Chapter 2: Theoretical Concepts and Frameworks

The present clinical-trial study focused on children who were living in families with living violence problem. However, psychological sequelae of domestic violence in these children were assessed. Then, they randomly assigned to either abuse focused cognitive behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR) or control conditions.

Hence, it is imperative to explain the meaning of these variables as well as the theoretical frameworks related to them.

Domestic Violence (DV)

Violence against children by adults within the family is one of the least visible forms of child maltreatment, it generally takes place in the privacy of domestic life. Child maltreatment is linked to other forms of violence within the family including intimate partner violence and highly co-occurred with child physical abuse.

Violence is an act carried out with the intention or perceived intention of physically hurting another person. This definition is synonymous with the legal concept of “assault” and the concept of “physical aggression” (Straus and Gelles, 1986, 1988).

Browne (1989) suggested that domestic violence categorized into active and passive abuse. Active abuse involves violent acts in a physical, emotional or sexual context. Passive abuse refers to neglect which can only be considered violent in a metaphorical sense as it does not involve physical force. Neglect can, of course, result in both physical and emotional injury.

O’Leary (1999) defined intimate partner violence (IPV) as “the presence of at least two acts of physical aggression within a year (or one severe act) and/or physical
aggression that leads the partner to be fearful of the other or that results in injury
requiring medical attention”.

Hobbs, Hanks and Wynne (2001) considered domestic violence as a disorder
within the system of family function that occurs in more than one type of abuse that
includes: child abuse, spouse abuse, elder abuse, courtship abuse, sibling abuse and
even parent abuse.

Levesque (2001) stated that family violence includes family members’ acts of
omission or commission resulting in physical abuse, sexual abuse, neglect or other
forms of maltreatment that hamper individuals’ healthy development.

The term domestic violence is commonly defined as a behavior, or pattern of
behaviors, that occurs between intimate partners with the aim of one partner exerting
control over the other. Domestic violence may include psychological threats, emotional
abuse, sexual abuse, and/or physical violence. This clinical definition is broader than
the legal definition, which may be restricted to acts of physical harm (CDCPP and

Tolan, Gorman-Smith and Henry (2006) defined it as a pattern of behavior that
may include physical and sexual violence, threats, insults, and economic deprivation
aimed at gaining and maintaining power and control over the mind, body, behavior, and
lifestyle of a partner. Under this definition, domestic violence is not limited to married
couples or even heterogeneous relationships. Domestic violence can and often does
occur within families and across generations.
WHO (2006) defined physical abuse as the intentional use of physical force against a child that results in — or has a high likelihood of resulting in — harm for the child’s health, survival, development or dignity. This includes hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning and suffocating. Much physical violence against children in the home is inflicted with the object of punishing.

According to WHO (2008) domestic violence is understood as abuse occurring within intimate relationships and encompasses a range of different behaviors, including physical violence, emotional and psychological abuse, sexual abuse and financial abuse. It is predominantly women who experience such abuse and predominantly men who perpetrate this violence.

British Governmental Home Office (2012): Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse include psychological, physical, sexual, financial and emotional.

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
Theoretical perspectives. Many theories have existed and evolved over time which have tried to explain unrestrained (and often unrestrainable) domestic violence. However, no one theory can fully explain what causes violence between family members.

I. Culture of violence theory by Straus (1980). Idea that in large, pluralistic societies, some subcultures develop norms that permit the use of physical violence to a greater degree than the dominant culture. Thus family violence will occur more frequently in violent societies than in peaceful ones. Peer-relationships that support patriarchal dominance in the family and use of violence to support it are exemplary of this subculture. This theory has also produced the theories that examples from pornography and violent images on TV can support a "culture of violence" against women. Straus (1980) identified four cherished cultural standards that not only permit but encourage husband to wife violence: a) the greater authority that men have compared with women in the culture. b) male aggressiveness, because aggression positively correlates to maleness and aggression is not only an acceptable tool for a man but a way to demonstrate male identity. c) the wife/mother role as the preferred status for women and d) male domination and orientation of the criminal justice system, which provides little legal relief for female victims.

II. Feminist theory by Bograd (1988). There are many different ideas within feminist theory of domestic violence, but there are four common strains. These are 1) that as the dominant class, men have differential access to material and symbolic resources and women are devalued as secondary and inferior, 2) intimate partner abuse is a predictable and common dimension of normal family life, 3) women's
experiences are often defined as inferior because male domination influences all aspects of life and 4) the feminist perspective is dedicated to advocacy for women.

III. Ecological theory by Walker (1996). This theory attempts to link violence in the family to the broader social environment. This includes the culture, the formal and informal social networks of the family, the closer family setting and circumstances, and the family history. This type of framework sets up a basis for a risk-theory of domestic assault based on the given criteria.

IV. Deterrence theory by Healey, Smith and O'Sullivan (1998). From a social control standpoint, deviant behavior is common when it does not engender many social or legal costs. According to this theory family violence is so common that the potential costs of committing a family violent act are almost nonexistent. Arrest and prosecution are unlikely, and incarceration or other punishments are even less probable.

V. Social-structural variables theory by Waters (2000). According to this theory, family violence links to certain socially defined classification such as low income, minority status and gender. Although abuse occurs in every socio-economic level, also the presence of stressors such as unequal opportunity and poverty produces high level of personal frustration which increases the risk of aggression.

VI. Evolutionary theory by Barnett, Miller-Perrin and Perrin (2005). This theory posits that as societies have changed from the relatively simple to the more complex, families have become smaller and nuclear in form and social relations have become more structured and thereby, more ambiguous. These changed circumstances result in different styles of parenting - for example, in tighter family networks less independence is granted to children and instead there is a reliance on physical punishment to secure
obedience. This theory argues that obedience is valued most in highly structured hierarchical societies where a lot of activity occurs in formal social encounters outside the home.

There are some other theories on domestic violence which based on system theory, called micro-system theories (Barnett, Miller- Perrin and Perrin, 2005) including following:

I. Learning theories. Learning principles apply to explain a broad repertoire of violent behaviors within families which include modeling (social imitation), classical conditioning (emotional learning) and operant conditioning (modification of behavior).

Classical conditioning can explain the intense level of fear experienced by battered child. Children through the pairing of a signal (angry voice) with a subsequent frightening and painful event (assault) learn to be victims (O'Keefe and Treister, 1998).

Children learn to be violent through operant conditioning (which shape their behavior step by step). When abusive persons get what they want by mistreating others, they are likely to become even more violent, similarly when abusive persons are not punished for their violent behavior, they gain further opportunities to hone their aggressive skills (Felson, 1992).

Evidences have shown that aggression can be learnt through modeling process and violence tends to be perpetuated from one generation to the next. Abuse during childhood is associated with later dating violence, marital violence and abused person's eventual abuse of his or her own children. The models of both victims and perpetrator behavior provide social learning opportunities (Widom and Maxfield, 2001).
II. Intrapersonal theories. These theories emphasize individual differences among offenders and victims including psychopathology, psychological traits, and psychobiological mechanisms. Narcissism, depression, and antisocial personality disorders are examples of psychopathology typical of family violence offenders. Sometimes some psychological traits that are not defined as psychopathological may be the result of family violence. For example, high hostility as a certain personality trait of offenders contribute to their perpetration of family violence. There is some evidence of genetic bases for such correlates of family violence as antisocial personality disorder, aggression, and alcoholism (Crouch and Behl, 2001).

III. Interpersonal interaction theories. Based on system theory domestic violence is a product of interaction between individuals in specific relationships and is not the result of the behavior of only one person, such as the perpetrator. In other words, it is the interaction of both partners that preserve the homeostatic balance (violence) of the relationship. In support for this, researches have shown that both partners in abusive relationships experienced high rates of discord or have deficits in communication skills (Johnson and Lebow, 2000).

According to interpersonal transaction theories, the reciprocal nature of the parent-child relationship initiates and maintains abusive and neglectful patterns of behavior. For example, child abuse results when the behavior problems of a parent interact with the conduct of a hard-to-manage child (Wolf, 1987).

Attachment theory describes the disturbed patterns of attachment in abusive and neglecting families. Experts have consistently observed defective patterns of
attachment in physically abused, neglected and psychologically maltreated children (Kolko, 1992).

Exchange models have been explicitly applied to the analysis of intimate aggression, particularly to explain stay/leave decisions. Women who return to an abusive partner consistently report substantial investments (dependent children and longer duration of their relationships), some remaining feelings of satisfaction with and psychological commitment to the relationship, and few alternatives (economic dependence, limited education/labor force skills; Rusbult and Martz, 1995).

Family systems theory analyzes both dysfunctional interaction patterns that provide the source and momentum for aggression, as well as the functions/rules/boundaries that intimate aggression serves to maintain within the family/dyadic unit (Giles-Sims, 1983). Here, intimate aggression is viewed as part of a larger pattern of coercion that may include negative reciprocity, rigid communication patterns, displays of dominance, the rejection of influence, and withdrawal. In addition, the family system may keep tight controls on information transmission, keeping aggression invisible to those outside the family. Systems models place the locus of intimate aggression within the dysfunctional dyadic/family unit, rather than the individual (Healy, Smith, and O’Sullivan, 1998). Giles-Sims (1983) has presented the family systems theory and stated a six-stage systems model of abuse and battering within a family.

According to relational control theory and communication models, communicative strategies are used to establish and maintain control in relationships and that aggressive behavior is associated with control-related conflict in relationships.
Conflict theory posits that all social relationships contain conflict, as do all social organizations. Violence is viewed as a powerful means of achieving one's motives (Coleman and Straus, 1986).

There is empirical support for elaborations of a cognitive behavioral model that posits the influence of parents' cognitive and behavioral repertoire in helping their children to negotiate developmental tasks. This model identifies key parental skills or behaviors that need to be understood, such as developmentally sensitive expectations, adaptive attributions, adequate child-rearing and problem-solving skills, and constructive self-management (coping and social) skills. The model also maintains that the child's competencies and challenges and other contextual obstacles to positive parenting influence parental behavior. This model has attempted to classify abusers based on observations of parent-child interaction (Kolko, 1996a).

Related ecologically based or transactional models have integrated dysfunctional child-caregiver-family-environment interactions in understanding the precipitants and correlates of child physical maltreatment. Ecological theorists advocate evaluation of the association between parental behaviors that elicit harsh parent-child interactions and children's coping strategies, among other family system characteristics. Within the interactional perspective, child physical maltreatment represents the interplay among child, parent, and family factors (Kolko, 1996b). As an extension of this perspective, Belsky's (1993) "developmental-ecological" model is heuristically important in its emphasis on developmental child and parental characteristics, immediate interactional processes, and broader social context associated with child maltreatment. Numerous
influences on the expression of punitive parental behaviors towards children are consistent with these perspectives and require integration in model development. These influences on parental behavior include observational learning (via modeling) of aggressive response patterns, failure to acquire pro-social parenting competencies or skills (especially in the face of heightened anger arousal), and development of coercive behaviors due to exposure to aggressive family interaction patterns and reinforcement for aggression. A multifactor model is needed because no single individual characteristic, especially among child factors, consistently has been related to abusive behavior and because few variables are directly related to abuse (Kolko, 1996a).

**Individual characteristics.** The characteristics can be broadly studied as:

**Child characteristics.**

a) Health/medical status: Early health and medical problems may place certain children at risk for abuse. Medical, intellectual, or developmental aberrations (e.g., birth complications, physical disability, low IQ) are some of the characteristics that may contribute to the emergence of abusive interactions (Belsky and Vondra, 1989). However, there is a mixed evidence that these characteristics significantly increase a child’s risk above and beyond parental characteristics. Instead, such problems are more likely to be sequelae than causes of abuse. Of course, health problems may increase parental responsibility and worry, financial burdens on the family, disruptions in routines, and, in cases of serious health complications, may result in long separations from parents (Kolko, 1996b).

b) Temperament/behavior: Other aspects of the child’s general behavior have been emphasized in child physical maltreatment formulations, including such
attributes as difficult temperament (e.g., impulsivity, crying) and both behavioral and emotional deviance (e.g., aggression, depression; Belsky and Vondra, 1989). Such characteristics (e.g., high activity level, limited sociability) may reduce parental tolerance and increase parental reliance on physical discipline. Although deviant child behaviors have contributed to abusive incidents and have differentiated abused from non-abused conduct-problem children, a child's behavioral deviance is an insufficient explanation of such events (Kolko, 1996a). Nevertheless, a child's difficult temperament and conduct problems are potent stressors that can disrupt parenting practices and effective parent-child interactions. A feature common to both categories is an adverse effect on attachment history. Difficulties occurring especially early in a child's life may create undue burden on parents while also limiting the development of positive parent-child bonds. Excessive child-rearing responsibilities or challenges created by these vulnerabilities may result in increased parental irritability and reduced patience, thus heightening the likelihood of inconsistent care or punitive treatment (Ciccheiti, 1990). That specific child characteristics have been so implicated in interactional models of child abuse highlights the importance of documenting a child's behavioral characteristics and pro social repertoire.

Parental characteristics. The majority of the parental characteristics reflect heightened levels of distress or dysfunction (e.g., depression, physical symptoms) and inappropriate parenting strategies rather than specific psychiatric disorders.

a) Childhood history of abuse: The connection between harsh punishment experienced as a child and subsequent family violence has been described as one primary interactional mechanism by which abusive behavior is transmitted. (Gelles and
Straus, 1987). An excellent prospective study extended these findings in showing a relationship between a grandparent's practices and an adult's subsequent use of harsh parenting practices, especially among mothers. Interestingly, they found aggressive parenting practices are not transmitted indirectly by influencing parental personality or beliefs about the legitimacy of harsh parenting practices. Rather, adults who experience or witness abuse during childhood, are exposed to aversive models and may learn to use aggressive methods of disciplining children (Kolko, 1996b).

Although the percentage of abused children who become abusive parents is not small (estimated at about 30), most of them do not grow up to be abusers, nor does early abuse always distinguish abusers from non-abusive parents. Early physical punishment is only one of the primary risk factors for child physical maltreatment (Straus and Smith, 1990) and may be related more to whether a child becomes the target (vs. source) of aggression. Besides childhood exposure, the likelihood of child's physical maltreatment is influenced by other psychological or contextual factors. Taken together, these studies suggest that early abuse and later child physical maltreatment are related indirectly and that many variables are related to child physical maltreatment.

b) Personality and psychiatric disturbances: Specific characteristics of parental personality may increase the likelihood of parental aggression. Hostile personality has been found to be significantly related to the use of harsh parenting, and parental explosiveness, as well as irritability and the use of threats, has been associated with aggression against children and disrupted discipline.

c) Psychiatric disturbances: (such as depression) and substance abuse have been implicated in cases of CPA. Both forms of dysfunction may render parents less
able or willing to maintain a high level of involvement with a child and more likely to exhibit irritability or anger in response to child misbehavior. Substance abuse may increase the risk of court noncompliance and, along with alcohol abuse, may increase the chance of a child's removal from the home. Likewise, maternal drug use has been associated with child maltreatment and child removal (Kelley, 1992). Recent evidence based on structured interviews has shown that current and past affective disorder, substance abuse, and posttraumatic stress disorder (PTSD) are more common in abusive than control parents.

d) Cognitive style: Recent perspectives have suggested that abusers have negative cognitive-attribitional styles or perceive their children in a more negative light than non-abusive parents. For example, abusive parents have displayed high expectations of their children's behavior, which maybe paralleled by a perception that the child's behavior is deviant. In one study, abusive parents reported higher levels of behavioral dysfunction among their children than those of comparison parents, even though home observations failed to reveal group differences (Whipple and Webster-Stratton, 1991). Parents who believe in the appropriateness of strict physical discipline and who also have high expectations of their children's behavior are more likely to engage in harsh parenting. Indeed, abusive parents are more accepting of physical punishment than non-abusive parents.

In suggesting the presence of negative child perceptions, these constructs imply that parents may view their children with limited acceptance or positivity, which, in turn, may influence their actual management practices at home. Plausible reasons for excessive parental negativity towards children's misbehavior include parental distortions
regarding the child’s responsibility for certain actions, parental unhappiness and psychiatric disturbances, and reduced tolerance for child problems (Kolko, 1996b).

e) Behavioral functioning: Abusive parents have been noted to exhibit inconsistent child-rearing practices that often reflect the presence of critical, hostile, or aggressive management styles. In addition, they may exhibit limited attention to their children, as reflected by low levels of positive affect and social behavior, poor problem solving, and less attention-directing verbal and physical strategies, with the latter study showing less mutual interaction in both free play and problem-solving situations. In some cases, abusive parents actually have responded aversively to child’s prosocial behavior (Kolko, 1996a).

Since deficits in parental coping skills may be identified in diverse areas (e.g., child management, anger control, finance), it is important to incorporate multidimensional measures that tap these broad domains of functioning. For example, self-reports of both positive and negative parenting behaviors would elaborate on the quality of parent-child relationships. The experience of serious parental stressors in some families (e.g., low parental social support, depression, marital discord) further may restrict parents’ abilities to support their children’s efforts to cope with adversity.

f) Biological factors: Few biological variables have been examined in relation to child physical abuse, but one characteristic, hyper arousal to stressful child-related stimuli, has been documented among physical child abusers, especially in skin conductance (a measure of autonomic arousal). Greater autonomic activity also has been found in response to non child-related stimuli perceived as stressful (Casanova,
Domanic, McCanne, and Milner, 1991), which may contribute to parents' impulsive behavior and problem-solving difficulties.

**Family-system characteristics.**

a. Coercive parent-child interactions: Family influences on abusive behavior reflect a broad range of functional and structural characteristics. For example, observational studies have shown that abusive parents and their victimized children exhibit aggressive or coercive behavior towards one another (Kolko, 1996a).

Parents' aversive behavior often is reinforced negatively during coercive interactions because it terminates children's deviant behavior. Other factors contributing to coercive interactions include the use of ineffective child management techniques, such as the limited use of positive affect and general discussion. Indeed, limited positive interactions actually may be more characteristic of abusive families than excessive negativity (Caliso and Milner, 1992).

Overall, social-interactional studies identify patterns characterized by excessive family coercion and limited positive exchanges, with some evidence for aversive child behaviors. These findings stress the potential significance of aversive confrontations with family members as antecedents to or sequelae of child physical abuse. It should be pointed out that sometimes gender affects the quality of the overall patterns. For example, Whipple and Webster-Stratton (1991) found that increased harsh physical punishment was observed among fathers but not mothers in abusive families, but only mothers were more critical verbally.
b. Poor family relationships: Physically punitive family environments may support psychologically abusive or coercive communications that contribute to the level of psychopathology evinced by child victims. This family context of hostility may interact with other child and parental variables which maintain abusive behavior, such as heightened conflict and decreased cohesion or partner abuse. Although, it follows that hostile relationships within the family contribute to abusive behavior, more empirical evidence examining this relationship is needed.

Other contextual and social system variables: Diverse stress-eliciting factors or family socioeconomic disadvantages (e.g., limited income, unemployment, family size, youthful parenthood, single parent-ship) contribute to the expression of violent behavior. Abusive families have experienced numerous child and parent stressors and social disadvantage. Poverty alone has emerged as a significant predictor of abuse status, and parental insularity or isolation has been regarded as a significant correlate. The experience of few positive extra familial relationships and much frustration with family members may compromise parents’ overall effectiveness.

In one study, the developmental ecologies of the families of abused children were found to be characterized by parental worries, dissatisfaction with their children and the parenting role, limited emotional expressiveness, social isolation, and lack of encouragement for the development and autonomy of their children (Trickett, Aber, Carlson, and Cicchetti, 1991). Interestingly, the findings differentiating abusive from non-abusive families were more pronounced among cases from higher rather than lower socioeconomic status. The social disadvantage of abusive families, then, involves impoverishment in both social and community resources.
Domestic violence risk factors. Domestic violence risk factors include following:

I. Risk factors for perpetrators. Risk factors for perpetrators include followings:

   a) Age: One of the most consistent risk factors for perpetration is age. As in violence between non intimates, family violence is most likely to be perpetrated by those between ages 18 and 30. For child abuse, the age of the mother at the birth of the abused child has been found to be related to rates of physical abuse, with younger mothers exhibiting higher rates of abuse. An analysis of data from the 1985 National Family Violence Survey found young men significantly more likely to abuse their spouses (Chalk and King, 1998).

   b) Gender: Men are the most likely offenders in acts of intimate as well as non intimate violence. However, the differences in the rates of offending between men and women are much smaller for family violence than for violence outside the home. Men and women have comparable rates of child homicide. Although women have been regarded as more likely to be offenders when the child victim is young (under 3 years of age) because of their traditional roles as primary caregivers for infants and toddlers, recent research suggests that extremely stressed or enraged male adults (including birth fathers, stepfathers, and boyfriends) are more often the cause of physical abuse fatalities involving an infant or small child. The extent of male victimization is controversial in the field of family violence. The earliest studies of spousal violence reported violence by women toward their husbands. The two National Family Violence Surveys also found a higher than expected incidence of violence toward men, the rate of violence was the same or even higher than that
reported toward women (Straus and Gelles, 1986; Straus, Hamby, Finkelhor, Moore and Runyan, 1998). In addition, women initiated violence about as often as men did (Straus, 1991). However, the researchers qualified their findings by noting that much of the female violence appeared to be in self-defense and that women, because of their size and strength, appeared to inflict less injury than male attackers. In contrast to the National Family Violence Surveys, the National Crime Victimization Survey found women reporting much higher rates of victimization by partners or ex-partners than men reported (Chalk and King, 1998).

c) Income: A series of research studies over the past decades has found consistent evidence of strong relationships between poverty and the reported occurrence and severity of child maltreatment. Stress is thought to be the dominant variable associated with the relationship between low income and care giving behaviors, but research attention has recently focused on other factors as well, including material hardships, housing, coping and care giving strategies, and dangerous environments (Pelton, 1994). Severe violence toward children is more likely in poor families who have fewer economic and social resources to help with child care responsibilities, especially among those who are least able to cope with the material hardships of poverty (Gelles and Straus, 1988). Although most poor people do not use violence toward intimates, self-report surveys and official report data find that the rates of all forms of family violence, except child sexual abuse, are higher for those whose family income is below the poverty line. As noted above, poor families are more likely to be in contact with social service agencies and hence be under greater scrutiny, thereby increasing the likelihood that they will be reported for abuse or neglect.
Nonetheless, the association between child maltreatment and poverty persists in self-report data as well as in official data (Chalk and King, 1998). In a review of studies of risk markers for domestic violence, Hotaling and Sugarman (1990) reported that, although wife assault occurs across all occupational, educational, and income groups, it is more common and more severe in families with lower socioeconomic status. In addition, higher-socioeconomic-status women seem to be just as likely as lower-socioeconomic-status women to report being verbally assaulted and just as likely to have experienced minor physical violence (i.e., having something thrown at them, being pushed, shoved, slapped, or grabbed). But the frequency and severity of serious assaults appear to be linked to socioeconomic status.

d) Race: The picture is less clear on race. Both official report data and self-report survey data often report that child abuse and violence toward women are overrepresented among minorities. Data from the National Crime Victimization Survey indicate that the rate of domestic violence is essentially the same for whites (5.4 per 1,000), blacks (5.8 per 1,000), and Hispanics (5.5 per 1,000). All three National Incidence Studies of Child Abuse and Neglect found no significant relationships between the incidence of maltreatment and the child's race or ethnicity (Sedlak and Broadhurst, 1996).

II. Situational and environmental factors. Situational and environmental factors include the following:

a) Personality characteristics: Researchers have searched for personality characteristics or psychiatric disorders to explain the behavior of family violence perpetrators. Although a consistent profile of parental psychopathology or a
significant level of parental mental disturbance has not been supported (Polansky, Gaudin and Kilpatrick, 1992), a set of personality characteristics associated with child maltreatment has emerged with sufficient frequency to warrant attention. These characteristics include low self-esteem, external locus of control, poor impulse control, depression, anxiety, and antisocial behavior. A number of studies have found a high incidence of psychopathology and personality disorders, most frequently antisocial personality disorder, borderline personality organization, and post-traumatic stress disorder among men who assault intimate partners (Dutton and Starzomski, 1993). Nonetheless, batterers appear to be a heterogeneous group, a finding that has led some researchers to develop typologies to represent different subgroups. In some cases, the psychological needs of perpetrators can reflect socially constructed role expectations, especially when cultural norms can provide social permission for males to terrorize and control their partners (Chalk and King, 1998).

b) Stress and marital conflict: A number of stressful life events, such as unemployment, financial problems, and sickness or death in the family have been identified as possibly related to violence. For example, an association between unemployment and child maltreatment has been documented by a number of researchers (Whipple and Webster-Stratton, 1991). In another analysis, high levels of marital conflict and low socioeconomic status emerged as the primary predictors of increased likelihood and severity of wife assault (Hotaling and Sugarman, 1990). The relationship among stressful life events, the personalities of the people affected by them, and the role of stress as a factor in marital conflict and family violence remains
poorly understood. For example, it is not certain whether individuals in violent relationships lack specific skills that can improve their ability to negotiate and compromise and eliminate the use of violence as a strategy to resolve conflict, or whether the sources of marital conflict in seriously or frequently violent relationships are different from those that characterize other relationships (Hotaling and Sugarman, 1990).

c) Social isolation and social support: The data on social isolation are somewhat less consistent than are the data for the previously discussed correlates. First, because so much of the research on family violence is cross-sectional, it is not clear whether social isolation precedes violence in the home or is a consequence of it. Second, social isolation has been crudely measured, and the purported correlation may be more anecdotal than statistical. Nevertheless, researchers often agree that people who are socially isolated from neighbors and relatives are more likely to be violent in the home. Social support appears to be an important protective factor. One major source of social support is the availability of friends and family for help, aid, and assistance. The more a family is integrated into the community and the more groups and associations they belong to, the less likely they are to be violent (Straus, Hamby, Finkelhor, Moore and Runyan, 1998).

d) Intergenerational transmission of violence: The notion that abused children grow up to be abusing parents and violent adults has been widely expressed in the family violence literature (Gelles, 2007). One review that examined self-reports of the intergenerational transmission of violence toward children concluded that the best estimate of the rate of inter-generational transmission is 30
percent (Kaufman and Zigler, 1987). Although a rate of 30 percent is substantially less than the majority of abused children, it is considerably more than the rate of 2 to 4 percent found in the general population (Straus and Gelles, 1986). A study that examined continuity and discontinuity of abuse in a longitudinal study of high-risk mothers and their children found that mothers who had been abused as children were less likely to abuse their own children if they had emotionally supportive parents, partners, or friends. In addition, the abused mothers who did not abuse their children were described as "middle class" and "upwardly mobile," suggesting that they were able to draw on economic resources that may not have been available to the abused mothers who did abuse their children. A study that looked prospectively at the cycle of violence hypothesis found that physically abused and neglected children are at risk of becoming violent offenders when they grow up, compared with matched controls of the same age, sex, race, and approximate social class (Widom, 1989). Evidence from studies of parental and marital violence indicates that, although witnessing or experiencing violence by caregivers in one's family of origin is often correlated with later violent behavior, such experience is not the sole determining factor. When the intergenerational transmission of violence occurs, it is probably the result of a complex set of social and psychological processes and confounded with other, more discriminating risk markers, such as marital conflict and socioeconomic status (Hotaling and Sugarman, 1990). Although experiencing and witnessing violence is believed to be an important risk factor, the actual mechanism by which violence is transmitted from generation to generation is not well understood. The role of the media, for example, may have a powerful
influence in transmitting sex-role expectations, conflict resolution strategies, and images of family interactions (Chalk and King, 1998).

e) Alcohol and drug use: The use of alcohol is often associated with aggression, suggesting that it may be a risk factor for family violence, but the associations among alcoholism, drug use, and family violence are poorly understood. Results of studies on alcoholism and child maltreatment have been contradictory, with some studies finding a significant relationship and others not (Widom, 1992). Estimates of the extent of alcoholism among abusive parents range from 18 to 38 percent, compared with estimates of 6 to 16 percent for the general population (Harford and Parker, 1994; Widom, 1989 and 1992). Alcohol use has been reported in 25 to 85 percent of incidents of domestic violence. Although alcohol consumption patterns are associated with other variables related to violence (such as witnessing violence in one’s home; Kantor, 1993), the positive relationship of men's drinking to domestic violence persists even after socio demographic variables, hostility, and marital satisfaction are statistically controlled for. Men's drinking patterns, particularly binge drinking, are associated with domestic violence across all ethnic and social classes (Kantor, 1993).

f) Gender inequality and sex-role expectations: An important risk factor for violence against women appears to be gender inequality. Individual, aggregate, and cross-cultural data find that the greater the degree of gender inequality in a relationship, community, and society, the higher are the rates of violence toward women. One review of 52 case-comparison studies did not find significant differences in measures of sex role inequality between violent and nonviolent couples (Hotaling and
Sugarman, 1990). In a later analysis, the authors observe that expectations about division of labor in the household was one of four markers associated with a risk factor that they labeled “marital conflict.” The other three markers were marital conflict, frequency of husband’s drinking, and educational incompatibility (Hotaling and Sugarman, 1990).

g) Presence of other violence: A final general risk factor is that the presence of violence in one family relationship increases the risk that there will be violence in others. For example, children in homes in which there is violence between their parents are more likely to experience violence than are children who grow up in homes where there is no such violence. Moreover, children who witness and experience violence are more likely to use violence toward their parents and siblings than are children who do not experience or see violence in their homes (Chalk and King, 1998).

h) Risk factors for victims: Early research in domestic violence and child maltreatment looked for factors that differentiated victims from non victims. It was suggested that personality or other personal traits of victims could provoke anger or aggression. Much of this research has been criticized on methodological grounds and it has been suggested that personality traits of victims identified in some early studies were the result rather than the cause of the violence (Hotaling and Sugarman, 1990). Compared with research on offenders, there has been somewhat less recent research on victims of family violence that focuses on factors that increase or reduce the risk of victimization. Most research on victims examines the sequelae of victimization (e.g., depression, psychological distress, suicide attempts, symptoms
of post-traumatic stress syndrome) and the effectiveness of various intervention efforts (Chalk and King, 1998).

i) Children: Early research suggested that a number of factors raise the risk of a child's being abused. Low-birth weight babies, premature babies, and children with developmental or other disabilities were all described as being at greater risk of being abused by their parents or caregivers. However, a review of such studies calls into question many of these findings (Starr, 1988). One major problem is that few investigators used matched comparison groups. More recent studies did not find premature babies or children with disabilities as being at higher risk for abuse (Starr, Dubowitz and Bush, 1990). The very youngest children appear to be at the greatest risk of abuse, especially the most dangerous and potentially lethal forms of violence. Not only are young children physically more fragile and thus more susceptible to injury, but also their vulnerability makes them more likely to be reported and diagnosed as abused when injured. Older children are most likely to be underreported as victims of abuse (Chalk and King, 1998).

j) Marital partners: Being female is the most consistent risk factor for being a victim of domestic violence (Hotaling and Sugarman, 1990). Early studies unsuccessfully attempted to find a psychological profile that put a woman at risk of being battered. Early descriptive and clinical accounts described battered women as dependent, having low esteem, and feeling inadequate and helpless and reported a high incidence of depression and anxiety among clinical samples. Later studies have questioned whether these victim characteristics were present before the women were battered or are the result of the victimization (Hotaling and Sugarman, 1990).
Clinical studies often use small and selective samples and fail to have comparison groups. A comprehensive review of risk factors found that the only one consistently associated with being a victim of physical abuse was having witnessed parental violence as a child. As noted earlier, this finding was modified in a later review, and the authors attribute this modification to the use of multivariate analysis that can distinguish between minor and severe violence, marital conflict, and the use of violence in the home (Chalk and King, 1998).

**Frequency of domestic violence.** As domestic violence is hidden, subjectively defined and difficult to measure, it is impossible to estimate precisely how frequently it occurs. However, the fact that it is rarely seen and difficult to measure should not be taken to mean that it rarely occurs. In fact, if there is one point about which all family violence experts seemingly agree, it is that domestic violence is far more common than is generally realized (Gelles and Cornell, 1990). In the recent report of WHO and UNICEF (2008), it was discussed that injuries and violence are a significant cause of child death, physical and psychological disability. Every year injuries and violence kill approximately 950,000 children (aged less than 18 years) and injure or disable tens of millions more. Known, effective prevention and treatment strategies remain greatly underutilized, especially in low- and middle-income countries where 95% of child injury deaths occur. The WHO Global Burden of Disease Database estimated that 1.2 million children experienced some form of violence in 2004, in the WHO Eastern Mediterranean Region. Levesque (2001) cited, estimates that made by the United Nations that between 17-38% of world women are victims of intimate violence as high as 60% in developing countries. World health organization (2008) in a survey in 12 countries showed that 43% of males and
29% of females between 13 and 15 years of age were physically or psychologically abused, in 2006–2007. Finding from the National Violence Against Women Survey in US indicate similar rate of child abuse, with 52% of adult women and 66% of adult men in the survey sample reporting that they were assaulted as children by adult caretakers (Tjaden and Thoennes, 2000). Approximately 1200 children die annually in US as a result of abuse or neglect and estimated 50% of all homicide victims under the age of 10 are killed by family members (Barnett, Miller-Perrin and Perrin, 2005). Kilpatrick, Saunders and Resnick (1998) in a study on sample of four thousand of 12-17 years old American adolescents found that 8% had experienced sexual assault, 17% physical abuse and 39% had witnessed significant acts of violence. They also estimated out of twenty four million, 12-17 years American adolescents, approximately 1.9 million had experienced sexual assault, 4.1 million physical abuse and nearly 10 million had witnessed significant act of violence. One forth of Americans were victims of domestic violence. Battering is the primary cause of injury to women in the United States. (Barnett, Miller-Perrin and Perrin, 2005). There is estimated that 10 million children annually witness the punching, kicking, and beating of their parent, most commonly their mother (McNeal and Amato, 1998). Zoloter, Theodore, Coyne-Beasley and Runyan, (2007) determined the prevalence of child maltreatment in homes with and without interpersonal violence using cross-sectional analysis of survey data of mothers with partners (n = 1,232). Inter parental violence was associated with all forms of child maltreatment in this sample. Demographers estimate that about 12% of Chinese girls infants go missing each year. Approximately 14000 Russian women are killed each year by intimates (it is five times the rate found in America; Barnett, Miller-Perrin and Perrin,
Aberle et al. (2007) determined the prevalence of different forms of child abuse among 2140 high school pupils in Slavonski Brod of Croatia. They found that almost 80% of pupils had been verbally or nonverbally punished for disobedience at homes. Physical abuse was less common and usually did not result in serious injuries. Panter-break, Eggerman, Gonzalez and Safdar (2009) did a survey on 1011, 11-16 years old children in Afghanistan to assess the traumatic events experienced by them and their mental status. Two thirds of children reported traumatic experiences, out of which the most common was domestic violence. Also 8.4% were exposed to five or more events. The most distressing lifetime trauma (about 60%) was related to violence; this encompassed injury, witnessing violence to another person, the death or disappearance of close relatives, living in a combat zone, and forced displacement. A study conducted in India by international center for research on women, report that 45% of interviewed women had been victim of domestic violence (Manohar, 2001). In 2007, the Ministry of Women and Child Development of India released a study report on child abuse. The report discusses incidence of child abuse nationwide. It is estimated that 150 million girls and 73 million boys under 18 have been subjected to forced sexual intercourse or other forms of sexual violence. The study found that 69% of children reported to have been physically abused. Out of these 54.68% were boys. 52.91% of boys and 47.09% of girls reported having been abused in their family environment. Of the children who were abused in family situations 88.6% were abused by their parents. Every two out of three school children reported facing corporal punishment. Half the children reported facing emotional abuse with 83% of that abuse begin conducted by parents. 70.57% of girls reported having been neglected by family members. 48.4% of girls wished they
were boys. 27.33% of girls reported getting less food than their brothers. They also reported in 2002, there were 53,000 reported cases of child homicide in India. Kermanshahi, Hamidi and Asadollahi (1997) have assessed child maltreatment by parents in 555 7-11 years old students girls in Tabriz city of Iran. They found that, physical abuse was reported by 67.7% and mental maltreatment was reported in 47.6% of girls. Stephenson, Sheikhattari, Assasi, Zamani and Eftekhar (2006) examined the determinants of three types of child maltreatment in Kurdistan province of Iran. Data were collected from 1370 school students age 11-18 years. Results showed that boys were maltreated more than girls in any kind of child maltreatment. Residency in a rural area, poor parental relationships and the use of addictive substances by household members were associated with increased Odds Ratio of reporting child maltreatment. Jaberghaderi et al. (2008) found that physical abuse in the family was the most common event reported by 65% of the participants in Kermanshah city of Iran. Sexual abuse was reported by at least 7 boys (1.4%) and 11 girls (2.3%). Family violence was found in 38.1% of pupil and parents divorce was reported by 6.7% of the participants.

**Domestic Violence Sequelae**

**Theoretical perspective.** 1. Attachment theory: This theory provides a valuable conceptual model for understanding the role of the parent–child relationship and its sequelae for the child’s emerging self-concept and view of the social world. Attachment style is an individual-difference variable that is rooted in the child’s early rearing experience and provides the context for later emotional, behavioral, and cognitive transactions with the environment. Damaged attachment, rooted in the work of Bowlby (1969) and, attachment theory examines the almost universal tendency for infant
attachment to a caregiver. Some argue that attachment difficulties in the parent precipitate abuse of the child. In addition, abusing mothers tend to exhibit more negative-type behaviors (harshness, excessive control) in interactions with their children. Maltreated children tend to be anxiously attached to parents. Beyond the emotional bond, which Bowlby (1969) argues is the essence of attachment, there is the concept of attachment security. Insecurely attached children have difficulty managing their environments. In these cases, the parent’s presence does not inspire confidence either that there will be protection or, more simply, that the parent will be available. Consequently, without a secure base in light of danger, poorly attached children are less likely to explore their environments. In sum, it is reasonable that children with problematic attachment circumstances will develop repertoires more likely to isolate them in a variety of ways. Attachment theory (Bowlby, 1969) also addresses the tendency for children to develop internal representational models of their caretaker and themselves. Such internal working models portray images of the outside world to the child. Abused children fail to learn empathy, which helps one to feel for others and serves as an inhibiting factor for engaging in harmful behaviors toward others. Rather than an intergenerational transmission of empathy from caregiver to child, abused children internalize a more hostile view of the world, which has negative implications for healthy engagement with others. Indeed, “an infant who experiences a secure attachment relationship is thought to internalize a sense of others as available and of the self as worthy of attention and care”. Abused children, lacking such secure attachment, learn the opposite: abandonment and unworthiness. In addition, social network theory proposes that insecure attachments can lead to a generalized
fearfulness of others in the child, which consequently can encourage the child to avoid peer relations (Elliott, Cunningham, Linder, Colangelo and Gros, 2005)

2. Parental acceptance- rejection theory (PARTheory): The strategies that the physically abused and neglected children adapted for interactions with their parents also marked their relationships outside the family. Thus, physically abused children are at risk of antisocial behavior and sustained suspicion toward the others, and neglected children are at risk of social withdrawal, and social rejection and feelings of incompetence (Finzi, Ram, Har-Even, Shnit and Weizman, 2001). Perceived rejection by an attachment figure at any point in life is likely to be associated with the same cluster of personality dispositions found among children and adults rejected by parents in childhood. In PARTheory, parental acceptance-rejection refers to a bipolar dimension, with parental acceptance on one end and parental rejection on the other end. Parental acceptance reflects warmth, care, affection, support, and all other positive things that parents do for their children, while parental rejection reflects the opposite. According to PARTheory, humans need to feel accepted by the people most important to them in childhood (Rohner, 1986). When people feel that their need for acceptance has not been met, they may develop a specific collection of dispositions that together define the acceptance-rejection syndrome. The acceptance-rejection syndrome includes: 1) hostility and aggression; 2) dependence; 3) negative self-esteem; 4) negative self-adequacy; 5) emotional unresponsiveness; 6) emotional instability; 7) negative worldview; 8) anxiety; 9) insecurity; and 10) cognitive distortions (Rohner, 1986).
3. Psychological trauma theory: in this perspective, psychic trauma occurs when a sudden, unexpected, overwhelming intense emotional blow or a series of blows assaults the person from outside. Traumatic events are external, but they quickly become incorporated into mind. Traumatization occurs when both internal and external resources are inadequate to cope with external threat. Clinicians make the point that it is not the trauma itself that does the damage. It is how the individual’s mind and body reacts in its own unique way to the traumatic experience in combination with the unique response of the individual’s social group. Children are traumatized whenever they fear for their lives or for the lives of someone they love. A traumatic experience impacts the entire person - the way we think, the way we learn, the way we remember things, the way we feel about ourselves and other people, and the way we make sense of the world are all profoundly altered by traumatic experience (Bloom, 1999). Posttraumatic stress symptoms and posttraumatic stress disorder (PTSD) are important sequelae of exposure to violence because they can impair social and behavioral functioning. Many children who do not meet diagnostic criteria for PTSD may experience troublesome symptoms. Physical and sexual abuse, community violence, and exposure to domestic violence are linked with posttraumatic stress symptoms, with links particularly well documented for sexual abuse. The degree to which exposure leads to posttraumatic stress symptoms in children may vary with the intensity of the violence and the degree to which the violence has lasting effects on the people most important to them (e.g., witnessing a stranger being punched vs. seeing a parent being assaulted vs. being directly victimized; Margolin and Gordis, 2004).
4. Psychobiological perspective: Researches on Psychobiological perspective showed that response to traumatic stressors is not a purely cognitive construct, but is also associated with physiological and neuroendocrine-mediated mechanisms. Biological correlates of trauma include apparent altered limbic system functioning, electroencephalogram abnormalities, hypersecretion of the neurotransmitter dopamine and increased levels of cerebral spinal fluid and plasma concentrations of beta-endorphins, an endogenous opioid. In addition, PTSD symptoms have been linked to differences in both major neuroendocrine stress responses, catecholamines, and adrenal glucocorticoids. The majority have determined that increased sympathetic nervous system functioning is more representative of a stress or trauma response. Functionally, this neurochemical response leads to diffuse behavioral arousal, essentially the basis of the “fight-or-flight” survival response. Increased levels of cortisol work to suppress or contain other physiological stress defense responses, regulating against chronic over-reactivity. The relation between hypothalamic–pituitary–adrenal (HPA) axis functioning and a diagnosis of PTSD is much more controversial. Contrary to the positive relation between stress and cortisol levels, some laboratories report lower cortisol levels in patients with PTSD. Further, children exposed to marital violence differed significantly from comparison children with respect to sympathetic nervous system functioning and HPA axis functioning. Specifically, elevations were seen in heart rate and salivary cortisol levels, but not in orthostatic challenge response or blood pressure. These results indicate that children exposed to marital violence have a different physiological presentation than controls and may be physiologically
"traumatized" by virtue of marital violence exposure (Saltzman, Holden and Holahan, 2005).

5. Emotional security theory: This theory was originally developed to account for why children exposed to high levels of inter parental conflict evidenced a range of mal-adaptive outcomes. Extant research at the time led to the conclusion that there were two primary pathways underlying the risk posed by inter parental conflict. First, in supporting a direct path model, evidence suggested that inter parental conflict increases children’s vulnerability to adjustment problems by progressively amplifying their distress and reactivity to subsequent adult conflicts. Second, consistent with an indirect path model, findings from an independent line of research supported the prediction that disturbances in parenting practices and parent–child relations mediated the link between inter parental conflict and child psychological maladjustment. The emotional security theory posits that preserving emotional security is an important goal that organizes children’s emotional experiences (e.g., fear), action tendencies (e.g., withdrawal, involvement) and appraisals of the self and others (e.g., perceptions of threat to well-being) across multiple family relationships, including the inter parental subsystem. Although the emotional security theory does not deny the significance of multiple goals and tasks for children’s adaptation, the emotional security theory postulates that within the hierarchy of human goals, protection, safety, and security are among the most salient and important. Thus, one implication is that a child’s sense of security in the inter partner relationship is a prominent process that is relatively distinct in its origins, organization, and sequelae from security within the parent–child relationship. Building on the assumption that children develop their own distinct sense of
security in the inter parental relationship, the direct path component of the emotional security theory proposes that children's security in the inter parental relationship is a central mediating mechanism underlying the direct risk posed by inter parental conflict for children. Repeated exposure to heightened hostility, distress, and disengagement between parents is specifically theorized to increase children's concerns about their security over time as they grapple with worries about the welfare of their parents, proliferation of parental discord into the parent–child subsystem, and the implications for family instability and dissolution (Davies, Winter and Cicchetti, 2006).

Despite the above theories' explanation regarding the impacts of domestic violence on child victims, there are still some paradigms which should be considered before. One primary issue on sequelae is the extent to which physically abusive behavior represents a traumatic experience and how the development of posttraumatic symptoms relates to the psychosocial context of DV, such as disruption in family life processes, deviations in child development, severe family dysfunction and cultural context. The specificity of the attachment disturbance and types of PTSD symptoms seen among CPA victims could be examined in comparison with child victims of other forms of trauma including violent crime and sexual abuse. These comparisons would help researchers to evaluate the unique clinical pictures associated with different traumatic experiences (Kolko, 1996c).

The strongest evidence regarding sequelae points to problems with aggression, peer social behavior and parent–child interactions, all of which may reflect disturbances in attachment or the maintenance of relationships. However, it is important to determine how unique these symptoms are in comparison to those of other children seen in clinics.
or assumed to be at risk. Another related issue is the nature and extent to which these sequelae persist into later childhood and adolescence like peer relations, school adjustment and academic progress and cognitive-attributional repertoire. So evaluation of neurological impairment, academic problems, social competence, depression, suicidality, drug use and involvement in violent and criminal activities is also important. And, it is important to evaluate other family problems such as coercion, verbal hostility and poverty because those may contribute to increased child dysfunction (Kolko, 1996c).

Sugaya et al. (2012) in their recent national study in U. S characterized adults who report being physically abused during childhood, and examined associations of reported type and frequency of abuse with adult mental health. Data were derived from the 2000-2001 and 2004-2005 National Epidemiologic Survey on Alcohol and Related Conditions, a large cross-sectional survey of a representative sample (N = 43,093) of the U.S. population. Logistic regression models were used to examine the strength of associations between child physical abuse and adult psychiatric disorders adjusted for socio-demographic characteristics, other childhood adversities, and comorbid psychiatric disorders. Child physical abuse was reported by 8% of the sample and was frequently accompanied by other childhood adversities. Child physical abuse was associated with significantly increased adjusted odds ratios (AORs) of a broad range of DSM-IV psychiatric disorders (AOR = 1.16-2.28), especially attention-deficit hyperactivity disorder, posttraumatic stress disorder, and bipolar disorder. Of those incurring such abuse, 84% had lifetime histories of at least one psychiatric disorder. The association between frequency of abuse and risk for later psychopathology occurred in
dose–response patterns. Compared with individuals without histories of childhood physical abuse, those who were hit hard enough to cause marks or injuries were at greater risk for attempting suicide (odds ratio for often hit hard, 9.42) and for anxiety, mood, and substance use disorders. Additional childhood adversities (sexual abuse, neglect, and parental psychopathology) were reported by 79% to 90% of those experiencing childhood physical abuse. After adjustment for numerous sociodemographic factors, comorbid psychiatric disorders, and the other childhood adversities, individuals with childhood physical abuse were still at higher risk for such disorders as attention-deficit/hyperactivity disorder (adjusted OR, 2.28), post-traumatic stress disorder (AOR, 1.55), bipolar disorder (AOR, 1.48), and psychosis (AOR, 1.27; borderline significance). These findings suggest that childhood physical abuse is independently associated with a range of psychiatric disorders, although the cross-sectional study design limits interpretation. For example, children with ADHD or bipolar or psychotic behavior might be at greater risk for receiving childhood physical abuse. Also, survey diagnoses of bipolar disorder might occasionally instead reflect cluster B personality disorders (not assessed in this study). The findings support the practice of asking about childhood physical abuse and other adversities when assessing patients with psychiatric conditions, including bipolar disorder and other psychotic illnesses.

Another issue is the relationship and co-morbidity of parent conflict and child physical abuse. Children as very much silent victims of domestic violence may witness parent conflict or be subject to it, but often their voice is not heard. In a review of studies, Hughes (1992) found correlations of 40–60 percent between child abuse and domestic violence. In a later review, Edleson (1999) reported that in 32 per cent to
53 per cent of all families where the men are physically abusive to their female partners, the men were also abusing the children. In 85 per cent of families children were present when their mothers were being abused in some way and in 71 per cent of these families children witnessed their mothers being physically assaulted. In 58 per cent of families, children overheard the violence to their mothers and from children’s accounts it would seem that hearing the violence but not seeing what was happening or knowing what to do about it has the potential to increase children’s feelings of powerlessness and trauma. In 27 per cent of families children overheard the verbal abuse of their mothers and they experienced this as abusive themselves. In a further 27 per cent of families children witnessed the outcome of the violence, particularly cuts and bruising to their mothers or damage to property. Clearly children were aware of the abuse of their mothers. If they were not physically present during an assault, they witnessed the verbal abuse and the outcomes of the man’s violence. Nevertheless, not talking to children about domestic violence did not protect them from it. They were already very much aware that it was happening; instead the silence just reinforced the idea that this was a shameful family secret (McGee, 2003; Sterne, Poole, Chadwick, Lawler and Dodd, 2010).

Different factors will influence how and to what extent children are affected, and the longer-term impact. These include:

• the age and developmental level of the child

• the length of time child has been exposed to domestic violence. For some, this will be his or her entire life
• the nature of the abuse and the levels of fear experienced. The child will worry greatly about the mother’s well-being and safety. Living in fear long term has a profound effect.

• the relationship with the abuser, e.g. parent, step-parent, brother

• the effect on the mother’s mental health and ability to parent effectively.

It should also be noted that some children who live with domestic abuse achieve highly in school; throwing themselves into school life and work can provide an escape. Yet in terms of emotional development, they are unlikely to emerge unscathed. There are three factors in children’s and young people’s lives that can result in them being at increased risk of developing mental health difficulties; these include:

• loss or separation – including resulting from parental separation, divorce or hospitalization, loss of friendships especially in adolescence, family breakdown that results in the child having to live elsewhere;

• life changes – including moving house, changing schools;

• traumatic events – including abuse and violence.

Many children who live with domestic abuse experience all of these (Sterne, Poole, Chadwick, Lawler and Dodd, 2010).

Domestic violence exposure not only may result in physical harms but also associated with detrimental effects on victims’ emotional, behavioral and cognitive functioning. It has been documented widely that children who have experienced maltreatment are at a risk for maladaptation and psychopathology (Briere and Scott,
One can not necessarily assume that child physical abuse is the cause of the various problems observed in its victims. Physical abuse often occurs in association with other problems within the family or in the environment, such as marital violence, alcohol, drug or substance use by family members, parental depression, psychological maltreatment and low socio-economic status (Barnett, Miller-Perrin and Perrin, 2005). Men’s severe IPV seldom occurs in the absence of other forms of family violence, and these other forms appear to contribute to children’s adjustment problems (McDonald, Jouriles, Tart, and Minze, 2009). Certainly it is not surprising to find that an abused child who regularly witnesses violence between his parents or is smacked by an older sibling but it is surprising if such a child is not having problem.

Some theoretical models attempting to identify mechanisms accounting for the negative reactions exhibited by child witnesses to marital aggression and child outcomes. Despite widespread acknowledgment that both the marital relationship and parenting relationship have significant effects on children. According to Baron and Kenny (1986), demonstration of a mediated model requires three steps: that marital aggression is related to child outcomes, that marital aggression is related to the parent-child relationship and that the relationship between marital conflict and child outcomes is significantly reduced once parenting is accounted for in the equation. Margolin and John (1997) in their study to examine the impact of marital aggression on children adjustment found that marital aggression spills over into the parent-child relationship. For boys the spillover is found in the association between parental power assertiveness and marital aggression. In fact men who abuse their wives are most aggressive toward their children, particularly their sons. So it is associated with creating hostility and
depression/anxiety in boys. For girls parental dimension mediate the effects of marital aggression on hostility but not on depression/anxiety. In over all marital aggression makes parents less emotionally available to the child. The perpetrator may be viewed by the child as dangerous and frightening whereas the victim may be perceived as overwhelmed and requiring caretaking herself. Thus child consider their parents as low on positive parenting if their fight is continued and increased. Children adjustment negatively associated with marital aggression and positively accounts for parents power assertiveness. When parent’s power assertion is entered simultaneously to marital aggression, children’s hostility and depression is significantly reduced. Thus improving parenting skills for the benefit of the child may be reduce the psychological impacts of marital conflicts and enhance children adjustment. Social support has been identified as a non familial variable that serving as an important protective function for children exposed to marital conflict (Jenkinz and Smith, 1990). Girls more than boys’ overall adjustment is associated with social relations external to the family (Margolin and John, 1997).

Nevertheless, aggression/violence has negative sequelae for children but bilateral intimate partner violence is associated with more total, externalizing, and internalizing problems, meta-analysis of 188 studies on the psychosocial outcomes of child witnesses to DV found that although witnesses had more negative out-comes than children who were not exposed or children from verbally aggressive homes, the outcomes did not differ significantly from those of physically abused children (English et al., 2009).

Physical abuse Sequelae. Physical abuse sequelae include following:
i. Medical sequelae. The physical harms of child physical abuse are numerous and range from minor physical injuries to serious physical disfigurements and disabilities and even death.

Bruises are one of the most common types of physical injuries associated with child physical abuse. Although non-abused children also incur bruises, physically abused children have bruises in uncommon sites (for example: buttocks, back, abdomen and thighs). Child physical abuse victims may also have other marks on their bodies as the result of being grabbed or squeezed or of being struck with belts or cords. When a child has a series of unusual injuries, this is often an indication of child physical abuse (Myers, 1992).

Another most dangerous kind of abuse injuries is head trauma. Various actions on the part of an abuser can result in head injury, including a blow to the child head by an object, punching the head with a fist, compressing the head between two surfaces, and throwing the child against a hard surface. Grasping and vigorously shaking can result in a particularly dangerous type of head injury known as shaken baby syndrome, that can cause the child’s brain to move within the skull, stretching and tearing blood vessels and may be result in coma or death. This kind of head trauma is different of fell from some item of furniture because those are commonly result in minor injuries (Lyons and Oates, 1993).

Other common physical injuries associated with child physical abuse is chest and abdominal injuries, burns and fractures. Abdominal injuries may occurs by being struck with objects, being grabbed tightly or being punched or kicked in the chest or abdomen.
which result in organ ruptures and compression. Burns which are often inflicted as punishment can result from contact with objects such as irons, cigarettes, stove burners and heaters. Fractures of bones in various areas of the body often result from child physical abuse that may be caused by punching, kicking, twisting, shaking and squeezing.

Neurobiological deficits Sequelae associated with child physical abuse may result in language skills deficits, memory, spatial skills, attention, sensor-motor functioning, cognitive processing and overall intelligence. Some studies have shown impaired neuro- transmitters and hormones and also smaller specific brain organs in abused children (De Bellis, 2001).

ii. Cognitive problems: Exposure to severe CPA may produce cognitive or intellectual deficits or other related limitations in cognitive (e.g., limited intellectual functioning), language (e.g., limited verbal ability), or perceptual motor deficits. While controlled studies extend these findings in showing reduced task initiation and motivation as well as limited intellectual functioning among maltreated youngsters and schoolchildren. Other studies, however, have failed to find differences in these areas between abused and non-abused children. The varied outcomes in this area may be attributable to several background factors, such as the failure to distinguish between types and severity of maltreatment or use objective measures (Kolko, 1996c).

Recent studies have shown that physically abuse children exhibited lower intellectual and cognitive functioning relatives to comparison groups of children on general intellectual measures as well as on specific measures of verbal facility, memory, dissociation, verbal language, communication ability, problem solving skills and
perceptual motor skills (Macfie, Ciccetti and Toth, 2001). Academic performance is another area of substantiated difficulty in physically abused children. Compared with non abused children, victims of CPA display poor school achievement and adjustment, score lower on reading and math tests, exhibit more learning disabilities and are more likely to repeat a grade. The authors concluded that the academic careers of maltreated children may be marked by considerable discontinuity due to frequent moves, school transfers, and tardiness, suggesting the potential utility of specialized school programs (Kolko, 1996c). Another difficulties are included problems in motivation and task initiations and termination (Hines and Malley-Morrison, 2005). Cognitive functioning may be related closely to the quality of the caretaking environment, as shown in one study that found that young victims of CPA had more receptive language problems than non abused children but did not differ from children residing in low socioeconomic status families. Given that the level of stimulation in the daily living environment may influence a child’s cognitive abilities, family environmental variables merit further evaluation (Kolko, 1996b). So cognitive problems of physically abused children may directly because of abuse injuries or indirectly related to low socio economic status or combination of both.

iii. Cognitive- attributional deficits: Children with a history of CPA may develop perceptions of physical discipline that are related to their experiences. Although studies indicate that both non-abused and abused children infrequently suggest the use of physical punishment but abused children show a greater willingness to use physical punishment. The increased attention to aggressive stimuli in maltreated versus control children is to have greater problems with perspective taking. For example, some
evidence has shown that abused compared to control youngsters generate fewer alternative solutions to hypothetical social problems and are more likely to perseverate on negative solutions (Haskett and Kistner, 1991).

These few findings provide only limited investigation of the cognitive deficits or distortions evinced by abused children. This area could be extended by examining other aspects of children’s cognitive-constructive repertoire as they pertain to their acceptance of violent behavior. It would be instructive to learn, for example, whether victims of CPA show negative attributional biases comparable to those of aggressive children or the types of cognitive distortions of depressed children (Kolko, 1996a).

iv. Behavioral problems: Physical aggression and antisocial behavior are among the most common correlates of CPA. In most studies abused children have been found to show more aggression than non-abused children (McDonald, Jouriles, Tart and Minze, 2009). Abuse seems to have effect on behavior independent of the potential contribution of other factors. Negative behaviors have been widely observed in schools, summer camps and preschool and day care program. Other behavioral problems displayed by CPA victims include drinking and drug use, non compliance, defiance, fighting in and outside the home, property offenses and arrests (Barnet, Miller-Perrin and Perrin, 2005). Physical abuse during the preschool period is predictive of externalizing and aggressive behaviors, the more severe the abuse, the more severe the problem (Brown and Kalko, 1999). That is, physically abused children are more at risk for poor anger modulation, increased rule violations, oppositionalism and delinquency. They are more likely to drink to commit property offenses and be arrested and commit a serious antisocial act (Hines and Malley-Morrison, 2005). Brown et al.
(2009) examined associations between exposure to physical violence or sexual violence and adverse health behaviors among a sample of children in five African countries (Namibia, Swaziland, Uganda, Zambia and Zimbabwe). Moderate to strong associations were observed between exposure to physical violence or sexual violence and measures of mental health, suicidal ideation, current cigarette use, current alcohol use, lifetime drug use, multiple sex partners and a history of sexually transmitted infection \((P \leq 0.05)\) for all associations.

Victims of CPA exhibit less pro social behavior and may experience poor peer relations. Young maltreated children are less friendly or positive in their interactions with peers. One study of maltreated preschoolers showed that they engaged in more repetitive motor play and less parallel or group play than their normal treated peers, which may implicate the presence of developmental delays in play behavior (Alessandri, 1991). Other evidence suggests that abused youngsters are less likely to initiate positive peer interactions, are less well-liked by peers, and receive fewer peer responses to their initiations (Haskett and Kistner, 1991). Likewise, older child victims show limited social competence, problems making friends and reciprocity, and greater peer isolation. Children who do not sustain social relationships may be less likely to exhibit empathy or perspective taking, though this outcome may relate to limited parental social competence and generalized exposure to an impoverished or aversive social environment. Due to their limited social skills or friendship experiences, interventions designed to help maltreated children initiate, maintain, and enhance their peer interactions may be warranted. Of course, limited social competence may be a
feature of other problem groups, such as non abused problem children or victims of child sexual abuse (Kolko, 1996c).

Association between child maltreatment and self-injurious behaviors (SIBs) is widely observed. Over time, SIB emerges as a compensatory, regulatory and relational strategy to facilitate young people's negotiation of developmental challenges despite their vulnerabilities. The relationship between childhood maltreatment and SIB was suggested to be mediated by alexithymia. Difficulties in expressing emotions may place children at increased risk for developing SIBs as a way of expressing emotional pain and distress. Some populations, such as homeless adolescents and juvenile offenders, have been shown to experience particularly high rates of early trauma (e.g. physical, sexual abuse and violent crime). As a consequence, they exhibit high rates of PTSD. A link between trauma exposure, psychological disorders and antisocial behavior has been suggested (Caffo, Forresi and Lievers, 2005).

Socio-emotional difficulties: Additional problems frequently observed in physically abused children are internalizing behavioral symptoms that include social as well as emotional difficulties. Masten et al. (2008) examined processing of facial emotions in a sample of maltreated children showing high rates of post-traumatic stress disorder (PTSD). Maltreated children displayed faster reaction times than controls when labeling emotional facial expressions, and this result was most pronounced for fearful faces. Relative to children who were not maltreated, maltreated children both with and without PTSD, showed enhanced response times when identifying fearful faces. There was no group difference in labeling of emotions when identifying different facial emotions. Maltreated children show heightened ability to identify fearful faces,
evidenced by faster reaction times relative to controls. This association between maltreatment and atypical processing of emotion is independent of PTSD diagnosis.

Several studies have documented higher levels of internalizing symptoms among physically abused children compared with non-abused children. Bordin et al. (2009) did a cross-sectional study in Embu, São Paulo, Brazil, on children aged 6–17 years to examine the relationship between specific types of child mental health problems and severe physical punishment, in combination with other important known risk factors. Multivariate modeling showed that severe punishment was an independent correlate of comorbid internalizing and externalizing problems but was not associated with internalizing problems only. It increased the risk of externalizing problems alone only for children and adolescents not exposed to maternal anxiety or depression. Severe punishment may be related to child mental health problems, with the mechanism depending on the type of problem. Its influence persists in the presence of family stressors such as the father’s absence and maternal anxiety or depression. Sternberg, Lamb, Guterman and Abbott (2006) examined the effect of different forms of family violence on a sample of 110 Israeli children. Girls were found to be more at risk for internalizing and externalizing behavior problems than boys. Younger children may be more susceptible to the effect of family violence than older children. Alink, Cicchetti, Kim and Rogosch (2009) investigated underlying processes of the effect of maltreatment on psychopathology (i.e., internalizing and externalizing problems) in a group of 111 maltreated and 110 no maltreated 7–10 year-old children (60% boys). Emotion regulation, but not the pattern of relatedness, mediated the relation between maltreatment and psychopathology. McDonald, Jouriles, Tart and Minze (2009) in their
research on 258 children and their mothers who were recruited from domestic violence shelters, examined whether additional forms of family violence (partner-child aggression, mother-child aggression, women's intimate partner violence) contribute to children's adjustment problems in families characterized by men's severe violence towards women. The relation of mother-child aggression to externalizing problems was stronger for boys than for girls; gender differences were not observed for internalizing problems or threat appraisals. In terms of social difficulties some researchers argue that victims of CPA suffer from problems related to attachment caregivers. They suggest that the violence that occurs between parents and child in such families might disrupt the development of healthy parent-child relationship. Hesse and Main (2000) in their research have suggest that child maltreatment is also associated with a form of attachment referred to as disorganized/disoriented attachment (Hines and Malley-Morrison, 2005) or type D, which is characterized as insecure as well as disorganized and disoriented. For these children, the parent-child relationship presents an irresolvable paradox because the caregiver is at once the child's source of safety and protection and the source of danger or harm. Disturbances in the formation of stable attachments are of developmental importance due to their association with significant forms of child adjustment, such as the child's individuation, personal sense of competence, and ability to regulate affect (Cicchetti, 1990). Studies examining the quality of the parent-child relationship among maltreated youngsters consistently have shown insecure attachments as reflected by increased avoidance and resistance and separation problems. Consistent with claims that attachment problems may set the
foundation for subsequent problems, evidence suggests that attachment disturbances may be related to children's roles as victims, victimizers, or non victims.

Maltreated children also have shown evidence of limited self-esteem (particularly in school age children) on self-report and parental report measures relative to controls, with some exceptions. Although these findings suggest that victims of CPA view themselves more negatively than their non abused peers, it is not clear whether these differences reflect problems with self-esteem following CPA or the presence of broad aspects of personal and family dysfunction (Kolko, 1996b; Finzi, Ram, Shnit and Har-Even, 2001, McDonald, Jouriles, Tart and Minze, 2009).

Older children who physically abused may have social interaction difficulties with peers as well as adults. Their problems include difficulty in making friends, deficits in pro-social behavior (for example smiling) with peers, peer rejection and delays in interactive play skills (Barnet, Miller-Perrin and Perrin, 2005). Otherwise in comparison to non abused children, they tend to display less friendly positive peer interaction. They have limited social competence and are less cooperative and more disturbed in their interactions. Indeed their play is often marked by fights, war and conflicts. These negative ways of interaction may make them most disliked children in their classes. Moreover, the abused children had limited ability to generate alternative solutions to social problems, focused only on negative solutions, believed in appropriates of violence as a problem-solving technique and have little ability to identify nonaggressive solutions to social problems. In trans aggression situation, physically abused boys were less angry at being victimized than non-physically abused boys, and normally observed
gender distress and concern for another hurt feelings were not observed in physically abused children (Hines and Malley-Morrison, 2005).

Studies have also demonstrated a higher incidence of emotional difficulties in physically abused children relatives to comparison children. School age victims may exhibit feeling of internalizing symptoms such as hopelessness, depressive symptoms, suicidality and feeling of low self worth (Finzi, Ram, Shnit and Har-Even, 2001).

Expanding on initial clinical descriptions of the development of affective symptoms (e.g., depressive states, anxiety) among traumatized children, empirical evidence supports the presence of negative affects in younger and older abused children and higher levels of depression and hopelessness have found among abused versus non abused psychiatric patients(Kolko,1996a). In a large community sample, physically abused children were more likely than non abused children to suffer from major depression, conduct disorder, oppositional defiant disorder, agoraphobia, overanxious disorder and generalized anxiety disorder, even after controlling for potential confounds such as income, family history of psychiatric disorder and prenatal problems (Hines and Malley-Morrison, 2005). Hobbs, Hanks and Wynne (2001) divided the psychological sequelae for child abuse in three groups: A- often perform below average on IQ tests, are aggressive and lack impulse control and are frustrated, anxious and non-compliant. B- have low self steam and confidence, problems in social relationship with peers and adults, anxious attachment, difficulties in accepting and giving affection and poor relationship within the family and at school. C- show a high degree of avoidance, non-compliance and fail to make transition into adulthood. Greenwald and Rubin (1999) and Kaminer, Seedat and Stein (2005) have explained the
post traumatic symptoms (PTS), after violence. It includes post traumatic stress disorder (PTSD), depression, anxiety, internalizing problems like feeling guilty or/and shameful, externalizing behaviors like cling to adult or/and avoid former interests, and also physical symptoms like headaches or/and bedwetting and so on.

Much of the recent research lends support to the association between exposure to domestic violence and symptoms of post-traumatic stress. In a sample of 349 adolescents from nine US middle schools, 76% reported witnessing or being victimized in at least one violent event in the prior 3 months. More exposure to violence was associated with more self-reported post-traumatic stress disorder (PTSD) and depression. Similarly, Seedat, Van Nood, Vythilingum, Stein and Kaminer (2000) found that more than 80% of a sample of 2041 Kenyan adolescents reported exposure to violence, either as victims or witnesses. Only 5% of the sample developed symptoms of full PTSD, and 8% developed symptoms of partial PTSD. Abused and maltreated children are at risk for PTSD, self-injurious behaviors (SIBs), alexithymia, mood disorder, substance abuse disorder, sexual behavior problems, positive psychotic symptoms, psychological dissociation and somatoform dissociation (Caffo, Forresiand Lievers, 2005). Hyper vigilance is one PTSD symptom found to be associated with CPA, especially in boys (Kolko, 1996c).

Psychiatric disorders: CPA children are at increased risk for psychiatric disorders. Kaplan, Pelkowitz, and Labruna (1999) in their review concluded that approximately 40% of CPA victims will meet criteria for major depression disorder during their life time, and at least 30% will meet criteria for disruptive behavior disorder such as oppositional
defiant disorder or conduct disorder. A history of CPA has also been associated with attention-deficit/hyperactivity disorder as well as borderline personality disorder. Post traumatic stress disorder also has been found in CPA victims. Dubner and Motta (1999) have found that in a group of faster home children 42% of physically abused children receive diagnoses criteria of PTSD. Begic and Jokic-Begic (2002) in their review on violent behavior and PTSD suggested that violent behavior creates PTSD and PTSD contains violence. There is an established connection between violent exposure and the occurrence of post traumatic stress disorder. They also stated that exposure to domestic violence, especially childhood sexual abuse can lead to depression, aggression, interpersonal problems and PTSD. Keyes et al. (2012) in their research concluded that childhood maltreatment increases vulnerability to numerous specific psychiatric disorders.

Long term sequelae: People with history of physical abuse have been shown to have problems in their financial, social, emotional, marital and behavioral functioning. Long term sequelae may include commit in antisocial acts and chronically involve in criminal behavior, enter prostitution and other sexual risk taking behaviors, abuse drug and alcohol, physically abusing their children and significant others and becoming victim of spousal abuse. Min, Minnes, Kim and Singer (2012) in their research suggested that physical and emotional neglect is related to poor adult physical health through health risk behaviors (obesity, substance dependence, and smoking), adverse life events, and psychological distress. Other long term psychological problems are being at an increased risk for depressive and anxious symptoms, emotional-behavior problems and suicidal ideation and attempts (Hines and Malley-Morrison, 2005). Greenfield and Marks (2009) examined
linkages between physical and psychological violence in childhood from parents and three dimensions of adult health (self-rated health, functional limitations, chronic conditions) by using data from the 1995 and 2005 waves of the National Survey of Midlife in the U.S. Results suggested that having a history of frequent physical and psychological violence in childhood is a risk factor for poorer adult health status and declining trajectories of health throughout adulthood. Fry, McCoy and Swales (2012) suggested that children who experiencing maltreatment are at increased risk of experiencing mental health sequelae, physical health sequelae, high-risk sexual behaviors, and increased exposure to future violence.

Child physical abuse and child sexual abuse (CSA) are distal risk factors for development of psychosocial problems in adolescence and adulthood. Deterioration of interpersonal resources (reduced capacity for relying upon interpersonal coping resources, isolation and deterioration of support systems), adult re-victimization (e.g., rape), and physical and sexual victimization (especially by intimate partner) are secondary traumas that may influence the development of PTSD in adulthood. Child maltreatment is also a distal risk factor for adolescent dating violence, and trauma-related symptoms have been found to be a significant mediator in this relationship (Caffo, Forresi and Lievers, 2005). Chronic child victims tend to show detachment, estrangement, restricted affect, thoughts that life is difficult or hard, and unhappiness. Acute victims are more likely to be anxious or agitated. A history of maltreatment also has been associated with borderline personality disorder, attention deficit hyperactivity disorder, or oppositional disorder (Kolko, 1996a; Greenfield and Marks, 2009).
Witnessing parents' conflict sequelae. It is estimated that 3.2 million American children witness incidents of domestic violence annually. Witnessing domestic violence can lead children to develop an array of age-dependent negative effects. Research in this area has focused on the cognitive, behavioral, and emotional effects of domestic violence. Children who witness violence in the home and children who are abused may display many similar psychological effects. These children are at greater risk for internalized behaviors such as anxiety and depression, and for externalized behaviors such as fighting, bullying, lying, or cheating (Moylan et al., 2010). They also are more disobedient at home and at school, and are more likely to have social competence problems, such as poor school performance and difficulty in relationships with others. Child witnesses display inappropriate attitudes about violence as a means of resolving conflict and indicate a greater willingness to use violence themselves. School-aged children also can develop a range of problems including psychosomatic complaints, such as headaches or abdominal pain, as well as poor school performance. They are less likely to have many friends or participate in outside activities. Witnessing partner abuse can undermine their sense of self-esteem and their confidence in the future. School-aged children also are more likely to experience guilt and shame about the abuse, and they tend to blame themselves. Adolescent witnesses have higher rates of interpersonal problems with other family members, especially parent-child conflict. They are more likely to have a fatalistic view of the future resulting in an increased rate of risk taking and antisocial behavior, such as school truancy, early sexual activity, substance abuse, and delinquency (Wood and Sommers, 2011). It is important to note that many children who witness domestic violence do not have adverse cognitive, behavioral, and
emotional effects. Several variables may lessen the effects of witnessing violence. These variables include female gender, intellectual ability, higher levels of socioeconomic status, and social support for the children. The studies on resilience also have been limited by small sample sizes but show promise in identifying potential protective factors that mediate the negative effects of witnessing domestic violence (Stiles, 2002; Zolotor, Theodore, Coyne-Beasley and Runyan, 2007).

Shipway (2004) stated that being witness of parents violent behavior may have the following sequelae:

i. The immediate impact: Children responses vary enormously with some children being affected far more than others, and children within the same family can be affected differently. Each child’s experience and reactions is unique, it will be hard to discern the impacts of living with domestic violence on children especially as some of the resulting behaviors also occur in children experiencing other forms of abuse and neglect.

These possible negative effects can appear endless and includes:

- Being secretive, silent and afraid to tell.
- Being protective of their mother and/or siblings, which may lead to them having a maturity beyond their years, whilst other children exhibit regression. Alternatively they may mimic the aggression of the abusive parent and be abusive to the mother and siblings.
- Attitudes to their father or stepfather may be ambivalent, often due to a feeling of confusion.
- Being fearful, hyper-vigilant, mistrustful, anxious and sometimes excessively agitated.
- Experiencing feeling of guilt and helplessness and even thinking that the violence is their fault. This is particularly so if the violent episode follows an argument between the adult that is related to the child.
- Experiencing nightmares, bedwetting, sleep disturbances, eating difficulties leading to weight loss or obesity.
- In some children, long periods of sadness, which may progress to depression.
- In younger children, delay in developmental milestones.
- In contrast in some older children, a very adult way of acting in order to minimize the violence or protect the mother (Shipway, 2004).

Hester, Pearson and Harwin (2000) found that while some children have poor social skills, others attain a high level of social skills development with an ability to negotiate difficult situations. A child’s ability to acquire sophisticated coping strategies to deal with the on-going abuse should never be underestimated; neither should the child’s attachment to abusive parent which, for some, may continue to be strong.

ii. Long term effects: Wood and Sommers (2011) in a meta-analysis suggested that being witness of inter parental violence ends to more long and short term psychological problems. According to Kashani and Wesley (1998), children who have grown up in an abusive home whilst remaining a heterogeneous group, nevertheless have similarities in their responses at the time, and in the future. Children’s responses to living in a violent and abusive home can include:
• Pre-school children, particularly boys, seem to be at risk of developing behavioral problems.
• They may express anger and distress in ways viewed by others as inappropriate.
• Adolescent boys from abusive homes were more prone to running away, possibly as a mean of avoiding violence against themselves. Similarly, he found adolescent male witnesses to family violence were more apt to use physical violence against their mothers.
• Young males from violent homes had often experienced suicidal thoughts. Kashani, Darby, Allan, Harte and Reid (1997) found that juveniles who had committed interfamilial homicide had frequently experienced a significant history of family violence. Moreover the homicide commonly followed an unsuccessful suicide attempt.

According to APA (2004), children of all ages from violent homes may exhibit somatic concerns, including headaches, school avoidance, and abdominal complaints. Pre-school children most often develop stuttering, enuresis, insomnia and separation anxiety. School children frequently develop impaired concentration and difficulty staying focused on schoolwork. Older children often manifest aggressive behavior, which girls are more likely to have such aggressive behavioral problems, while girls are more likely to have somatic concerns. Both sexes often express guilt at not being able to stop domestic violence.

Studies suggest that mothers do not discuss the violence with their children and children equally avoid talking about their experiences with outsiders for fear of being
taken into care. Many retain a degree of loyalty to the abusing father as they have good memories as well as bad ones (Shipway, 2004).

iii. The psychological impact: Children who live with domestic violence live with high and sometimes unbearable levels of fear and insecurity. They may arrive at school tense, hating having to leave their mothers in the morning and there may have been resistance or tantrums. They may be anxious during the day, dreading what will happen when they get home. Yet frightened children do not always present as such in school, and the fear that underlies emotional and behavioral difficulties can go unrecognized. Arguably, this is the most common and pernicious form of child emotional abuse (Sterne, Poole, Chadwick, Lawler, and Dodd, 2010).

Children living with domestic violence may fear of injury or death to their mother, disputes and violence happening while they are at school, the stress and toll that the violence takes on their mother, for the safety and well-being of other family members such as siblings, or of their pets, injury to themselves, damage to their home or possessions, the police intervening in disputes, the embarrassment of neighbors and friends hearing or seeing the violence, family separation, being uprooted; having to leave their home, possessions, pets, arguments about contact visits – centered on them, punishment and other sequelae of telling someone and social services getting involved; being removed from their family (Holmes, 2013).

A number of studies (Pynoos and Eth, 1986) stated that many children witnessing domestic violence meet the clinical criteria for Post-Traumatic Stress Disorder (PTSD); a severe anxiety disorder following a traumatic event or a succession
of traumatic events. What is particularly difficult for children living with domestic violence is the fact that the trauma occurs within the family and the perpetrator, as parent, may be someone they love and who should be protecting them from harm. The violence takes place in the home, which should be a safe haven. The impact on children has been compared to that observed in children living in war zones. Symptoms of post-traumatic stress in children include repetitive dreams and nightmares, flashbacks, joyless play, a feeling of going mad, over-activity and irritability, impaired concentration and memory, bed-wetting and soiling and self-abuse.

PTSD will affect every aspect of school life; it can prevent children from learning effectively, participating fully, deriving enjoyment, achieving their potential, behaving appropriately and establishing positive social relationships. Some children have said that they thought there was something wrong with their brains; that they might be insane or schizophrenic (Moylan et al., 2010).

Many children think domestic violence must remain a family secret. This may be out of shame and embarrassment, out of fear of the abuser, of splitting the family, or of social services intervening and removing them. Quite young children soon learn that domestic abuse is not something openly discussed. They may lie to teachers, other professionals, extended family or friends to conceal the violence (Sterne, Poole, Chadwick, Lawler, and Dodd, 2010).

Children often feel that they take some blame for the violence and even that they may be an underlying cause of conflict and therefore of violence: maybe their bad behavior has driven a parent to violence; maybe they are a financial burden; maybe
they have caused arguments about discipline or have made excessive demands for time and attention. Children from mixed-race relationships may suffer the additional problem of not knowing which parent to identify with (Hester, Pearson and Harwin, 2000). These feelings are an enormous burden for children. They may feel they should try and stop the violence occurring and many intervene either verbally or physically. In so doing, they can put themselves in danger.

Many young people feel ashamed or embarrassed about family violence and dread others knowing about it. They fear neighbors hearing shouting, or parents arguing in front of friends. Young people from some minority ethnic communities may be afraid of bringing shame on their family honor if others find out about the domestic violence (Wood and Sommers, 2012).

Domestic violence can adversely affect children’s relationships with their peers. Some will deliberately distance themselves, fearing their friends knowing about their family situation. Children who constantly worry about home life may feel inhibited and appear guarded or passive. Other children may talk about home with their friends and invite them round to play, but that is difficult for children living in violent homes. They may choose not to have friends round to the house because of family volatility and unpredictability. Children who frequently move house and school may be unwilling to invest in new friendships. On the other hand, some young people can be overly clingy, possessive, insecure and suffer an underlying fear of further loss. They may be controlling in their relationships with other children or with adults, wanting to be in charge and may have difficulty working or playing to another’s agenda. Some may find it difficult to maintain friendships. Speech, language and learning delay or difficulties.
Young children who have lived with domestic violence may have delayed speech and language development and cognitive skills. This can be because an abused mother is less able to interact and play with her children. A withdrawn, passive or anxious child may spend far less time communicating and developing language and thinking skills than other children. A high level of distress can make a child less able to engage with learning, concentrate and take in new information. In addition, periods of absence from school mean missed learning opportunities and gaps in learning (Brown et al., 2009)

Research suggests that around 40 per cent of children who have experienced domestic violence show clinically significant behavioral problems (Calder, Harold and Howarth 2004). When traumatized children are in stressful situations at school they can become agitated quickly and appear to over-react. Teachers often remark how difficult it is to identify any particular trigger to a behavior outburst; an innocuous comment may touch a raw nerve; a seemingly minor incident may provoke stress or panic. For example, a child might not have heard the teacher's instructions so cannot start their work; might be stuck; over-react to a negative comment from a peer; or be thrown by a change of routine. Some children may respond to threatening or stressful situations by going into ‘fight’ mode and become aggressive and hostile; others may take flight and run out of a lesson or out of school. These children may be particularly sensitive to shouting, angry adult interactions and to physical contact. They are more likely than other children to interpret their teachers and peers as having hostile intent. They may complain about receiving dirty looks or being picked on. They may be particularly sensitive about verbal abuse directed towards their mothers, as they feel protective; beware of the trend among young people for name-calling directed at mothers.
Beneath the rage, it is frightening for children to feel so out of control. After an outburst, the child can feel terrible – shame, embarrassment and feelings of having let themselves and those who help them down (Sterne, Poole, Chadwick, Lawler, and Dodd, 2010).

There can be severe sequelae in school for children who have difficulties containing their anger, including exclusion from lessons and fixed-term or permanent exclusion. Severe behavior outbursts are indicators of unbearable levels of tension.

Domestic violence provides children with a negative model of how arguments are resolved. Children observe that threats, screaming, swearing and fighting are effective means of exerting control; that one person can frighten another into letting them have their way. They see power imbalances between men and women. Therefore in school, children may also resort to aggressive means: Attention and concentration difficulties, It can be difficult for children who are living in fear to concentrate in school. Their preoccupation with safety and security can be a source of concentration difficulties (Sternberg, Lamb, Guterman and Abbott, 2006).

Traumatized children with long-term anxieties may seem to be in a continual state of high arousal. Teachers will be familiar with the child who cannot keep still; who may be fiddling, rocking on their chair, turning round and out of their seat. Some children behave impulsively: shouting out, poking others, lashing out or destroying their work. Some children grow up with the core beliefs ‘I am never safe’ and ‘I must always be on my guard’. They may be ‘hypervigilant’, continually scanning the class, distracted from their work. Some may crave adult attention and behave so as to get it; negative
attention being better than no attention. These children can be wearing for staff, and their behavior impacts heavily on their learning and that of others (Sterne, Poole, Chadwick, Lawler, and Dodd, 2010).

A child who has found adults to be unreliable or untrustworthy may have difficulties trusting school staff. Some children may have observed that authority figures such as a controlling father or older brother, the police or a social worker can do sudden and drastic things. Some may have developed core beliefs that people in authority are to be feared (Sternberg, Baradaran, Abbott, Lamb and Guterman, 2006).

Parenting can be inconsistent if one parent is depressed and oppressed, living under a regime where the other adult dictates the rules. It will be difficult to impose consistent discipline, and behavior boundaries may be unclear. Where a mother and her children have moved away from the perpetrator, the family dynamics can change completely. If the father was the disciplinarian and the mother had little authority, she may subsequently struggle to impose her own boundaries. A family support worker noticed that some children seem to ‘go off the rails’ in school when they no longer live with the abuser and are no longer in fear (Brown et al., 2009).

Some children cope with overwhelming feelings by dissociating; this is a protective response, where, unconsciously, children temporarily shut down or disengage from their environment so they do not have to feel hurt any more. In school, children who dissociate may present as being in their own world, unresponsive to unpleasant things that are happening around them (Brown, 2005).
Some children may be prevented from sleeping by arguments and fighting or woken by them. Children who are anxious often do not sleep well and their sleep may be disrupted by nightmares. Fatigue has an obvious impact on learning and behavior (Sterne, Poole, Chadwick, Lawler, and Dodd, 2010).

Young children may be excessively clingy and reluctant to separate from their mothers in the morning. They may be very challenging when getting ready for school and use extreme delaying tactics, such as running away or wetting themselves – this can also be an anxiety response. They may arrive at school in a tense and anxious state (Brown, 2005).

Some children from backgrounds of domestic abuse, in particular those who feel threatened by their parents’ violent disputes, may present as quiet, shy and avoidant. It may not be obvious to school staff that they are showing signs of depression (Moylan et al., 2010).

Many of the above difficulties will affect a child’s capacity to learn. The following are other reasons why children from backgrounds of domestic abuse miss out on education. Some mothers and children move house, some repeatedly, to escape violent or abusive partners. This may involve several changes of school. Finding new school places can be problematic and time consuming, especially secondary placements or placements in the same school for two or more siblings. Children may miss out on weeks or even months of education. Once in a new school, it can take time to assess a child and it can be difficult to get information from previous schools, especially where there has been a rapid succession of changes. This means there can be delay in
implementing appropriate interventions, e.g. in literacy and numeracy. There can be particular difficulties implementing appropriate programmes of support where a child has complex needs or a statement of educational needs as it can be hard for schools to find additional support staff at short notice (Sterne, Poole, Chadwick, Lawler, and Dodd, 2010).

Many children who live with domestic violence are reluctant to attend school. Often they have valid reasons for wanting to stay at home, related to their concern for their mother’s safety and well-being. They may feel she is in danger from the abuser, or in need of their emotional support. By staying nearby, children retain peace of mind. Children may also therefore behave so as to get sent home; this could be by feigning illness or being disruptive (Holmes, 2013).

Domestic violence can severely undermine a mother’s ability to parent. Some rely on their children for emotional and practical support; older children may take on the role of caregivers both of their mother and younger siblings. Some girls, in particular, have a considerable burden of responsibilities so feel they need to stay off school. They see that their mother needs practical help and emotional support (Wood and Sommers, 2011).

**Cognitive Behavioral Therapy (CBT)**

Cognitive behavioral therapy is a form of brief, structured psychotherapy based on the premise that thoughts, feelings, and behaviors affect each other in reciprocal ways (Kendall, 1993). For example, negative thoughts often engender negative feelings and vice versa. Fearful thoughts, on the other hand, often increase anxious feelings and
anxiety-related avoidant behaviors. Angry thoughts can contribute to angry feelings and aggressive behavior. Because changing unpleasant feelings directly can be difficult, CBT aims to do so indirectly by having the client change the associated thoughts and behaviors. What distinguishes CBT from other therapies, however, is (1) the highly structured nature of sessions and (2) the discussion of therapeutic elements as explicit strategies with the client (Alford and Beck, 1997).

CBT was originally developed by Aaron Beck, who focused on challenging cognitive distortions in depressed adults. Child CBT was originally developed by adapting adult models to child clients (Kendall, 1993). This is important, because difficulties in child CBT can occur when we treat our child clients as “little adults” rather than appreciating their unique therapeutic needs. Different cognitive, behavioral, and family factors may be implicated in the etiology and maintenance of the same disorder for children versus adults. It stands to reason that, if the nature of the disorder differs between children and adults, the interventions must differ as well. Developmentally sensitive assessment of disorder is needed, because the conclusions drawn and intervention provided could differ depending on whether or not this is done. Finally, intervention itself must be developmentally sensitive. For example, family-based CBT would rarely be considered in adults, but has been found efficacious in anxious children (Bagels and Siqueland, 2006)

While the principles of child CBT and adult CBT are the same, the manner in which they are communicated to and applied with the client is quite different. There are differences in the therapeutic experience, the role of the family and other environmental factors, the client’s cognitive level, and motivational factors. The child CBT client comes
to see a therapist because his or her parents insisted upon it. The child may or may not know why this has happened, and may even assume that it is some sort of punishment for being “bad.” Almost always, the child does not know any other children who see a therapist and therefore assumes that seeing a therapist means he or she is different from other children in a negative way.

The child has little idea what to expect from therapist or what therapist will expect from him or her, causing anxiety about seeing a therapist. The child may or may not report distressing symptoms, and may or may not understand that thoughts, feelings, and behaviors are connected. So it becomes obvious that children in CBT need extra time to learn to trust the therapist and to understand why they are being seen.

The reasons for the therapy and how it is supposed to help need to be spelled out, and the role of the parents in therapy needs to be clarified. Also asking about other significant adults that have frequent contact with the child (teachers, relatives that live in the home or often look after the child, sports coaches, and so forth), and spell out their involvement. If they do not want to be involved, therapist has to talk to them once to provide information about coping skills the child will be learning, address any concerns they have, and ensure that their behavior toward the child generally facilitates (or at least does not impede) the use of new coping skills.

Developing the child’s trust in the therapist may take time, but can be facilitated in several ways. Examples include sitting beside (rather than opposite) the child, taking an interest in the child’s world, starting your work together by focusing on issues relevant to the child, and consistently praising even minimal child participation in the interaction. Sometimes, it can also be helpful to offer limited self-disclosure (for
example, by providing an example of how you dealt with a fairly generic anxious situation such as giving a presentation), as long as this is done for the child’s benefit (rather than your own), and normalizing certain symptoms by pointing out that you have met other children who experience them as well (without disclosing details about those clients, of course). Probing for possible negative attitudes toward therapy either in the child or in the child’s peer group can also foster trust and avert problems later. Providing clear expectations or “ground rules” for your interaction with the child can be reassuring as well. The child needs to know what the goals of therapy are, how your time together will be structured to achieve those goals, what behaviors will or will not be tolerated in therapy, and sequelae for breaking the rules. Furthermore, friendly overtures toward the child without such clear limits usually do not result in the structured, focused, skill-building sessions needed to do CBT. For example, some children or teens enjoy talking about events in their lives and having an attentive listener, but do not realize that this activity does not constitute therapy. When redirected to the task at hand, they may become sullen or withdrawn. Rather than considering the child oppositional, it is often helpful to provide a frank explanation of the nature of therapeutic change. You can then become less formal as you get to know the child if that is your therapeutic style. Trying to increase formality later is rarely successful (Manassis, 2009).

Children who have experienced physical abuse are at risk for developing significant psychiatric, behavioral, and adjustment difficulties. During the past three decades, research has documented the efficacy of several behavioral and cognitive-behavioral methods, many of which have been incorporated in abuse-focused cognitive
behavioral therapy (AF-CBT). AF-CBT has been found to improve functioning in school-aged children, their parents (caregivers), and their families (Kolko, 1996a; 1996b). AF-CBT is an evidence-supported intervention that targets individual child and parent characteristics related to the abusive experience, and the family context in which coercion or aggression occurs. This approach emphasizes training in interpersonal skills designed to enhance self-control and reduce violent behavior.

The families in which physical child abuse occurs have often experienced stressful life events that may lead parents to maintain negative perceptions or attributions of their children, heightened anger or hostility, coercive family interactions, and harsh or punitive parenting practices. As a result, abused children from these families may experience aggression, behavioral problems, trauma-related emotional symptoms, poor social and relationship skills, and cognitive impairment. AF-CBT addresses both the risk factors and the sequelae of physical abuse in a comprehensive manner. This approach draws from a variety of therapeutic approaches and implements procedures that have been successful in improving positive family relations and reducing family conflict in diverse populations of parents, children, and families (Kolko, Igelman, Taylor, Wilson and Thorvaldsen, 2007).

**AF-CBT characteristics.** AF-CBT characteristics include followings:

1. Reflects a comprehensive treatment strategy. The diversity of family circumstances and individual problems associated with physical abuse points to the need for a comprehensive treatment strategy that targets both the contributors to abusive behavior and children's subsequent behavioral and emotional adjustment (Chadwick Center, 2004). Treatment approaches that focus on several aspects of the
problem (for example, a caretaker’s parenting skills, a child’s anger, family coercion) may have a greater likelihood of reducing re-abuse and more fully remediating any mental health problems (Kolko and Swenson, 2002). Therefore, AF-CBT adopts a comprehensive treatment strategy that addresses the complexity of the issues more completely (Kolko, Igelman, Taylor, Wilson and Thorvaldsen, 2007).

ii. Integrates several therapeutic approaches. AF-CBT combines elements drawn from:

- Cognitive therapy, which aims to change behavior by addressing a person’s thoughts or perceptions, particularly those thinking patterns that create distorted views.

- Behavioral and learning therapy, which focuses on modifying habitual responses (e.g., anger, fear) to identified situations or stimuli.

- Family therapy, which examines patterns of interactions among family members to identify and alleviate problems.

- Developmental victimology, which describes processes involved in the onset and maintenance of abusive behavior, and how the specific sequelae of the abusive experience may vary for children at different developmental stages and across the lifespan.

AF-CBT pulls together many techniques currently used by practitioners, such as behavior and anger management, problem solving, social skills training, and cognitive restructuring. The advantage of this program is that all of these techniques, relevant handouts, training examples, and outcome measures are integrated in a structured
iii. Treats children and parents simultaneously. During AF-CBT, school-aged children and parents (or caretakers) participate in separate but coordinated therapy sessions, often using somewhat parallel treatment materials. In addition, children and parents attend joint sessions together at various times throughout treatment. This approach seeks to address individual and parent-child issues in an integrated fashion (Kolko, Igelman, Taylor, Wilson and Thorvaldsen, 2007).

iv. Discourages aggressive or violent behavior. The AF-CBT approach is designed to promote appropriate and pro-social behavior, while discouraging coercive, aggressive, or violent behavior. Consistent with cognitive behavioral approaches, AF-CBT includes procedures that target three related ways in which people respond to different circumstances: cognition (thinking), affect (feeling), behavior (doing). AF-CBT includes training in various psychological skills in each of these channels that are designed to promote self-control and to enhance interpersonal effectiveness (Kolko, Igelman, Taylor, Wilson and Thorvaldsen, 2007).

v. Tailors treatment to meet specific needs and circumstances. Child maltreatment research has documented a variety of risk factors and sequelae of physical abuse, and this variability requires treatment that can be adapted for different needs. So, for example, the treatment needs of a suicidal teen abused by an alcoholic father may differ from those of a child reported to be aggressive at school and hostile toward a mother who is also a victim of violence. AF-CBT begins with a multisource assessment to identify the nature of the problems the child is experiencing, specific
parental and family difficulties that may be contributing to the risk of abuse, and the child’s and family’s strengths that may help influence change. Tailoring the treatment to the family’s specific strengths and challenges is key to efficient outcomes (Kolko and Swenson, 2002).

Treatment delivering:

AF-CBT is a short-term treatment typically provided over the course of 12 to 24 hours during 3 to 6 months (although treatment may last as long as determined necessary). Treatment generally is provided in an outpatient or in-home setting, but it may be used in residential settings (e.g., group home, residential treatment facility) or other placement settings (e.g., foster care) when the parent or caregiver is in regular contact with the child. Treatment includes separate individual sessions with the child and parent. Joint sessions with the child and parent also are held. Where relevant, family interventions may be applied before, during, or after the individual services. Following a brief outline of treatment goals, the key components in each treatment area are listed below (Kolko, Igelman, Taylor, Wilson and Thorvaldsen, 2007).

The delivery of treatment is organized into three phases:

• Phase 1: Joining with Family/Setting the Stage
• Phase 2: Skills Building: Individual and Family
• Phase 3: Applications: Family Routines

Treatment population

AF-CBT is most appropriate for use with physically abusive or coercive parents and their school-aged children (Kolko, 1996a; 1996b).
Appropriate candidates for this program include: parents of physically abused children who:

- Need to improve their child behavior management skills
- Lack knowledge of alternatives to punitive forms of child discipline
- Need guidance in creating more positive interaction with their child
- Physically abused children who exhibit externalizing behavior problems, including aggressive behavior and poor social competence. Often these characteristics are found in families with heightened levels of conflict and coercion.

Generally, the goals of AF-CBT treatment are to:

- Reduce parental anger and use of force
- Promote alternative (nonaggressive) discipline approaches
- Minimize risks for additional abusive incidents
- Enhance the child’s coping skills and overall adjustment
- Encourage pro social problem-solving and communication in the family

i. Treatment for School-Aged Children: The school-aged child-directed therapy elements include the following:

- Identifying the child’s exposure to and views of family hostility, coercion, and violence.
- Understanding the child’s perceptions of the circumstances and sequelae of the physical abuse.
- Educating the child on topics related to child welfare and safety, child abuse laws, and common reactions to abuse.
Discussing healthy vs. unhealthy coping

- Training in techniques to identify, express, and manage emotions appropriately (for example, anxiety management, anger control)
- Training in interpersonal skills to enhance social competence
- Developing social support plans

The treatment program for children incorporates the use of specific skills, role playing exercises, performance feedback, and home practice exercises.

ii. Treatment for Parents (or Caregivers): Parent-directed therapy elements include:

- Identifying views on violence, physical punishment, and sources of stress
- Understanding the role of parental and family stressors that may contribute to conflict
- Examining the role of expectations related to child development and general attributions that may promote coercive interactions
- Identifying and managing reactions to abuse-specific triggers, heightened anger, anxiety, and depression to promote self-control
- Training in effective discipline strategies (e.g., time out, attention reinforcement) as alternates to the use of physical force

The treatment program for parents incorporates the use of specific skills, role playing exercises, performance feedback, and home practice exercises.
iii. Treatment for Families (or the Parent and Child): Parent-child or family therapy elements include:

- Conducting a family assessment using multiple methods and identifying family treatment goals
- Discussing a no-violence agreement
- Clarifying attributions of responsibility for the abuse and developing safety plans, as needed
- Training in communication skills to encourage constructive interactions
- Training in nonaggressive problem-solving skills with home practice applications
- Involving community and social systems, as needed

Parents with psychiatric disorders that may significantly impair their general functioning or their ability to learn new skills (e.g., substance use disorders, major depression) may benefit from alternative or adjunctive interventions designed to address these problems (Chadwick Center, 2004). In addition, children or parents with very limited intellectual functioning, or very young children, may require more simplified services or translations of some of the more complicated treatment concepts. Children with psychiatric disorders such as attention-deficit disorder (ADD) or major depression may benefit from additional interventions. Traumatized children, especially sexually abused children, may respond better to trauma-focused therapy (Kolko, Igelman, Taylor, Wilson and Thorvaldsen, 2007).
Eye Movement Desensitization and Reprocessing (EMDR)

Francine Shapiro (1995) developed EMDR based on clinical observation, controlled research, feedback from clinicians whom she had trained, and previous scholarly and scientific studies of information processing. EMDR is a phased, scientifically validated, and integrative psychotherapy approach based on the theory that much of psychopathology is due to traumatic experience or disturbing life events. These result in the impairment of the client’s innate ability to process and to integrate the experience or experiences within the central nervous system. The core of EMDR treatment involves activating components of the traumatic memory or disturbing life event and pairing those components with alternating bilateral or dual attention stimulation. This process appears to facilitate the resumption of normal information processing and integration. This treatment approach can result in the alleviation of presenting symptoms, diminution of distress from the memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers (Shapiro, 2001).

EMDR is intended to alleviate human suffering and assist individuals and society to fulfill their potential for development while minimizing risks of harm in its application. For the client, the aim of EMDR treatment is to achieve the most profound and comprehensive treatment effects in the shortest period of time, while maintaining client stability within a balanced family and social system.

EMDR is an approach to psychotherapy that supports the premise that most people have both an innate tendency to move toward health and wholeness, and the inner capacity to achieve it. It consists of a unique standardized set of procedures and
clinical protocols which are combined with the unique element of dual attention/bilateral stimulation, activates the components of the memory of disturbing life events and appears to facilitate the resumption of normal information processing and integration. Intervention by the therapist is kept to the minimum that is necessary to keep that processing moving until resolution is reached. EMDR is compatible with elements from various psychotherapies (e.g., psychodynamic, cognitive-behavioral, interpersonal, person-centered, and body-centered; Shapiro, 1995)

EMDR uses specific psychotherapeutic procedures to 1) Access existing information, 2) introduce new information, 3) facilitate information processing and 4) inhibit accessing of inappropriate information. Unique to EMDR is the view that incomplete processing and incomplete integration of memories of trauma and/or disturbing life experience are a primary basis of psychopathology. Specific procedural steps are used to access and process information and incorporate alternating bilateral sensory stimulation. These well-defined treatment procedures and protocols are intended to create states of dual attention to facilitate information processing (Zaghrout-Hodali, Alissa and Dodgson, 2008).

**Adaptive information processing.** While EMDR is a specific integrative psychotherapeutic approach, Adaptive Information Processing (Shapiro, 1995) represents the general model that provides the theoretical framework and principles for treatment and an explanation of the basis of pathology and personality development. The Adaptive Information Processing model is consistent with Freud, Ferenczi, Abraham, Simmel and Jones (1921) and Pavlov’s (1927) early understanding of what is now referred to as information processing. Specifically, there appears to be a
neurological balance in a distinct physiological system that allows information to be processed to an "adaptive resolution." By adaptive resolution I mean that the connections to appropriate associations are made and that the experience is used constructively by the individual and is integrated into a positive emotional and cognitive schema. Essentially, what is useful is learned and stored with the appropriate affect is available for future use. For example, let us say that something negative happens to us, such as a humiliation at work, and we are disturbed by it. We think about it, dream about it, and talk about it. After a while, we are no longer bothered by it, and the experience may be used appropriately as information to guide our future actions. Thus, we learn something about ourselves and other people, we better understand past situations, and we are better able to handle similar situations in the future.

When someone experiences a severe psychological trauma, it appears that an imbalance may occur in the nervous system, caused perhaps by changes in neurotransmitters, adrenaline, and so forth. Due to this imbalance, the information-processing system is unable to function optimally and the information acquired at the time of the event, including images, sounds, affect, and physical sensations, is maintained neurologically in its disturbing state. Therefore, the original material, which is held in this distressing, excitatory state-specific form, can be triggered by a variety of internal and external stimuli and may be expressed in the form of nightmares, flashbacks, and intrusive thoughts—the so-called positive symptoms of PTSD.

The hypothesis is that the procedural elements of EMDR, including the dual attention stimuli, trigger a physiological state that facilitates information processing.
Various mechanisms by which this activation and facilitation of processing occurs have been proposed, including the following:

1. De-conditioning caused by a relaxation response

2. A shift in brain state, enhancing the activation and strengthening of weak associations.

3. Some other factor involved in the client's dual focus of attention, as he simultaneously attends to the present stimuli and the past trauma (e.g., "mindfulness," orienting response, disruption of the function of the visual spatial, etc.).

Therefore, in EMDR when we ask the client to bring up a memory of the trauma, we may be establishing a link between consciousness and the site where the information is stored in the brain. In the context of the other procedural elements, the dual stimulation appears to activate the information-processing system and allows processing to take place.

Whether this is due to a direct alteration of the physiological substrate of the targeted network, or through engendering the state of mind necessary for information assimilation, or both, is as yet unknown. However, with each set of stimulation, we move the disturbing information (at an accelerated rate) further along the appropriate neuro physiological pathways until it is adaptively resolved.

For instance, resolution may come when the previously isolated disturbing information is brought into contact with currently held adaptive information (such as "It wasn't my fault my father raped me"). One of EMDR's main assumptions is that activating the processing of the trauma memory will naturally move it toward the adaptive information it needs for resolution.
Inherent in the Adaptive Information Processing model is the concept of psychological self-healing, a construct based on the body’s healing response to physical injury. For instance, when you cut your hand, your body works to close and heal the wound. If something blocks the healing, such as a foreign object or repeated trauma, the wound will fester and cause pain. If the block is removed, healing will resume. A similar sequence of events seems to occur with mental processes. That is, the natural tendency of the brain’s information-processing system is to move toward a state of mental health. However, if the system is blocked or becomes imbalanced by the impact of a trauma, maladaptive responses are observed. These responses may be triggered by present stimuli or perhaps by the attempt of the information-processing mechanism to resolve the material. For instance, the rape victim may automatically continue to recall images of the rape in a blocked attempt to reach resolution and complete processing (Horowitz, 1979). If the block is removed, processing resumes and takes the information toward a state of adaptive resolution and functional integration. This resolution is manifested by a change in the images, affect, and cognitions the client associates with the event. Metaphorically, we can think of the processing mechanism as “digesting” or “metabolizing” the information so that it can be used in a healthy, life-enhancing manner.

Shapiro (2002) theorizes that the information-processing system is adaptive when it is activated because abuse victims begin an EMDR treatment with a negative self-concept in regard to the event and consistently end with a positive sense of self-worth. Moreover, the opposite does not occur. That is, EMDR treatments reveal an accelerated progression toward health (positive emotions and higher self-regard), but
not toward dysfunction (inappropriate blame and self-loathing). The notion of activating the adaptive information-processing mechanism is central to EMDR treatment and has been critical in its application to a variety of pathologies.

**Dual attention stimulation.** There are other stimuli besides directed eye movements that can activate the information-processing system. For instance, alternating bilateral hand taps and auditory tones have also proven clinically effective (Shapiro, 1995). Although it is not yet clear whether such stimuli are as effective as the directed eye movements, the possibility should not be precluded inasmuch as the dual-focus hypothesis mentioned earlier may prove to be the most useful explanation of EMDR’s accelerated effects. Specifically, the information-processing mechanism may be activated when attention is elicited by or focused on the external cues (e.g., attending to tactile or auditory cues, or by the act of merely fixating a stimulus). The simultaneous focus on the traumatic memory may cause the activated system to process the dysfunctionally stored material. Alternatively, if the eye movements themselves induce an altered brain state that modifies the behavior of the information-processing system, we might expect other rhythmical movements or forms of sustained or repeated stimulation to have a similar effect. In addition, it should be noted that recent studies indicate that patterns of regional brain activation produced by attention alone show significant overlap with those produced by eye movements (Corbetta et al., 1998).

As previously mentioned, I am offering a theoretical model to interpret the clinical effect, not to prove the existence of specific mechanisms. For example, the REM hypothesis only attempts to explain the apparent role of the eye movements in the treatment effects; it does not preclude the possible usefulness of other stimuli, such
tactile or auditory cues. Even if directed saccadic or tracking eye movements do prove to stimulate a mechanism that also operates during REM sleep, this finding does not discount the potential effectiveness of other stimuli used in the waking state. Obviously, there may be other choices of stimuli, even though the body in a sleep state is incapable of generating auditory stimuli, hand taps, blinking lights, or other external fixating devices. The repetitive reorienting of attention may produce specific shifts in regional brain activation and neuro modulation similar to those produced during REM sleep.

Regardless of the exact mechanism that brings about EMDR’s effects, it is the activation of the information-processing system that provides the clinical focus for treatment. Therefore, although the terms sets and eye movements are used throughout this text, they are meant to refer to sets of other effective stimuli as well.

The eight phases of EMDR treatment. EMDR treatment consists of eight essential phases. The number of sessions devoted to each phase and the number of phases included in each session vary greatly from client to client.

The first phase involves taking a client history and planning the treatment. This is followed by the preparation phase, in which the clinician introduces the client to EMDR procedures, explains EMDR theory, establishes expectations about treatment effects, and prepares the client for possible between-session disturbance. The third phase, assessment, includes determining the target and baseline response using the SUD and VOC Scales. The fourth phase, desensitization, addresses the client’s disturbing emotions, and elicits insights and appropriate associations. The fifth, or installation,
phase focuses on an enhanced integration of the cognitive reorganization. The sixth phase, which evaluates and addresses residual body tension, is the body scan.

Next comes closure, a phase that includes debriefing and is essential for maintaining client equilibrium between sessions. The eighth and final phase is termed reevaluation.

While each phase focuses on different aspects of treatment, it may be useful to remember that many of their effects: an increase in self-efficacy, desensitization of negative affect, elicitation of insight, shifting of body tension, and a cognitive restructuring—occur simultaneously as the dysfunctional information is processed.

i. Phase one-client history and treatment planning: Effective treatment with EMDR demands knowledge both of how and when to use it. The first phase of EMDR treatment therefore includes an evaluation of the client safety factors that will determine client selection. A major criterion for the suitability of clients for EMDR is their ability to deal with the high levels of disturbance potentially precipitated by the processing of dysfunctional information. Evaluation therefore involves an assessment of personal stability and current life constraints. For example, a client might be facing major deadlines at work and would not want to be distracted by the ongoing processing of traumatic material; in this instance, the clinician might delay processing until such work pressures have eased. In addition, a client should be physically able to withstand intense emotion. The clinician must evaluate potential problems due to age or a preexisting respiratory or cardiac condition.

Once the client has been selected for EMDR treatment, the clinician obtains the information needed to design a treatment plan. This part of the history-taking phase
entails an evaluation of the entire clinical picture, including the client's dysfunctional behaviors, symptoms, and characteristics that need to be addressed. The clinician then determines the specific targets that will need to be reprocessed. These targets include the events that initially set the pathology in motion, the present triggers that stimulate the dysfunctional material, and the kinds of positive behaviors and attitudes needed for the future. EMDR should be used to reprocess information only after the clinician has completed a full evaluation of the clinical picture and designed a detailed treatment plan.

ii Phase two- preparation: The preparation phase involves establishing a therapeutic alliance, explaining the EMDR process and its effects, addressing the client's concerns, and initiating relaxation and safety procedures. It is essential that the clinician clearly inform the client of the possibility for emotional disturbance during and after EMDR sessions. Only in this way will the client truly be in a position to give informed consent. Not only does this warning give clients the opportunity to make appropriate choices, but it allows them to prepare their work and social schedules to accommodate any emotional upheaval. Clinicians should also be sure that clients have an audiotape that includes guided relaxation exercises (such as "Letting Go of Stress"; Miller, 1994; or "Light stream Technique," EMDR-HAP, 2001) and that they practice these exercises before beginning the EMDR reprocessing sessions. The goal is for clients to be proficient in these relaxation techniques and capable of using the tape with confidence so that they can deal with any between-sessions disturbance that may occur. Before processing begins, clinicians should also use with the client the guided visualization techniques. If the client is unable to completely eliminate moderate levels
of disturbance with these techniques, the clinician should not continue EMDR. Relaxation techniques like these may be necessary to help the clinician bring to a close an incomplete session and to assist the client in dealing with memories or unpleasant emotions that may emerge after the session. The effective use of these techniques can give clients the confidence to deal with the high levels of disturbing material that may emerge during the session, whereas an inability to handle the disturbing feelings can increase the client’s level of fear and make processing even more difficult. The preparation phase also includes briefing the client on the theory of EMDR and the procedures involved, offering some helpful metaphors to encourage successful processing, and telling the client what he can realistically expect in terms of treatment effects. During the preparation phase the clinician should also explore with the client the possibility of secondary gain issues. What does the client have to give up or confront if the pathology is remediated? If there are concerns in this area, they must be addressed before any trauma reprocessing begins. Included in this precaution is the development of an action plan to handle specific situations that may arise, situations such as the client’s need to find a new job or a new place to live. If the secondary gains are fed by feelings of low self-esteem or irrational fears, they should become the first target of processing. Until these fears are re-solved, no other significant therapeutic effects can be expected or maintained.

iii Phase three- assessment: In the assessment phase the clinician identifies the components of the target and establishes a baseline response before processing begins. Once the memory has been identified, the client is asked to select the image that best represents that memory. Then he chooses a negative cognition that expresses
a dysfunctional or maladaptive self-assessment related to his participation in the event. These negative beliefs are actually verbalizations of the disturbing affect and include statements such as “I am useless/worthless/unlovable/dirty/bad.” The client then specifies a positive cognition that will later be used to replace the negative cognition during the installation phase (Phase Five). When possible, this statement should incorporate an internal locus of control (e.g., “I am worthwhile/lovable/a good person/in control” or “I can succeed”). The client assesses the validity of the positive cognition using the 7-point VOC Scale.

At this point the image and negative cognition are combined to identify the emotion and the level of disturbance, the latter being measured by the 10-point SUD Scale, described previously. The client is asked to pick a number that indicates the intensity of his emotions when the memory is currently accessed. As reprocessing commences, both the emotions and their intensity will probably change, with the disturbance often becoming temporarily worse.

Next, the client identifies the location of the physical sensations that are stimulated when he concentrates on the event. Thus, the assessment stage offers a baseline response with respect to the target memory and the specific components necessary to complete processing.

iv. Phase four- desensitization: The fourth phase focuses on the client’s negative affect, as reflected in the SUD Scale. This phase of treatment encompasses all responses, including new insights and associations, regardless of whether the client’s distress level is increasing, decreasing, or stationary. During the desensitization phase the clinician repeats the sets, with appropriate variations and changes of focus, if
necessary, until the client's SUD level is reduced to 0 or 1 (when "ecologically valid," or appropriate to the individual given his present circumstances). This indicates that the primary dysfunction involving the targeted event has been cleared. However, reprocessing is still incomplete, and the information will need to be addressed further in the crucial remaining phases. It should be emphasized here that in many cases the sets of eye movements (or alternative forms of stimulation) are not sufficient to complete processing. Clinical reports suggest that at least half the time the processing will stop and the clinician will have to employ various additional strategies and advanced EMDR procedures to re-stimulate it.

v. Phase five- installation: The fifth phase of treatment is called the installation phase because the focus is on accentuating and increasing the strength of the positive cognition that the client has identified as the replacement for the original negative cognition. For example, the client might begin with an image of her molestation and the negative cognition "I am powerless." During this fifth phase of treatment the positive cognition "I am now in control" might be installed. The caliber of the treatment effects (i.e., how strongly the client believes the positive cognition) is then measured using the VOC Scale. The installation phase starts once the client’s level of emotion about the target event has dropped to 0 on the SUD Scale. At this point the clinician asks the client to hold the most appropriate positive cognition in mind along with the target memory. Then the clinician continues the eye movement sets until the client’s rating of the positive cognition reaches a level of 7 on the VOC Scale. Keep in mind that the client should rate the cognition based on how she feels at a gut level. The most appropriate positive cognition might be the one the client identified during the
assessment phase of the EMDR treatment session, or it might be one that has emerged spontaneously during the successive sets. The clinician should continue the sets (with the client simultaneously focusing on the positive cognition and the target event) in order to ensure the greatest possible strengthening of the cognition.

vi. Phase six- body scan: After the positive cognition has been fully installed, the client is asked to hold in mind both the target event and the positive cognition and to scan her body mentally from top to bottom. She is asked to identify any residual tension in the form of body sensation. These body sensations are then targeted for successive sets. In many cases the tension will simply resolve, but in some cases additional dysfunctional information will be revealed. As mentioned previously, there appears to be a physical resonance to dysfunctional material, which may be related to the way it is stored physiologically. Identifying residual physical sensation and targeting it in this sixth phase of EMDR treatment can help to resolve any remaining unprocessed information. This is an important phase and can reveal areas of tension or resistance that were previously hidden.

vii. Phase seven- closure: The client must be returned to a state of emotional equilibrium by the end of each session, whether or not the reprocessing is complete. In addition, it is vital that the client be given the proper instructions at the end of each session. That is, the clinician must remind the client that the disturbing images, thoughts, or emotions that may arise between sessions are evidence of additional processing, which is a positive sign. The client is instructed to keep a log or journal of the negative thoughts, situations, dreams, and memories that may occur. This instruction allows the client to cognitively distance herself from emotional disturbance.
through the act of writing. Specifically, the client is told to “take a snapshot” of any disturbances so that they can be used as targets for the next session. The use of the log and the visualization techniques taught by the clinician or via a relaxation tape are extremely important for maintaining client stability between sessions. As with any trauma treatment, unless the clinician appropriately debriefs his EMDR client, there is a danger of de-compensation or, in an extreme case, suicide, which can occur when the client gives her disturbing emotions too much significance or views them as indications that she is permanently damaged. The clinician should provide the client with realistic expectations about the negative (and positive) responses that may surface both during and after treatment. This information increases the likelihood that the client will maintain a sense of equilibrium in the face of possible disturbance engendered by the stimulation of the dysfunctional material. There may be a domino effect that stimulates other negative memories as the information processing continues.

vii. Phase eight- reevaluation: Reevaluation, the eighth phase of treatment, should be implemented at the beginning of each new session. The clinician has the client re-access previously reprocessed targets and reviews the client’s responses to determine if treatment effects have been maintained. The clinician should ask how the client feels about the previously targeted material and should examine the log reports to see if there are any reverberations of the already processed information that need to be targeted or other-wise addressed. The clinician may decide to target new material but should do so only after the previously treated traumas have been completely integrated. Integration is determined in terms of intra psychic factors as well as systems concerns. The reprocessed traumas may have resulted in new behaviors on the part of the client,
requiring the clinician to address problems that arise in the family or social system. The reevaluation phase guides the clinician through the various EMDR protocols and the full treatment plan. Successful treatment can only be determined after sufficient reevaluation of reprocessing and behavioral effects.

While the standard EMDR procedure takes place during each reprocessing session, the standard three-pronged EMDR protocol guides the overall treatment of the client. Each reprocessing session must be directed at a particular target. The generic divisions of these targets are defined in the standard protocol as (1) the past experiences that have set the groundwork for the pathology, (2) the present situations or triggers that currently stimulate the disturbance, and (3) the templates necessary for appropriate future action. All of the specialized EMDR protocols (e.g., those regarding phobias or somatic disorders) are interfaced with this standard format.

As EMDR is a process, not a technique; it unfolds according to the needs, resources, diagnosis, and development of the individual client in the context of the therapeutic relationship. For instance, when working with children, especially with young children who might be preverbal or unable to determine a Negative Cognition, drawings might be used instead. A dissociative or learning disabled client might also be unable to determine a Negative Cognition but could instead articulate a somatic or affective aspect of the target. Therefore, different elements may be emphasized or utilized differently depending on the unique needs of the particular client or of special populations (Zaghrout-Hodali, Alissaand and Dodgson, 2008).

**EMDR with children.** Eye Movement Desensitization and Reprocessing (EMDR) is a therapeutic technique that works very effectively with children. It uses to help children...
deal with; sexual abuse, witnessing and experiencing physical and emotional abuse, automobile accidents, parental deaths, hospitalizations, negative reactions to parental separations and divorces, problems related to ADHD, abandonment issues, low self esteem, being hit by a car, anxieties and fears, anger management issues, and problems with being teased and bullied.

Strategies which facilitate conducting EMDR with children (Shapiro, 2001):

- Parental awareness and support of the EMDR process. Sometimes it is very effective to have parents collaborate in writing a therapeutic story of their child’s trauma which can be used in the EMDR processing.

- The child’s sense of safety and trust in the therapeutic relationship.

- Having the child symbolically represent their feelings about the trauma or problem situation before processing with EMDR.

- The therapist’s sensitivity and creativity in helping the child process difficult feelings and memories. It is helpful if the child realizes that the uncomfortable feelings and memories can be released from the body and mind.

- Allowing the child to feel like they are in charge of the EMDR process and can take a break when they need to.

- Using of some interesting methods to create the primary safe place likes butterfly hug.

Included in the many pleasures of working with children is the satisfaction of seeing the traumatic residue disappear quickly and of knowing that the children will be spared years of suffering and will not be driven to engage in behaviors that repeat the abuse on others. A controlled study of traumatized children also indicates that EMDR
can successfully reduce physical as well as psychological symptoms. To ensure the successful use of EMDR with children, the clinician must pay special attention to creating a safe psychological environment. As with any other procedure, EMDR should not be used with children unless the clinician is already comfortable working with them (Shapiro, 2001).

During the initial history-taking phase it may be useful for the parent to brief the clinician about the problem with the child present and then to leave the room while the child presents his version of the situation. This two-step process may allow the parents' authority to be tacitly transferred to the clinician and may give children a sense of being special when the clinician's full attention is turned exclusively to them.

During the EMDR treatment session the child should generally be seen without the parents present, if possible, in order to maximize the child's focus on the target. Obviously, there will be times when it is advantageous for parents to be in the room because of the child's fears about separation. Indeed, some strategies specifically utilize the parent(s)' presence. However, every effort should be made to create for the child an optimal level of comfort when alone with the clinician. This goal may be facilitated by giving the child permission to bring along a favorite stuffed animal or toy to the next treatment session (Shapiro, 2002).

While the clinician must use the language of the child to explain EMDR, it is preferable to refrain from referring to EMDR as a magical cure, even if the child spontaneously adopts such an expression (e.g., "It's magic") when noticing how much better she feels. Rather, as with all EMDR clients, it is preferable to provide the child
with a sense of self-healing and self-efficacy. If the clinician indicates instead that the power to remove the negative affect is vested in the method or in his own expertise (e.g., by saying, “I’m going to make it go away”), the child is likely to remain at a level of dependency and powerlessness that is detrimental to overall therapeutic goals.

Before attempting to target dysfunctional material, the clinician should make sure the child has a usable “safe place.” A feeling of safety and assurance is induced in the child through use of eye movement sets in the context of an actual positive experience. For example, the clinician might ask the child to remember a time when he was in control and felt good and might have the child imagine looking, feeling, and acting in a positive way. As the child holds this scene in mind, the sets are repeated until the child feels happy or positive, as in the imagined scene. This positive experience with the eye movements (or hand taps) allows children to trust the process, since pleasant feelings are immediately evoked, and they are left with positive associations to the therapeutic experience (Shapiro, 2001).

Because the difficulties that clinicians generally encounter with young children are primarily due to concentration problems and relatively short attention spans, the average EMDR treatment session with children is about 45 minutes, during which eye movements are often interspersed with other activities. Fortunately, despite their comparative brevity, such sessions are likely to be therapeutically effective because children appear to respond favorably to EMDR very rapidly (Shapiro, 2002).

In order to enhance the child’s concentration, the standard EMDR procedure should be adjusted in a variety of ways. In particular, the clinician will need to engage
many external stimuli as focal points. Greenwald (2007) have described some primary adjustments in the treatment of children are addressed in the following paragraphs.

Concrete Definitions of Feelings: Children typically cannot conceptualize feelings using the SUD Scale because it is too abstract for them. Clinicians should have children use their hands to indicate the magnitude of a feeling. For example, holding the hands at chest level, with arms parallel to the arms of the chair, can be defined as “very bad/terrible/awful” or some other word that evokes the child’s negative experience. Clasping the hands can be defined as feeling wonderful or as feeling “as good as looking at bunny rabbits.” Children can also be taught to report accurately any changes in distress by indicating these concretely; for example, holding the hand close to the floor can indicate a little hurt whereas a hand held at shoulder height means a big hurt. Another option is for the clinician to draw on a piece of paper a horizontal line with a smiling face on one end and a crying face at the other and to ask the child to indicate where he is located on the line. Aids for this purpose have been used successfully with traumatized children in many countries.

i. Holding the Child’s Attention: In order to assist children in eye tracking, the clinician can draw happy faces on her fingers or use puppets or other toys. Puppets or toys may also be used in the two-handed. The two-handed technique is often useful with young children because of their inability to cross the midline. For instance, when he is asked to draw a line on a piece of paper from the far left to the far right of his body, a young child will start drawing and then lift the pencil in the middle, putting it down again to complete the line. If the single-hand technique is used with a young child, his head will often move along with his eyes. This is acceptable and can achieve treatment
effects, but a full range of eye movement should still be attempted. For children who have an eye-tracking problem because of dyslexia, using small elliptical movements about 3 inches in diameter at the usual 12- to 14-inch distance from the eyes can be effective. Dyslexic children (even when older) cannot track a wide range of motion.

In children with attention-deficit/hyperactivity disorder (ADHD) there is often a tactile defensiveness that makes them uncomfortable when in close contact with the clinician. These children should be asked to move their eyes back and forth between two spots on the wall. To engage their attention these spots may be in the form of colored circles, cartoon figures, or comic book heroes.

For many children the best form of stimulation is tactile. For instance, games of “patty-cake” have been used to engage the participation of children as young as 18 months. A recently introduced form of dual stimulation is the “butterfly hug” which, combined with repeatedly drawing the target memory, has been successfully used to treat groups of traumatized children in Mexico, Nicaragua, and Kosvar refugee camps.

Children place their arms across the chest, with the right hand on the left shoulder and the left hand on the right shoulder. The dual stimulation is accomplished by the child’s tapping each shoulder alternately.

In order to increase the child’s level of involvement when processing a traumatic memory, the clinician should be prepared to engage the child in a variety of ways. For example, during the eye movement sets the clinician might vocalize a lively tune like the William Tell Overture and should be prepared to make rapid rhythmic movements with his upper body to maintain the child’s attention. Clinicians may also attempt to harness
the child’s imagination. For example, the EMDR treatment session may be initiated by asking the child to “imagine what happened” or to “bring up the picture.” After the eye movement set the child can be asked to “blow up the picture” or “explode” it. The clinician can assist by making the sound of an explosion and by using gestures that the child can mimic. The clinician then asks, “How does it feel now?”; after redirecting the child’s attention to the picture, the clinician adds a set of eye movements and repeats the request to “blow up the picture.”

When reprocessing is complete, the positive cognition is installed. The clinician should offer (without any special fuss) an easy cognition such as “I’m fine” or “Mommy/Daddy will take care of it” or “I’m safe now.”

It can be useful for young molestation victims to address and replace the negative cognition “Don’t tell” or “I can’t tell.” Having the child concentrate on these negative cognitions during successive sets, without pressing for details, allows the fear engendered by these injunctions to dissipate. Then substituting the words “I’m safe now” or “It’s okay to tell” can have excellent effects.

When working with school-age children it is preferable to elicit the negative and positive cognitions, rather than merely suggest them, even though they might not be ideally constructed. The clinician initiates a set of eye movements after asking the child to imagine the scene and respond to a question such as “What thoughts do you have?” or “What do you think about in the picture?” Most often, the child will respond with statements that indicate an external locus of control (e.g., “The teacher hates me” as a negative cognition and “The teacher likes me” as a positive cognition). The clinician may
ask the child to hold a picture of the “teacher hating” while one or two sets are induced. The child is then asked “What thoughts do you have?” or “What do you think about your self now?” The child will generally reveal a spontaneous switch from a cognition like “The teacher hates me” to a negative cognition like “I’m not motivated” or “I’m distracted” and a positive cognition like “I can do well in school.”

While clinicians will typically attempt to contribute to an initial internal locus of control when working with an adult client, it is important for them to remember that children are frequently in a threatening environment and that they are indeed powerless. In addition, the child may not have a well-developed cognitive structure. Therefore, the clinician should offer the child the closest approximations to self-efficacy statements (e.g., “I’m okay” or “I feel good”) without needing to adhere completely to the guidelines about positive cognitions for adults.

iii Generalizing Treatment Effects: In addition to treating individual memories that a child might reveal, it is advisable with this population to do additional EMDR work with the child concentrating on the perpetrator alone, that is, without imagining the perpetrator engaging in a specific action. Using such a procedure assists in generalizing the treatment effects throughout the entire associated memory network. For instance, a 5-year-old molestation victim was ritually abused by her father while he was wearing a black gown and mask. In addition to targeting her memories of abuse, which included seeing her dog killed, she was asked to hold in mind the picture of her father in his gown and mask. Using a still picture, instead of one in which the perpetrator is taking a particular action, allows a desensitization effect to generalize to all memories that include the cue of the still picture (in this case, the image of the father in mask and
Children as young as 2 years are quite capable of bringing up an image. Be prepared for especially rapid treatment effects (presumably because young children have had relatively few experiences and therefore have fewer associations to be accessed). The child may start smiling happily after only a few sets, which is quite consistent with high therapeutic effect giveness. The clinician should check for subsequent changes in symptomatology, such as bed-wetting, nightmares, and panic attacks, which may disappear after only one or two sessions. However, while bed-wetting and night terrors may end for one child after a single session devoted to processing a molestation incident, cessation of symptoms may require many more sessions for other children. Once again, do not view EMDR sessions as a race. The rate at which treatment effects occur will vary from one client to another.

Creative Therapy: A number of clinicians have recognized the efficacy of the creative process (e.g., drawing, painting, sand-tray play) in the treatment of children. One clinical case example involved the pre- and post treatment pictures drawn by a young boy. When the child was asked to make a picture of the problem, he drew a big black cloud that covered nearly the entire page. He was then asked to hold this picture in mind during successive sets. After showing signs of relief, he was asked to draw the situation again: It now appeared as a small black speck being chased out of the room. The child was then asked to hold this picture in mind for one or two additional sets, after which it was supplemented with a positive cognition.

Sand-tray play, dolls, and pieces of games can all be used as targets for children if the proper foundation is laid to allow them to link their feelings about the negative incident or perpetrator to the object. The full EMDR procedure may be implemented
using these targets. However, the clinician should eventually return to the primary trauma images to check for complete resolution (Shapiro, 2002).