development of associated risk factors, such as child maltreatment.

Secondary prevention: targeted to individuals at high risk of experiencing or perpetrating child maltreatment or IPV, with the goal of preventing its occurrence or progression.

Tertiary prevention: occurs after child maltreatment or IPV has been identified, with interventions designed to minimize its impact for survivors and decrease the risk of recurring abusive behaviour by perpetrators.

2.3 Evidence-based and Promising Prevention by Life Stage

i. Infancy/Pre-School

Sexual abuse, physical abuse, psychological abuse, and neglect occur most frequently when children are 0-3 years old, and decrease as children get older (Gerwitz & Edleson, 2007). Given the vulnerability, dependency, and relative social invisibility of infants and pre-school children, it follows that they experience such a high risk of fatal maltreatment (WHO, 2006). Pre-school age children are also at a greater risk of exposure to IPV than older children (Fantuzzo & Fusco, 2007). IPV exposure may have particularly negative effects for children of pre-school age because they spend a significant amount of time with their parents and have limited peer/academic outlets to escape or cope with the violence. Higher rates of aggression, fighting, and antisocial behaviour can result as well as difficulties with emotional and behavioural regulation, leading to episodes of aggression later in life.

Evidence-Based Programs

Table 7 summarizes three evidence-based programs targeted at this life stage, two of which operate at the secondary level of prevention (Nurse-Family Partnership; Healthy Start Program) and one at the tertiary level (Child-Parent Psychotherapy). Initiatives tend to focus on the primary caregiver or

both parents, although child-parent psychotherapy also involves children in treatment.

The efficacy of each program has been assessed using randomized control trials, exhibiting an impact on several early life risk factors for later perpetration of violence, such as increasing secure attachment among children (Child-Parent Psychotherapy), reducing child behaviour problems (Nurse-Family Partnership; Child-Parent Psychotherapy), reducing trauma symptoms (Child-Parent Psychotherapy), and reducing incidents of child abuse/neglect as well as IPV (Nurse-Family Partnership; Healthy Start Program). Although studies of these programs have not specifically examined subsequent adult IPV perpetration among participating children, research demonstrates that the aforementioned outcomes counter risk for engagement in future IPV (e.g. Levendosky et al., 2011, 2012; CDC, 2015; Maguire et al., 2015; Fang & Corso, 2008).

One program, Child-Parent Psychotherapy, will be featured here, and details on the other two programs can be found in Table 7, with additional information available in the cited selected references.

Table 7. Summary of evidence-based child maltreatment/future IPV prevention programs: Infancy/pre-school

Program Name	Level of Prevention	Purpose/Description	Significant Outcomes	Selected References
Nurse-Family Partnership	Secondary	<ul style="list-style-type: none"> Targets low-income families experiencing first-time pregnancy with the goal of assessing quality of relationships and identifying violence before it starts. Program also aims to improve pregnancy outcomes, child health and development, and economic self-sufficiency of family. Home visits by registered nurse from pregnancy until baby is 2 years old. 	<ul style="list-style-type: none"> Improvement in parenting skills (mothers) and children's developmental outcomes. Reduction in child abuse and neglect. Increase in father involvement. Reduction in emergency room visits for accidents and poisoning. Reduction in child arrests at age 15. Reduction in behavioural/intellectual problems at age 6. Acceptability and effectiveness with fathers currently being tested in Canada and US: initial positive experiences. 	<p>Nurse Family Partnership, 2014; Ammerman & Teeters, 2013; Canadian Nurse Family Partnership, 2011</p>
Healthy Start Program	Secondary	<ul style="list-style-type: none"> Aims to prevent child abuse/neglect and promote child health and development among families with newborns at risk for poor child outcomes (e.g. families where intimate partner violence, poor mental health, parental substance use, etc. present). Two components: (1) early identification of families with newborns at risk of abuse/neglect; (2) home visiting by trained paraprofessionals (up to age 3; continue until age 5 if necessary). Frequency of home visits decreases as family functioning improves. 	<ul style="list-style-type: none"> Moderate prevention of neglect. Reduction in incidents of physical partner violence. Greater accessibility, engagement, and sharing of responsibility among violent fathers who saw child's mother infrequently at baseline. 	<p>Duggan et al., 1999, 2004a, 2004b</p>
Child-Parent Psychotherapy	Tertiary	<ul style="list-style-type: none"> Targets children age 0-5 who have experienced a trauma and their caregivers. Child and primary caregiver participate in treatment together with goal of strengthening caregiver-child relationship to restore and protect child's mental health. Recommended intensity: Weekly 1 to 1.5 hour sessions; Recommended duration: 52 weeks. 	<ul style="list-style-type: none"> Reduction in parent and child traumatic stress disorder symptoms. Reduction in child behaviour problems. Increase in secure attachment among children. 	<p>Lieberman, Gosh Ippen, & Van Horn, 2006; Cicchetti, Rogosh, & Toth, 2006; Lieberman, Van Horn, & Gosh Ippen, 2005</p>

Child-Parent Psychotherapy

Child-parent psychotherapy (CPP) is a tertiary intervention that involves therapeutic treatment for children aged 0 to 5 who have been exposed to trauma (The California Evidence-Based Clearinghouse for Child Welfare, 2016). Treatment is provided to the child and primary caregiver together, with intervention focusing on the parent-child relationship and reflective supervision. Other components of CPP are summarized in Table 8.

CPP treatment examines the impact of the trauma and the relational history of the caregiver on the developmental trajectory of the child and the caregiver-child relationship (The California Evidence-Based Clearinghouse for Child Welfare, 2016). Contextual factors that may influence this relationship, such as culture and socioeconomic status, are also taken into consideration. As the treatment progresses, the child and caregiver work together under

supervision to generate a narrative of the traumatic event and to identify and address associated triggers.

CPP has been found to successfully reduce children's traumatic stress symptoms and behaviour problems and to increase secure attachment among children (e.g. Lieberman et al., 2006; Cicchetti, Rogosh, & Toth, 2006). Insecure attachment, traumatic stress symptoms, and behavior problems in early life have frequently been linked to IPV perpetration in adulthood (e.g. Levendosky et al., 2012; Costa et al., 2015; CDC, 2015), rendering CPP an important intervention to consider in IPV prevention. Indeed, CPP is specifically targeted to children who have experienced a trauma, including abuse, neglect, or IPV exposure, and addressing this risk factor and its associated outcomes may be key to breaking the link between boys' experiences of violence and subsequent perpetration of it.

Table 8. Essential components of child-parent psychotherapy

Component	Features
Focus on safety	<ol style="list-style-type: none">1. Focus on safety issues in the environment as needed2. Promote safe behavior3. Legitimize feelings while highlighting the need for safe/appropriate behavior4. Foster appropriate limit setting5. Help establish appropriate parent-child roles
Affect regulation	<ol style="list-style-type: none">1. Provide developmental guidance regarding how children regulate affect and emotional reactions2. Support and label affective experiences3. Foster parent's ability to respond in helpful, soothing ways when child is upset4. Foster child's ability to use parent as a secure base5. Develop/foster strategies for regulating affect
Reciprocity in relationships	<ol style="list-style-type: none">1. Highlight parent's and child's love and understanding for each other2. Support expression of positive and negative feelings for important people3. Foster ability to understand the other's perspective4. Talk about ways that parent and child are different and autonomous5. Develop interventions to change maladaptive patterns of interactions
Focus on the traumatic event	<ol style="list-style-type: none">1. Help parent acknowledge what child has witnessed and remembered2. Help parent and child understand each other's reality with regards to the trauma3. Provide developmental guidance acknowledging response to trauma4. Make linkages between past experiences and current thoughts, feelings, and behaviors5. Help parent understand link between her own experiences and current feelings and parenting practices6. Highlight the difference between past and present circumstances7. Support parent and child in creating a joint narrative8. Reinforce behaviors that help parent and child master the trauma and gain a new perspective
Continuity of daily living	<ol style="list-style-type: none">1. Foster prosocial, adaptive behavior2. Foster efforts to engage in appropriate activities3. Foster development of a daily predictable routine

Adapted from: The California Evidence-Based Clearinghouse for Child Welfare, 2016.

ii. School-Age

Evidence-Based Programs

Approaches that aim to reduce the physical, cognitive, emotional, and social adverse effects of violence in childhood have the potential to significantly reduce the prevalence of IPV as these children age, even if IPV perpetration by children when they are adults is not stated as an explicit goal and has not been studied (Harvey et al., 2007). School-age programs in particular show effectiveness in reducing many of the risk factors associated with IPV perpetration, such as oppositional defiant disorders (Project Support), internalizing disorders (Community-Based Intervention Program), and IPV exposure (Dads for Life Program) as well as in developing protective factors such as improved self-concept (Strengths- and Community-Based Support and Advocacy).

The programs listed in Table 9 are each geared toward reducing negative outcomes for school-aged children who have experienced or been exposed to violence, or who may be at-risk for such experiences. Of the four programs presented, three are tertiary modes of prevention (Community-Based Intervention Program, Project Support, Strengths- and Community-Based Support and Advocacy) and one is secondary (Dads for Life Program).

Project Support will be discussed as one example of a school-based program here, with information on other programs located in the following table.

Project Support I and II

Project Support operates at the tertiary level in that it targets families where severe IPV perpetrated by a male partner has taken place and at least one child meets the diagnostic criteria for conduct disorder or oppositional

defiant disorder (McDonald et al., 2011).

The program involves a family intervention comprised of parent-training and instrumental/emotional support provided to mothers. Project Support's parent-training element includes child management skills, such as listening and praising. Skills are taught sequentially, beginning with improving the parent-child relationship and increasing prosocial behaviour by the child, followed by a focus on reducing the child's problematic behaviour.

Project Support shows efficacy in reducing features of psychopathy among children who participate in the program (McDonald et al., 2011). At 24-month follow-up, Project Support I was found to significantly reduce children's oppositional defiant or conduct disorders, behavioural problems, and emotional problems as well as the perpetration of physical abuse by mothers, all risk factors for IPV perpetration (McDonald et al., 2006). Project Support I also increased children's levels of reported happiness and improved their social relationships (McDonald et al., 2006), which can be protective factors for children who have experienced or been exposed to violence.

At 12-month follow-up, Project Support II was also found to decrease children's behaviour problems, although it had no significant effect on oppositional behaviours, physical or emotional abuse by mothers, punitive parenting by mothers, or inconsistent parenting by mothers (Jouriles et al., 2009; McDonald et al., 2011). Nevertheless, the replication of findings between Project Support I and II concerning children's behavioural problems speaks to the strengths of this program.

Table 9. Summary of evidence-based child maltreatment/future IPV prevention programs: School-age

Program Name	Level of Prevention	Purpose/Description	Significant Outcomes	Selected References
Dads for Life Program	Secondary	<p>Aims to reduce conflict and improve parenting skills, anger management, and father-child relationship for recently divorced non-custodial fathers of children 4-12.</p> <p>Consists of 8 weekly group sessions and two individual counselling sessions, accompanied by homework assignments.</p>	<p>Reduction in inter-parental conflict.</p> <p>Improvement in child adjustment and well-being.</p>	Braver, Griffin, & Cookston, 2005. Cookston et al., 2007
Community-Based Intervention Program	Tertiary	<p>Targets children 6-12 exposed to IPV with goal of improving knowledge, attitudes, beliefs about family violence as well as emotional/social adjustment.</p> <p>Lessons provided in group therapy format spanning 10 weeks.</p>	<p>Decrease in children's externalizing and internalizing behaviours.</p> <p>Positive change in children's attitudes.</p>	Graham-Bermann et al., 2007
Project Support I and II	Tertiary	<p>Aims to reduce conflict problems and harsh parenting and provide support in transition from abusive home for children ages 4-9 who have been exposed to IPV (and their mothers).</p> <p>Involves weekly home visits by therapist for up to 8 months. Support and positive role modeling by trained university students provided to child.</p>	<p>Increased children's happiness.</p> <p>Improved children's social relationships.</p> <p>Reduction in oppositional defiant/conduct disorders, behavioural problems, emotional problems among children.</p>	McDonald, Jouriles, & Skopp, 2006. Jouriles et al., 2009; McDonald et al., 2011
Strengths- and Community-Based Support and Advocacy	Tertiary	<p>Weekly group sessions to provide safety and emotions education for children exposed to IPV, ages 7-11. Program length: 2.5 months. Also features advocacy component for mothers.</p> <p>Program activities to educate children about safety, feelings, and respect were varied and frequently used physical activity.</p>	<p>Increased child self-competence.</p> <p>Decreased daily contact with perpetrator.</p> <p>Improvement in mother's depression symptoms and self-esteem over time.</p>	Sullivan, Bybee, & Allen, 2002

iii. Adolescence/Secondary School and Young Adulthood

Adolescence can be a key time for prevention as perpetration is often predictable by this stage of life (Pepler, 2012; Teten Tharp, 2012; Dutton, 2012), and it appears to be a particular sensitive period for the intergenerational transmission of violence (Menard et al., 2014; Pinna, 2015).

In addition, experiences of violence can uniquely impact adolescents given that adolescence is a key developmental stage characterized by increased vulnerability to risk behaviours, new challenges (e.g. dating, sexuality), new types of relationships with parents and other adults, increased self-reliance and autonomy, increased importance of peer influence and desire for acceptance, and potential to engage in problematic coping strategies (e.g. drug use, early leaving from home/school) (Steinberg, 2008).

Prevention programs may also be most effective when provided at times of transitions, such as when youth enter high school, as they are often more receptive and motivated at these times. Examples of programs for adolescents include healthy relationship programs as well as juvenile violence prevention programs for young men with histories of maltreatment, which may offset offences in adolescence and prevent IPV perpetration in young and later adulthood (Millett et al., 2013).

Evidence-Based Programs

Evidence-based programs for adolescents are summarized in Table 11. One program engages in primary prevention (The Fourth R), one program in secondary (Youth Relationships Project), and one has both primary and secondary aims (Safe Dates Program). All have been rigorously evaluated,

and two of the three programs are school-based (Safe Dates Program, The Fourth R). The third program (Youth Relationships Project) involves group sessions in the community. Each program is associated with reductions in the perpetration of violence and other related symptoms and behaviours. As the Youth Relationships Project and the Fourth R are related Canadian-based programs, each will be discussed in further detail below.

Youth Relationships Project

While few child maltreatment intervention programs have the prevention of future IPV perpetration as an explicit goal, the Youth Relationships Project (YRP) is one school-based program that specifically aims to reduce the incidence of IPV perpetration among adolescents with histories of abuse, neglect, or exposure to IPV. YRP was developed in Canada and designed to help these at-risk adolescents develop healthy, non-abusive relationships with dating partners (Wolfe et al., 2003).

The group-based program spans 18 sessions and is comprised of skills development and education about abusive relationships in addition to a social action component that provides participants with the opportunity to develop a project on dating violence awareness within the community.

Evaluation of the YRP included the random assignment of 158 adolescents (92 boys) aged 14 to 16 who had experienced child maltreatment to treatment and control groups, with follow-up after 2 years (Wolfe et al., 2003). Participants were less likely to engage in dating violence following YRP treatment and experienced reduced symptoms of emotional distress.

The Fourth R

YRP lead to the development of the school-based program the Fourth R, a primary prevention program (Wolfe et al., 2008). The program, taught in the classroom, focuses on relationship knowledge and skill-building. It aims to reduce overlapping adolescent risk behaviours, including violence and bullying, substance use, and unsafe sexual behaviour. The universal approach involves adolescents in education to better equip them with the healthy relationship skills and the resilience necessary for successfully navigating the unique challenges associated with this life stage.

The Fourth R features 21 lessons delivered in Grade 9 Physical and Health Education. Teachers receive specialized training in order to

deliver the material. The program also involves opportunities to apply skills learned through role playing and practicing during realistic situations. Staff, teachers, and parents are oriented toward the program with awareness education and information.

The Fourth R has been found to be effective in significantly reducing dating violence perpetration among boys 2.5 years after completing the program, through a cluster randomized controlled trial involving 20 schools and over 1700 students (Wolfe et al., 2009). Satisfaction with the program remains high among teachers, who have continued to implement it even eight years after the training (Crooks et al., 2013). For a curriculum overview and examples, see Table 10.

Table 10. The Fourth R: Skills for youth relationships – Curriculum overview and examples^a

Unit 1: Personal Safety and Injury Prevention

1. Focus on healthy relationships (myths/facts about teen relationships, relationship rights and responsibilities)
2. Barriers to healthy relationships (active listening skills, types of violence and abuse)
3. Contributors to violence (group effects on violence, individual differences)
4. Conflict and conflict resolution (communication styles: passive, assertive, and aggressive; conflict scenarios)
5. Media violence (student presentations of examples of violence in the media)
6. Conflict resolution skills (rights and responsibilities when ending a relationship)
7. Action in the school and community

Unit 2: Healthy Growth and Sexuality

1. Focus on healthy sexuality (review of sexuality, myths clarified)
2. Sexuality in the media (media and peer pressure to have a partner or to have sex)
3. Responsible sexuality (communication with your partner, healthy relationships)
4. Preventing pregnancies and sexually transmitted infections
5. Assertiveness skills to deal with pressure in relationships (negotiation, delay, and refusal skills)
6. Sexuality: responsibilities and consequences (sexual abuse, dating violence, decision making)
7. Sexual decision making and community resources (scenarios and discussion, research community resources)

Unit 3: Substance Use and Abuse

1. Myths/facts and definitions (interactive game to get students to examine their opinions and values)
2. Effects of substance use and abuse (discussion of physical and nonphysical effects)
3. Making informed choices about smoking (discussion: why teens may smoke, health and financial costs)
4. Factors influencing decisions about drug use (discussion of media, culture, and peer pressure)
5. Building skills to avoid pressure to use substances (negotiation, delay, and refusal skills)
6. Practicing skills and community resources (role-play exercises: using skills and decision-making model)
7. Coping and making the connection between drug use, sex, and violence

^aEach of the 3 units consists of 7 classroom sessions of 75 minutes each. Examples of content are in parentheses. From: Wolfe et al., 2009.

Table 11. Summary of evidence-based child maltreatment/future IPV prevention programs: Adolescence/young adulthood

Program Name	Level of Prevention	Purpose/Description	Significant Outcomes	Selected References
Safe Dates Program	Primary/Secondary	<p>School-based program targeting students in grades 8 and 9 with focus on changing dating violence norms and gender stereotyping, developing conflict management skills, and promoting positive help-seeking behavior.</p> <p>Program aims to prevent first perpetration of dating violence and to stop further perpetration of violence.</p>	<p>Decrease in acceptance of dating violence.</p> <p>Increased perception of negative consequences for engaging in dating violence.</p> <p>Enhanced awareness of victim and perpetrator services.</p> <p>Reduction in psychological, physical, sexual violence perpetration at 4 year follow-up.</p>	Foshee et al., 1998, 2000, 2004, 2005
Youth Relationships Project	Secondary	<p>Group program targets adolescents 13-17 maltreated as children to facilitate development of healthy, non-abusive relationships.</p> <p>Involves 18 weekly two-hour sessions.</p> <p>Focusing on understanding gender-based violence, skill development, and social action.</p>	<p>Boys who experienced maltreatment less likely to engage in dating violence after this intervention.</p> <p>Reduction in incidents of physical and emotional abuse and symptoms of emotional distress.</p>	Wolfe et al., 2003
The Fourth R	Primary	<p>School-based program integrated into Grade 9 Health and Physical Education curriculum through 21, 75-minute lessons.</p> <p>Sex-segregated classes aim to define and practice healthy relationships skills, increase interpersonal and problem-solving skills, and reduce risk behaviours associated with dating violence among adolescents.</p>	<p>Reduced physical dating violence perpetrated by boys 2.5 years later.</p> <p>Boys also reported safer sexual practices (e.g. always using condoms).</p>	Wolfe et al., 2009a, 2009b

Promising Prevention Programs

There are two primary prevention programs (Uniting Our Nations, Mentors in Violence Prevention) and one secondary program (Changing Places) which show promise in preventing IPV through intervention in adolescence (see Table 12). Pilot studies reveal such outcomes as improved relationships and confidence, lower levels of distress, and increased awareness of gender-based violence. Two programs are discussed below – one that developed out of the Fourth R (Uniting Our Nations) and one with specific application to boys with histories of violence in childhood (Changing Places).

The Fourth R: Uniting Our Nations

The aforementioned Fourth R also includes culturally relevant versions, such as The Fourth R: Uniting Our Nations programs for Aboriginal Youth. Programs include an elementary mentoring program, Grade 8 transition conferences, a peer mentoring program for secondary students, a cultural leadership course, a cultural leadership camp, and a student advisory committee (for more information, see Crooks et al., forthcoming).

This program is strength-based and promotes healthy relationship and cultural connectedness. In addition, the programs aim to improve educational success while transitioning from elementary to secondary school.

Results are encouraging, with early indicators that the programming improves relationships, sense of belonging, student success, confidence, and leadership skills, which can serve as protective factors against the perpetration of violence. Program success was largely due to providing culturally relevant experiences and role models for participants.

Changing Places Program

Similar to the Youth Relationships Project, the Changing Places Program (CPP) was developed to break the link between child maltreatment and IPV perpetration, but targets those adolescents who have begun to engage in abusive behaviour patterns. The program consists of 3 pre-group sessions, 11 core group sessions, and 3 post-group sessions. CPP focuses on improving the self-awareness, self-control, social skills, problem-solving skills, decision making, confidence, and self-esteem of program participants. The sessions focus on teaching young people pro-social ways of handling conflict instead of resorting to abusive behaviour. Results from a pilot study are promising as program completion was found to be associated with lower levels of emotional distress, decreased risk of violent behaviour, and increased self-worth, empathy, and self-control (Curtis, 2010).

Research also indicates that the college/university setting offers unique opportunities for IPV prevention. Interventions in this stage of life, termed 'emerging adulthood', are critical based on the frequent continuation of patterns establishing in earlier relationships, including the use of aggression (Black et al., 2010). In fact, IPV incidence typically peaks between 20 and 25 years of age, with emerging adults reporting high rates of IPV in their own intimate relationships and previous exposure to IPV between parents (Black et al., 2010). In addition, dating violence prevention programs have been the most evaluated IPV prevention strategies (Patel, 2011), and the prevention of dating violence can be preventive of IPV in later life (Foshee et al., 2009). The Mentors in Violence Prevention initiative listed in the table below is one example of a promising prevention initiative for college/university aged students.

Table 12. Summary of promising child maltreatment/future IPV prevention programs: Adolescence/young adulthood

Program Name	Level of Prevention	Purpose/Description	Significant Outcomes	Selected References
The Fourth R: Uniting Our Nations	Primary	Promote healthy relationships, cultural connectedness, and educational success among Aboriginal Grade 8 youth through mentoring programs and cultural leadership initiatives.	Improved relationships, sense of belonging, student success, confidence, leadership skills.	Crooks et al., forthcoming
Changing Places Program	Secondary	Cognitive-behavioural therapy for adolescent boys 14-21 exposed to IPV now taking on role of perpetrator.	Lower levels of emotional distress. Lowered risk of violent behaviour. Increased self-worth, empathy, self-control.	Curtis, 2010
Mentors in Violence Prevention	Primary	Program developed with male student athletes in mind to raise awareness about violence against women, challenge gender norms, and promote leadership. Implemented at College/University (undergraduate) level with recent adaptation to Secondary School (Grades 9-12)	Increased knowledge and awareness about gender-based violence (GBV). Positive impact on men's attitudes toward GBV.	Katz, Heisterkamp, & Fleming, 2011; Cissner, 2009

iv. Adulthood

Promising Prevention Programs

Despite a major focus on primary prevention initiatives, there is relatively little evaluation of the effectiveness of primary strategies in adulthood. Although evaluation of primary prevention efforts holds many challenges, there are a variety of promising and worthwhile campaigns and programs present in Canada and abroad. Still, three of the six initiatives listed in Table 13 are classified as tertiary prevention, as they involve intervention after men have engaged in IPV perpetration, with the remainder being primary.

Findings on the efficacy of secondary and tertiary programs for IPV perpetrator intervention remain mixed, with some studies finding significant reduction in re-perpetration (e.g. Gondolf, 2002), and others suggesting intervention to be ineffective in promoting change (e.g. Davis, Taylor, & Maxwell, 2000). Nevertheless, there are over 200 programs in Canada which aim to help end men's perpetration of IPV (Public Health Agency of Canada, 2008), and many studies have emerged with useful implications for policy and research development (Scott & Stewart, 2004; Scott, 2006). Men can voluntarily participate in some programs, but most participate as a result of court-ordered treatment. Recognizing this, the Men's Domestic Abuse Check-Up intervention (MDACU), a tertiary program, utilized social marketing principles to recruit abusive men not served by the justice system and engage them in seeking help for their abusive behaviour. MDACU delivers a pre-

treatment intervention over the telephone with the goal of motivating these men to voluntarily enter treatment. It is currently undergoing a 3-year randomized trial for evaluation, but initial findings indicate increased motivation among men to seek help and reduction of incidents of self-reported IPV.

Another example of a tertiary level program is Partner Assault Response (PAR) programs, which are part of Ontario's Domestic Violence Court program (see Ministry of the Attorney General, 2015). PAR programs are specialized group educational and counselling services available to men who have assaulted their partners through various community-based agencies. PAR provides abusive men the opportunity to examine their beliefs and attitudes on IPV and teaches non-abusive ways to resolve conflict. Support is also provided to the victim through referrals to resources, help with safety planning, and updates on their abusive partner's progress. PAR programs have been found to generate positive change in attitudes and knowledge surrounding abuse (Scott & Stewart, 2004; Scott, 2006), but further evaluation is needed to determine how this impacts engagement in future abusive behaviour. This is particularly important as the number of sessions involved in PAR programs was reduced in 2015 from 16 to 12 as a result of cuts to government funding. Consequently, existing evaluations may not reflect the current level of effectiveness of these programs.

Table 13. Summary of promising IPV prevention programs: Adulthood

Program Name	Level of Prevention	Purpose/Description	Significant Outcomes	Selected References
Moderate Intensity Family Violence Prevention Program	Tertiary	<ul style="list-style-type: none"> Group/individual counselling for male offenders who have also perpetrated IPV. Program features 6 modules: motivational enhancement, awareness and education, managing thoughts and emotions related to abuse, social skills, self-management/relapse prevention plan, healthy relationship. Hours of intervention matched to offender's assessed level of risk to reoffend. There are 29 3-hour group sessions with min. 3 individual counselling sessions. 	<ul style="list-style-type: none"> Positive change in motivation and attitudes. Reduction in feelings of jealousy, anger, dependency. Increase in acceptance of responsibility. Improvement in recognizing and dealing with conflict. 	Connors, Mills, & Gray, 2012
Partner Assault Response (PAR) Programs	Tertiary	<ul style="list-style-type: none"> Specialized intervention programs with 3 purposes: 1) changing men's attitudes towards violence; 2) providing support and referral to women victims of men's abuse; 3) communicating information about men's progress to larger systems of justice and advocacy professionals promoting change in men's abusive behavior. Administered with Domestic Violence Courts. 	<ul style="list-style-type: none"> Positive change in abuse-supporting attitudes. Positive change in knowledge of abuse-supporting cognition. 	Scott, 2004, 2006
It's Not OK Campaign	Primary	<ul style="list-style-type: none"> Community-driven behavior change campaign to reduce family violence with the goal to change attitudes and behavior that tolerate any kind of family violence. Campaign tools: TV advertisements, community-led activities, family violence information telephone line, website, Facebook page, Twitter account, resources, merchandise, research and evaluation program. 	<ul style="list-style-type: none"> Increased awareness of and willingness to discuss family violence. Increased willingness to intervene. Decreased antisocial behavior. Changes in organizational culture (e.g. implementation of non-violence policies, referral programs). Developed sense of community ownership. Increased reports of family violence to police and lower thresholds for reporting. 	Roguski, 2015; Point Research Ltd., 2010
Men's Domestic Abuse Check-Up	Tertiary	<ul style="list-style-type: none"> Outreach program to encourage non-adjudicated, untreated, substance-using men who abuse their partners to refer themselves to treatment. Message delivery methods: news stories, paid advertisements in print media and on radio, bus ads, website, brochures/flyers. 	<ul style="list-style-type: none"> Greater motivation for treatment seeking. Reduction in self-reported IPV. Reduced misperceptions about frequency of men that engage in IPV and alcohol. 	Mbilingi et al., 2008, 2009, 2011; Neighbors et al., 2010
Working Together Against Violence	Primary	<ul style="list-style-type: none"> Campaign to create safe and respectful workplace, promote gender equality and non-violence norms, improve access to resources and systems of support. 	<ul style="list-style-type: none"> Improved understanding of IPV. Improved knowledge on how to support individuals involved in IPV. 	Durey, 2011

v. Prevention Programs with Applications for Multiple Life Stages

While the programs discussed above are specific to a given life stage, there are a variety of prevention programs available for multiple age groups.

In other words, these particular programs are comprised of applications tailored to different ages.

Evidence-Based Programs

Of the six evidence-based programs summarized in Table 14, two have both primary and secondary applications (Strengthening Families Program, Triple P Parenting Program), two involve secondary prevention only (Incredible Years Program, Fathers for Change Program), and two operate at the tertiary level (Trauma-focused Cognitive Behavioural Therapy, Multisystemic Therapy). The Triple P Parenting Program will be discussed below as an example of primary and secondary prevention, followed by the tertiary examples of Trauma-focused Cognitive Behavioural Therapy and Multisystemic Therapy.

Triple P Parenting Program

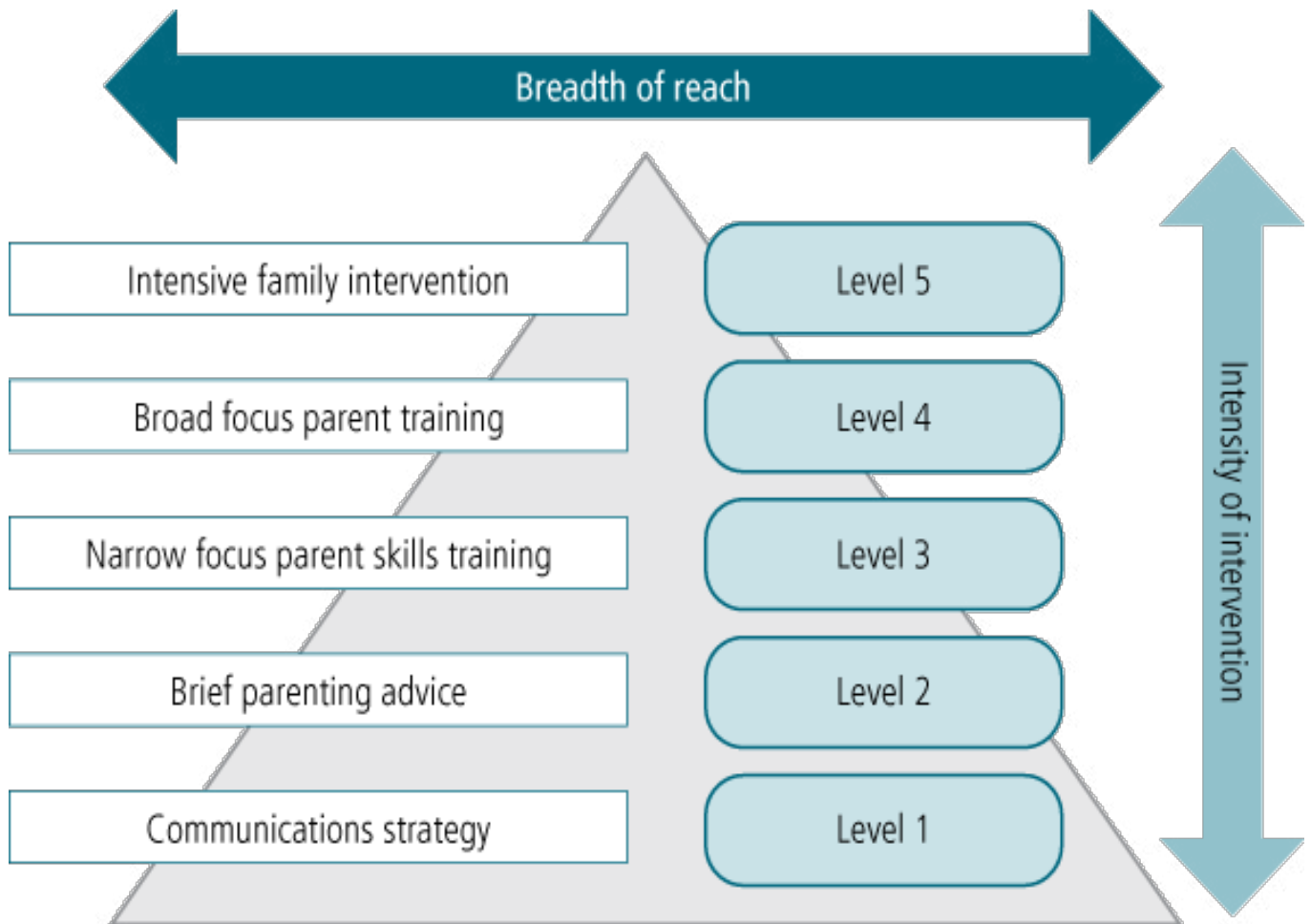
The Triple P Parenting Program is a public health intervention based on social learning theory (Sanders, 2012). It aims to “prevent severe behavioural, emotional, and developmental problems in children and adolescents by enhancing the knowledge, skills, and confidence of parents” (Sanders, 2012, p. 348). Triple P is comprised of five levels of intervention which operate on a continuum of increasing strength, providing both primary (universal) and secondary (targeted) interventions. The

multilevel strategy is designed to accommodate differences in the type, intensity, and mode of service children/adolescents and parents may require. These various levels are presented in Figure 2.

Briefly, Level 1 involves media and informational campaigns on positive parenting; Level 2 provides low intensity support to parents interested in general parenting advice or who have specific concerns regarding their child’s development/behaviour; Level 3 is a low to moderate intensity program for parents with specific concerns about their child and provides active skills training for managing discrete problem behaviours; Level 4 is a moderate to high intensity program for parents whose children have detectable behaviour problems that may or may not meet diagnosable criteria and wish for intensive training in positive parenting skills; and Level 5 is a high intensity program for families who face concurrent adversities (e.g. parental depression) in addition to child behaviour problems. The Pathways variant of Triple P is specifically for parents at risk of maltreating their children and targets factors associated with abuse (e.g. anger management).

Overall, Triple P has been found to improve children’s behaviour and adjustment and to decrease rates of child abuse over 6 month, 12 month, and 24 month periods (deGraaf et al., 2008; Sanders, 2012; Prinz et al., 2009).

Figure 3. The Triple P model of graded reach and intensity of parenting and family support services.



Source: Sanders, 2012.

Resolving Trauma

Interventions to resolve trauma and related symptoms resulting from abuse, neglect, and/or exposure to IPV can reduce the likelihood of future IPV perpetration given the link between the two (Reingle et al., 2014). Therefore, prevention efforts for child maltreatment can be a form of IPV prevention, although for many strategies, evaluation of their impact on subsequent IPV perpetration is currently lacking. Nevertheless, many child maltreatment prevention strategies have proven successful in reducing problematic behaviours in children that can serve as risk factors for subsequent IPV perpetration, such as unresolved trauma, conduct disorders, and depression (Costa et al., 2015). Multisystemic Therapy (Swenson et al., 2010) is one example of an effective tertiary program utilized with school-aged children and adolescents.

Multisystemic Therapy

Multisystemic Therapy (MST) (Henggeler et al., 2009) has been adapted for physically abused children and their families and shown to be effective (e.g. Swenson et al., 2010). Standard MST practices involve home-based service delivery where therapists provide interventions in the home as well as community locations such as school, at convenient times for families (e.g. evenings, weekends). Frequency of treatment is matched to family need, ranging from daily sessions to one or two sessions per week. In the case of MST for child abuse and neglect, the length of treatment is extended beyond the typical four to six months.

MST therapists assess how identified problem behaviours fit within a broader systemic context that includes family members, peers, school, and social support systems. The issues within and between each system is assessed (e.g. family

environment may influence decreasing school performance).

Treatment goals are individualized and geared toward the child and family's developmental stage and capacities. Interactions between the child, family, and therapist emphasize strengths and promote responsible behaviour. These interactions are also solution-focused and rooted in the present to ensure goals are clear and obtainable. Where child abuse and neglect is involved, a safety plan is developed for family members and the treatment team works closely with child protective services to foster positive relations between these organizations and family members.

MST for child abuse and neglect has been shown to reduce youth mental health symptoms, parent emotional distress, youth out-of-home placements, and parenting behaviours associated with maltreatment (Swenson et al., 2010). It should be noted, however, that evaluations of MST in Ontario did not find it to be effective and that this may be due to such factors as contextual differences between the United States and Canada (see Cunningham, 2002 for further discussion).

Trauma-Focused Cognitive Behavioural Therapy

Another example of tertiary level therapy with demonstrable success is Trauma-focused Cognitive Behavioural Therapy (TF-CBT). TF-CBT features treatment sessions for children and parents individually as well as joint sessions with both child and parent. Treatment components include psychoeducation, parenting skills, relaxation skills, affective regulation skills, cognitive coping skills, cognitive processing of the trauma experience, and safety skills (Cohen & Mannarino, 2008).

Psychoeducation involves providing the family with information about the child's diagnosis, the treatment plan, the impacts of trauma on children, and other information to normalize the situation faced by the child and parent. Parenting skills and relaxation skills are individualized for each child and parent and can respectively include such strategies as the use of praise, yoga, or mindfulness exercises. Affect regulation is also tailored to the individual and generally involves identifying where the child has difficulties (e.g. over-responsive, under-responsive, poor social skills) and works to strengthen and practice skills in this area.

TF-CBT also assists "children and parents in gaining cognitive coping skills, or recognizing connections among thoughts, feelings and behaviours as they relate to everyday situations" (Cohen & Mannarino, 2008, p. 160). Cognitive processing of the traumatic experience involves gradually telling the story of the distressing experience to overcome avoidance of traumatic memories, to identify cognitive distortions, and to contextualize the experience within the child's life. Last, children are taught additional skills in order to promote safety in the future, such as healthy sexuality and drug refusal skills.

Evaluations of TF-CBT show reduction in many emotional and behavioural problems among children, including PTSD and anxiety (Cohen, Mannarino, & Iyengar, 2011).

Table 14. Summary of evidence-based child maltreatment/future IPV prevention programs: Applications across life stages

Program Name	Level of Prevention	Purpose/Description	Significant Outcomes	Selected References
Incredible Years Program	Secondary	<ul style="list-style-type: none"> • Psycho-educational group program designed to develop self-esteem of parents and skills for managing children's behaviour in socioeconomically disadvantaged families. • Five programs: Baby (0-12months), Toddler (1-3), Preschool (3-6), School Age (6-12), Advance (4-12). 	<ul style="list-style-type: none"> • Improvement in parent-child interactions, positive family relationships and children's problem-solving, emotional regulation, school readiness. • Reduction in children's externalizing and internalizing problems. 	Perlson & Greene, 2014; Menting, Orobio, & Matthys, 2013
Strengthening Families Program	Primary/Secondary	<ul style="list-style-type: none"> • Group-based parenting program developed to strengthen parenting for both high-risk and general population families. • Programs available for children 3-5, 6-11, 12-16, and 7-17. 	<ul style="list-style-type: none"> • Improvement of parenting skills and family relationships. • Reduction in child maltreatment. • Reduction in children's problem behaviours, delinquency, and substance abuse. • Improvement in children's social competencies and school performance. 	Kumpfer et al., 2010, 2015
Triple P Parenting Program	Primary/Secondary	<ul style="list-style-type: none"> • Parenting and family support system designed to prevent social, emotional, behavioural, and developmental problems in children by enhancing knowledge, skills, and confidence of parents. • Five intervention levels matched to intensity of family needs. • Families with children 0-12 with extensions available for families with teens 13-16. 	<ul style="list-style-type: none"> • Reduction in child behavioural and emotional problems. • Improvement in parents' well-being and parenting skills. • Decreased rates of child abuse. • Decreased hospitalizations from child abuse injuries. 	de Graaf et al., 2008; Prinz et al., 2009; Sanders, 2012
Fathers for Change Program	Tertiary	<ul style="list-style-type: none"> • Individual counselling for fathers who have children under 10 years with a history of IPV with aim to reduce aggression, violence, and substance use; improve co-parenting and family interactions; improve parenting skills and parent-child relationships; decrease child symptoms. • Involves 16 topics covered in 60 minute sessions with father and both father and child over four to six months. 	<ul style="list-style-type: none"> • Reduction in perpetration of IPV. Improvement in relationships with children. • Greater likelihood of completing treatment for substance use. 	Stover, 2013, 2015
Trauma-focused Cognitive Behavioural Therapy	Tertiary	<ul style="list-style-type: none"> • Individual counselling for children and adolescents 3-17 who were abused or exposed to IPV and their parents. • Treatment is comprised of psychoeducation, parenting sessions, skill development, and processing trauma. 	<ul style="list-style-type: none"> • Reduction in emotional and behavioural problems in children, including PTSD and anxiety. 	Cohen & Mannarino, 2008; Cohen, Mannarino, & Lyengar, 2011
Multisystemic Therapy	Tertiary	<ul style="list-style-type: none"> • Home-based and clinical therapy for children and adolescents 10-17 of families being followed by Child Protective Services for child abuse/neglect. • Treatment aims to mitigate effects of abuse/neglect and keep children at home with their families. 	<ul style="list-style-type: none"> • Reduction in child mental health symptoms and problematic behaviours, parent emotional distress, parenting behaviours associated with maltreatment, child out-of-home placements. • Decrease in neglectful parenting, minor/severe child abuse, psychological aggression. 	Swenson et al., 2010

Promising Prevention Programs

In addition to the evidence-based programs discussed above, there are two promising tertiary prevention programs, the Caring Dads Program and the Strong Fathers Program (see Table 15). Pilot studies conducted for each initiative show promise for reducing men's abusive behaviours and improving father-child relationships, and both programs are similar in content and purpose.

The Caring Dads Program

The Caring Dads Program (CDP) targets fathers who have abused/neglected their children or exposed them to IPV (Scott & Crooks, 2007; Scott & Lishak, 2012). CDP is a voluntary group-based program spanning 17 weeks and developed in Canada. The program aims to enhance men's awareness of, and capacity for, child-centered fathering; to increase men's awareness of the impact of abusive and neglectful fathering on

children; to encourage responsibility for abusive and neglectful fathering; to rebuild trust with children; and to plan for additional support that may be needed in the future (Scott, 2010).

Preliminary studies indicate that CDP has potential to reduce risk mechanisms for child maltreatment (e.g. hostility, rejection, and anger toward child) (Scott et al., 2003; Scott & Crooks, 2007). CDP also highlights the importance of engaging fathers in ending children's experiences of family violence and abuse, again given the overlap in men's physical abuse of children and children's mothers. In addition, positive father involvement – especially for those fathers who have perpetrated IPV or may be at risk of perpetrating IPV and/or child maltreatment – has emerged as a primary IPV prevention strategy (Cooper, Wells, & Dozois, 2013).

Table 15. Summary of promising child maltreatment/future IPV prevention programs: Applications across life stages

Program Name	Level of Prevention	Purpose/Description	Significant Outcomes	Selected References
Caring Dads Program	Tertiary	<p>Program to engage fathers who have abused or neglected their children or exposed them to IPV in addressing their abusive behaviour through focusing on their relationship with their children (aged 0-12).</p> <p>Three components: 17-week fathering group, mother contact, collaborative case management.</p>	<p>Reduction in hostility and anger toward/ rejection of children.</p> <p>Increased understanding of negative effects resulting from IPV exposure.</p> <p>Decline in negative parenting.</p> <p>Improvements in perceptions of co-parenting.</p>	<p>Scott & Crooks, 2007</p> <p>Scott & Lishak, 2012</p>
Strong Fathers Program	Tertiary	<p>Psychoeducational and skills-building group for men referred by child welfare with history of IPV.</p> <p>Aims to improve how men relate to their intimate partners through improving how men relate to their children (aged 0-12). Also addresses men's childhood experiences.</p>	<p>Increased knowledge of child development.</p> <p>Reduction in abusive beliefs toward partners.</p> <p>Increased awareness of poor parenting behaviors. Increased ability to identify and overcome challenges in relating to children and their mothers.</p> <p>Maintained or increased time spent living with children.</p>	Pennell, Rikard, & Sanders-Rice, 2014

2.4 Developing Protective Resources & Resilience

In addition to reducing negative behaviours and minimizing the adverse consequences of violence, another important aspect of prevention involves developing protective resources and competencies. This approach may be especially valuable to high-risk young children and their families (Gerwitz & Edleson, 2007), such as boys who have experienced or are at-risk of maltreatment. Enhancing individual and family skills and coping mechanisms can also have a cumulative impact over time. Examples of protective factors include self-regulation, self-determination/self-efficacy, emotional literacy, social problem solving, help-seeking behaviours, intellectual capacity, school bonding and extracurricular involvement, community involvement, and positive interpersonal and family relationships (Patel, 2011; Baker et al., 2011; Benavides, 2015). Parental warmth and positive parent-child relationships appear to be particularly significant for reducing disruptive behaviour in adolescence (Pinna, 2015).

Age is also important to consider with regard to the presence of protective factors and the subsequent development of resilience (Benavides, 2015; Kliks & Herrenkohl, 2013). Resilience is increasingly considered a “dynamic developmental process or a developmental progression in which new strengths and vulnerabilities emerge over time and under changing circumstances” (Gerwitz & Edleson, 2007, p. 158). Resilient children, or those who develop successfully despite significant adversity, share such individual and environmental characteristics as easy temperament, social competence, intellectual resources, and competent parenting (Gerwitz & Edleson, 2007). Existing literature suggests that programs targeting major developmental tasks can be effective in reducing

the impact of stressors faced by children. Attention has also been paid to the need to develop social and emotional resilience during the transition into young adulthood (see Chadwick, 2014).

One primary/secondary prevention program that supports the development of protective factors is the Strengthening Families Program (SFP), which has programming available for general population and high-risk families with children from pre-school age to adolescence (Kumpfer et al., 2010, 2011). SFP is an evidenced-based program featuring 14 group-based sessions where parents and children learn and practice positive communication and interaction. Parent sessions also cover appropriate expectations for children based on developmental stages, effective discipline, active listening, and positive attention for children’s good behaviour. Training for children includes problem solving, anger management, identifying feelings, and coping skills. Results from a 5-year quasi-experimental study of SFP with over 1600 families indicate SFP is successful in reducing children’s problem behaviours and delinquency and greatly improves positive parenting, family communication, and family strengths and resilience (Kumpfer et al., 2010). Enhancing the capacity of children and their families to develop resilience through coping skills and other protective resources is therefore an important component of preventing intimate violence and reducing its consequences.

Summary: Part II

This section has provided examples of evidence-based and promising child maltreatment and IPV prevention programs at every life stage, contributing to the developing knowledge base on developmental pathways to violence for boys and men. There are a wide range of developmentally appropriate primary, secondary, and tertiary programs available, and it is important to recognize that each life stage presents unique opportunities and challenges that may require different perspectives or tools (US Department of Justice, 2000; Baker et al., 2011).

The existing evidence reviewed indicates interventions at each life stage can impact the correlates associated with men's perpetration of IPV. Risk factors for IPV perpetration can be present beginning in infancy, and the reviewed programs demonstrate that it is possible to attenuate their effects. While there are programs that specifically aim to reduce abuse, neglect, and/or IPV exposure for children in infancy, pre-school, or primary school, many prevention initiatives involving these life stages also focus on improving parent-child relationships and parenting skills, which can affect children's development of secure attachment and emotional and behavioural adjustment. Though longitudinal research has yet to be conducted investigating the impact of these programs on boys' engagement in partner violence in adulthood, insecure attachment and emotional/behavioural difficulties are established correlates of IPV perpetration. Accordingly, prevention efforts for infancy/pre-school and school-age children may play a key role in IPV prevention overall.

Adolescent and young adult programs largely focus on preventing dating violence at these life stages, another demonstrated predictor of IPV in adulthood. Of particular note is the evidence-based Youth Relationships Project, which actually targets boys who have experienced maltreatment in childhood with the goal of preventing their subsequent perpetration of IPV. Evaluation of this program shows it is successful in reducing incidents of dating violence. Based on the effectiveness of this program, the primary prevention program the Fourth R was developed, and again, demonstrated success in reducing physical dating violence perpetrated by young men.

When it comes to primary prevention in adulthood, however, evaluation is lacking. There is also mixed evidence on the effectiveness of secondary and tertiary interventions. Nevertheless, primary prevention is critical avenue to pursue given the widespread nature of intimate partner violence and its burden on adult victims/survivors and their children, as well as its overlap with child maltreatment.

This section also reviewed programs with applications for more than one life stage, which are also among the most widely evaluated methods of prevention. These programs have repeatedly been shown to decrease rates of child maltreatment (abuse, neglect, IPV exposure) and to reduce many additional correlates of IPV perpetration, such as substance abuse, delinquency, and emotional/behavioural problems.

Part III:

Implications for Health and Its Community Partners



Part III: Implications for Health and Its Community Partners

3.1 Considerations and Future Directions

Child maltreatment and intimate partner violence are inter-related public health issues with long-term impacts on health and well-being, and many implications for violence prevention initiatives. While the bi-directional links between child maltreatment and IPV are not inevitable, the evidence presented in this paper suggests that it is an important pathway to consider in the prevention of men's perpetration of violence and in the prevention of child maltreatment. Public health, in particular, brings a multidisciplinary focus and evidence-based approach to prevention. Such an approach can reduce the fragmentation of services for child maltreatment and IPV specifically, as the two often co-exist within families. Violence prevention, then, requires coordination between and participation by all essential stakeholders, including government institutions; multiple sectors, agencies, and groups (e.g. education, criminal justice, family violence agencies, communities); and those that may not be traditionally considered but can significantly impact child maltreatment/IPV risk factors (e.g. child care services, family planning and reproductive health services; housing agencies; neighbourhood community centres).

The IPV prevention strategies reviewed in this paper represent both promising and effective approaches to ending the intergenerational transmission of violence. However, continued investigation into the mechanisms linking child maltreatment and IPV perpetration as well as evaluation of existing prevention measures is needed in order to enhance knowledge on existing approaches and to ensure a rigorous evidence base that can inform the development of future programs. The prevention of child maltreatment in addition to the mitigation of its effects should

also be part of broader efforts to prevent IPV. Indeed, emerging evidence shows that parenting programs can actually prevent child abuse (Mikton & Butchart, 2009), and this may be key in breaking the link between victimization as a boy and perpetration of violence as an adult, particularly given the ability of some interventions to reduce conduct disorder and later antisocial behaviour, which are both strong predictors of future IPV perpetration (Heise, 2011). Further development and evaluation of IPV prevention programs specifically for boys who have experienced maltreatment is also needed. Specifically, forms of treatment that address childhood experiences of trauma among boys may be especially effective in preventing future IPV perpetration and requires trauma-informed health promotion, particularly when sexual abuse has occurred.

With regard to IPV prevention, it appears that infancy/pre-school and adolescence/young adulthood are critical stages of life, especially given the risk of maltreatment, including exposure to IPV, in early life and the unique effects such exposure may have in adolescence, a time of transition and relationship development. While this paper has focused on optimal times for prevention over the life course following a public health model, it is important to consider race/ethnicity, gender, socioeconomic status, religion, sexual orientation, and other social factors in addition to age/developmental stage (Lutzker & Wyatt, 2006). There is a demonstrated need for programs and policies to address and support diversities among boys and men (Murray & Graves, 2013; Alhusen et al., 2014), as "blanket" policies, or policies calling for the same prevention/intervention approach for all boys and men

are likely to be ineffective (Stover et al., 2009). Certainly, child maltreatment and intimate partner violence do not “occur in a vacuum” (Patel, 2011, p. 26) and have consequences that persist long after the violence has stopped. Prevention efforts must ultimately recognize and respond to the co-occurrence of violence with such factors as food insecurity, low education, poverty, chronic illness, and other related issues.

Attention to diversity among boys and men is one of the many challenges facing the future of child maltreatment/IPV prevention. Other challenges include: separating the effects of child maltreatment (abuse, neglect, IPV exposure) from other adverse childhood circumstances (e.g. poverty); designing studies involving community rather than clinical samples; developing sustainable programs; and reducing recall bias resulting from the use of retrospective surveys. In addition, research on dating violence prevention tends to use school age, adolescent, or college/university age samples which may not be generalizable to adolescents of similar ages who are not in school (i.e. have left school early or are truant). Accordingly, there is a need to investigate innovative prevention programs for individuals who are not well-represented in the education system (Cornelius & Resseguie, 2007). Reaching

youth through other venues such as community-based or faith-based organizations may offer different ways to engage young men and boys in addition to the development and evaluation of culturally sensitive programs (Whitaker et al., 2006).

Finally, while programs have proliferated over the last 20 years, evaluations of their effectiveness have not, particularly due to limited availability of longitudinal data and ethical concerns. Continued work in the area of child maltreatment and subsequent IPV perpetration is therefore a necessity. Primary prevention programs, in particular, are in need of examination, as these programs are among the most visible yet rarely receive outcome evaluations. White Ribbon Campaign and Neighbours, Friends and Families (see Flanigan, 2011) are examples of universal prevention campaigns warranting evaluation. A National Evaluation Framework for Assessing Change in Men and Boys has been developed by White Ribbon with their Canadian partners and can inform future evaluations (see White Ribbon Campaign, 2015). Prevention strategies must also be integrated into existing public policy and community structures if they are to be successful (Greeley, 2010).

3.2 Recommendations

Given the overlap between child maltreatment and IPV and the complex nature of the link between the two, recommendations for reducing family violence and its consequences, involving both public health and its community partners, are listed in Tables 16 and 17.

Table 16. Recommendations for Research

Data Collection	Program Development & Evaluation
<p>Enhance data collection on child maltreatment and IPV (e.g. prospective longitudinal studies following children from birth with the capacity to control for potential confounding factors) and dissemination of findings to relevant stakeholders.</p> <p>Increase longitudinal research on risk and resiliency among maltreated children, including those exposed to IPV.</p> <p>Collect data on partner violence outcomes for maltreated boys who have and have not received treatment</p>	<p>Enhance empirical evaluation of the long-term effectiveness of prevention programs (e.g. Neighbours, Friends and Families; White Ribbon Campaign).</p> <p>Develop and evaluate programs designed to restore parent-child relationships after violence has occurred.</p> <p>Develop and evaluate culturally relevant and gender-responsive programs for boys and men.</p> <p>Develop and evaluate programs designed to prevent IPV perpetration among boys who experienced maltreatment in childhood.</p> <p>Develop and evaluate differential responses to IPV perpetrators (e.g. based on type of violence, background, etc).</p> <p>Determine sufficient treatment levels in tertiary programs for IPV perpetrators.</p>

Table 17. Recommendations for Practice

Training	Collaboration	Service Provision	System Approaches
Integrate IPV curricula into schools of public health, nursing, and medicine as well as related fields (e.g. social work, justice sector).	Develop partnerships between public health and local IPV programs.	Address IPV and child maltreatment (abuse, neglect, IPV exposure) in tandem, including identifying shared risk factors, particularly in adolescent and young adult populations.	Conduct community needs assessments.
Provide ongoing opportunities for cross-training on IPV and the victimization experiences of boys/men from a health perspective.	Promote coordinated community responses to IPV through development of multidisciplinary task forces involving researchers, service providers, and policy makers.	Include the prevention of future IPV perpetration as an explicit goal in child maltreatment prevention programs.	Develop, implement, and monitor protocols for IPV in public health agencies.
	Engage in multi-level prevention efforts involving communities, families, and individuals.	Increase services to ensure well-being after violence has ended.	Increase funding for public health approaches to violence prevention.
		Multi-dimensional screening and follow-up for boys who have experienced abuse/neglect or who have been exposed to IPV, especially when other risk factors are present (e.g. low income family, little social support).	Invest in early prevention programs (e.g. dating violence prevention in adolescence with particular emphasis on boys with histories of victimization).

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Appendix

Risk factors for child maltreatment.			
Caregiver risk factors	Child risk factors*	Community risk factors	Societal risk factors
Victim or perpetrator of IPV Few social supports Mental health issues Alcohol/drug abuse History of foster care Physical health issues Cognitively impaired Early parenting (especially adolescent years) Time in custody/involvement in criminal activity Experience of/exposure to violence in childhood Difficulty bonding with newborn Lack of awareness of child development Use of inappropriate, excessive, or violent punishment for perceived misbehaviour Approves of physical punishment as method of discipline Lack of self-control when upset/angry Low self-esteem Poor parenting skills Young age Financial difficulties Lack of parent-child attachment/failure to bond Isolation	Disability Chronic illness “Unwanted baby” High needs infant (e.g. colic) Physical features (e.g. facial abnormalities) parent is aversive to Hyperactivity/impulsivity or other behavioural problems	Tolerance of violence High levels of unemployment Poverty Lack of or inadequate housing Lack of services to support families Transient neighborhoods Local drug trade	Socioeconomic inequality Gender inequality Social/cultural norms promoting violence Rigid gender roles
*These risk factors do not imply responsibility on the part of the child for maltreatment but rather that these particular children may be at increased risk of experience child maltreatment. Bolded factors are also risk factors for IPV perpetration. Informed by: Cooper, Wells, & Dozois, 2013; WHO, 2006			

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