NETWORK TO ELIMINATE VIOLENCE IN RELATIONSHIPS

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RELATIONSHIP VIOLENCE IN YOUTH

A Scoping Review

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Table of Contents

EXECUTIVE SUMMARY 2
Background *2*
Objectives *2*
Results *2*
Methodology *5*
REPORT 5
Background *5*
Objectives *6*
Methods *7*
Results *8*
DEFINITIONS 9
ADVERSE CHILDHOOD EXPERIENCES (ACES) 10
EARLY EXPERIENCES OF RELATIONSHIP VIOLENCE 17
CHILD ABUSE 17
PEER BULLYING 18
DATING VIOLENCE 20
SOCIOECONOMIC RISK FACTORS 22
INTERVENTION 27
IMPLICATIONS FOR POLICY AND PRACTICE 37
CONCLUSION 39
REFERENCES 41

Executive Summary

Background

This scoping review reports on the existing literature published in the past two decades (2003-2023) on relationship violence against and among children under 18 years old. The research is extensive in this field, and it points to the ways in which Adverse Childhood Experiences have long-lasting impacts on the well-being of individuals and lead to their engagement in and/or exposure to aggressive and violent behaviors across the lifespan. There is a substantial body of literature maintaining that child abuse, as a form of Adverse Childhood Experiences, contributes to a transgenerational transmission of violence.

Objectives

- Synthesize interdisciplinary literature on relationship violence against and among children under 18 years old and the ways in which violence is passed down from one generation to the next
- Analyze existing interventions and preventive measures and the literature on the best practices for maximum impact
- Explain how the scoping review can be used to inform policies and practices aimed at preventing and addressing the issue
- Identify gaps and emerging trends in the literature
- Provide insights that inform future research

Results

Child abuse, a prevalent form of relationship violence, significantly impacts individuals' long-term physical and mental health. This term encompasses a range of maltreatment towards children under 18, including physical, psychological, sexual, emotional, medical, educational abuse, neglect, and exploitation (World Health Organization, 2021). Child abuse can lead to cognitive

and academic challenges, mental health issues, substance use, and involvement in violent behaviors (World Health Organization, 2021; Public Health Agency of Canada, 2014; United Nation, 2006; Black et al., 2012; Ford et al., 2006) as well as chronic health conditions such as diabetes, cancer, cardiac disease and early death (National Conference of State Legislatures, 2023). Research has shown a strong link between child abuse and adulthood violence, particularly intimate partner violence, with associated mental health and physical health problems (Burczycka, 2017, Miller et al., 2011). This complexity is exacerbated by intersecting systems of oppression, socioeconomic disparities, cultural norms, and challenges in reporting and intervention. Child abuse is a key Adverse Childhood Experience.

The research on Adverse Childhood Experiences (ACEs) underscores their profound and lasting effects on physical and mental health, with implications for generational cycles of abuse. ACEs encompass various potentially traumatic events at an early age (Centers for Disease Control and Prevention, 2023), inducing toxic stress that leads to structural brain changes and physiological alterations (Shonkoff et al., 2021; McEwen, 2006). ACEs are associated with various illnesses and mental health disorders, including disordered behavioral functioning (Burke et al., 2011; Karlen et al., 2015; Miller et al., 2011). Experiencing ACEs can lead to emotion dysregulation and aggression that result in challenges in forming healthy relationships. Childhood maltreatment affects sensory systems and brain development, leading to mental health issues, health-harming behaviors against self and others, and emotional instability (Ashworth et al., 2023; Bellis et al., 2014; Curran et al., 2018; Kim et al., 2010; Mayer et al., 2008; Poletti et al., 2022; Swedo et al., 2023; Teicher et al., 2016).

Children and youth may experience relationship violence in various forms, including but not limited to peer bullying, dating violence, intimate partner violence, and family violence. Experiencing interpersonal violence in childhood is a form of Adverse Childhood Experiences that has significant implications for physical and mental health, resulting in chronic diseases, mental health issues, and physical changes associated with toxic stress. Studies indicate that those children experiencing violence are at a higher risk of developing mental health problems, engaging in aggressive or risky behaviors, and being revictimized (Afifi et al., 2020; Ackard et al., 2007; Ahonen et al., 2016; Breslau et al., 2011; Copeland et al., 2013; Due et al., 2005; Ehrensaft et al., 2003; Fisher et al., 2012; Houston et al., 2007; McNaughton et al., 2018; Olweus & Breivik, 2014; Sigurdson et al., 2015; Takizawa et al., 2014; Tharp-Taylor et al., 2009; Wekerle et al., 2009; Wolfe et al., 2018; Wolke & Lereya, 2015).

Individuals facing marginalization, oppression, or poverty often have a higher prevalence of Adverse Childhood Experiences (ACEs) and relationship violence and exhibit health disparities (Liu et al., 2020; Maguire-Jack et al., 2020). Inherent adversities, discrimination and marginalization can subject children to prolonged and chronic stress, leading to mental health issues, aggression, behavioral problems, inflammation, various diseases (cancer, diabetes, cardiac, etc), and early mortality (Ruffolo et al., 2022; Priest et al., 2013; Svetaz et al., 2018). Additionally, structural marginalization and discrimination such as systemic racism is not only an ACE but also contributes to the higher prevalence of other types of ACEs, as it impacts various aspects of people's lives, such as education, criminal justice involvement, child welfare, neighborhood safety, finances, and experiencing wars (Hayes-Greene and Love, 2018). Relationship violence disproportionately affects marginalized children, as they are at a higher risk of experiencing violence victimization and perpetration based on imbalanced systems of power and biased stereotypes and prejudices against them (Blake et al., 2012; Bradshaw & Johnson, 2011; Dank et al., 2014; Due et al., 2009; Earnshaw et al., 2018; Espelage et al., 2017; Garnett et al., 2017; Mittleman, 2019; Peguero, 2009).

Effective interventions aimed at reducing violence among school-age children encompass teaching conflict resolution skills, counseling, promoting emotional regulation skills, fostering empathy, and encouraging peer and parental support (Battey, 2009; Biswass et al., 2020; Cross et al., 2011; Domino, 2013; Fonagy et al., 2001; Midgett et al., 2015; Olweus et al., 2020; Sahin, 2012; Wolfe et al., 2003). Peer and family support play crucial roles in preventing and addressing interpersonal violence and need to be incorporated into intervention programs (Campos-Castillo at al., 2021; Meltzer et al., 2018; Papanikolaou at el., 2011; Rusch et al., 2019). The literature also points to the importance of integrating an intersectional approach in intervention programs in order to consider different axes of children's identities and the ways in which systems of power disproportionately affect their experiences of violence (Bauer et al., 2007; Garnett et al., 2017). Moreover, early mental health intervention can positively impact the mental health of children and promote healthy relationships among them (Kelly et al., 2007; McGorry & Mei, 2018; Schley et al., 2008), especially if they engage youth in the processes of designing and implementing the program and encourage help-seeking in young adults (Collin et al., 2011; Howe et al., 2011). Early intervention programs need to consider the barriers that marginalized populations face in accessing mental health systems and try to eradicate them (Alegría, et al., 2010; Bringewatt & Gershoff, 2010; Harrison et al., 2004; Yoshikawa et al., 2013).

Methodology

This scoping review follows established methodologies to systematically explore the literature regarding relationship violence against and among children. The review is guided by specific research objectives and aims to map the evidence in this field over the past decade, and focuses on key themes and trends within the literature. It employs a structured process to identify relevant studies, employs a combination of keywords and Boolean operators for literature retrieval, and utilizes thematic analysis to categorize key themes and trends. The search strategies encompass library and database searches, specific journal searches, Google Scholar searches, citation examination, and general Google searches. The primary goal is to present a clear and concise summary of the existing literature while identifying research gaps to inform future efforts in research, policy development, and intervention programs.

Report

Background

The term Relationship Violence refers to any form of violence occurring within the context of interpersonal relationships within any age group and any context (in person or online). As Gurm et al. (2020) state, it encompasses a range of harmful behaviors that occur among individuals with varying degrees of connection, be it in intimate partnerships, familial bonds, friendships, workplace/school relationships, or other social contexts. This review reports on the existing literature published in the past decade on relationship violence against and among children, its various forms and contexts, the risk factors, and the best prevention and intervention strategies. The literature published over the past decade indicates that relationship violence is not only a social issue but also a health problem disparately affecting children based on intersecting factors of their identities. According to Statistics Canada (2021), there were 127,082 victims of police-

reported family violence (violence committed by spouses, parents, children, siblings and extended family members) in 2021, a rate of 336 victims per 100,000 population, which is 3% higher than 2020. Non-family violence rates have also increased 6%. These rates mark the fifth consecutive year of family violence increase, while 2021 is the Seventh consecutive year of gradual increase in police-reported intimate partner violence (Statistics Canada, 2021). Recent estimates from the World Health Organization (2021) indicate that approximately one in three (30%) women across the world have experienced physical and/or sexual violence from an intimate partner or non-partner sexual violence at some point in their lives. In Canada, one women/girl is killed every 48 hours (Canadian Femicide Observatory for Justice and Accountability, 2022). On a global scale, up to 38% of all cases of female homicides are perpetrated by intimate partners (World Health Organization, 2021). Research conducted by Conroy (2018) showed that in 2019, There were 399,846 cases of police-reported violence in Canada, marking the third consecutive year of increasing family violence and the fifth consecutive year of intimate partner violence. Of these cases, three in ten (30%) were victimized by an intimate partner, which represented 107,810 survivors. Notably, 72% of intimate partner violence survivors suffered physical assaults. Over a six-year period (2014-2019), there were 497 cases of intimate partner homicide, with 80% of the victims being female. Among the cases of police-reported violence, 69,691 child and youth survivors were reported. Furthermore, 14,156 senior individuals reported incidents of violence in 2019. These statistics indicate that relationship violence, which profoundly impacts young individuals, is on the rise and is a multifaceted issue that requires early prevention and intervention efforts from various sectors and bystanders. This review aims to map the trajectory of research, identify emerging themes, and shed light on existing gaps, thereby contributing to a thorough understanding of early experiences of relationship violence, with a particular focus on informing prevention and intervention strategies. The report covers several key areas: an exploration of the existing knowledge on early relationship violence victimization and/or perpetuation, an examination of the primary factors contributing to early experiences of relationship violence, and an assessment of effective interventions and preventive measures for reducing instances of relationship violence among children.

Objectives

- Synthesize interdisciplinary literature on relationship violence against and among children under 18 years old and the ways in which violence is passed down from one generation to the next
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- Identify gaps and emerging trends in the literature
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Methods

This scoping review employs established methodologies used in scoping reviews set out by Bradbury-Jones et al. (2021) to systematically explore and synthesize the existing literature on the early experiences of relationship violence. The primary objective is to comprehensively map the evidence in this field. To begin, the research objectives of this review were clearly defined to guide the entire process, from study selection to knowledge synthesis. It is important to note that this review does not attempt to cover all available literature on this topic, as the subject area is extensive and cannot be fully addressed within the scope of this project. The primary aim of this review is to map and provide an overview of the critical literature over the past decade (with the exception of the work of Felitti et al. (1998) that is needed to explain the origin of ACEs studies) rather than comprehensively analyzing every single relevant study. Instead of an exhaustive review of all literature, this scoping review focuses on identifying the key themes, trends, and research gaps within the field. To achieve this, this review follows a systematic and structured process to identify and include a representative sample of relevant studies. The goal is to provide a comprehensive overview while managing the volume of literature. To ensure the relevance and rigor of the review, specific inclusion and exclusion criteria was established. These criteria encompass three factors: the publication date range (i.e., past decade), types of sources to be considered (i.e., peer-reviewed and academic articles, published books, and gray literature), and how relevant the works are to the scope and the questions of this specific review (i.e., if they are focused on children, early intervention, and systemic discrimination leading to ACEs and relationship violence).

The initial step in the literature search involved a comprehensive exploration of Simon Fraser University's library catalog, providing access to essential databases. This search also resulted in the identification of related journals, which were then searched to discover pertinent literature. Following the identification and selection of relevant literature based on predetermined criteria, a parallel search was performed using Google Scholar. The subsequent stage entailed a meticulous examination of the reference sections within the chosen literature and a study of the works cited therein. This approach facilitated the discovery of a cohesive network of interconnected works that engage in dialogue with each other, while also enabling the review to uncover foundational contributions to this field of study. The final stage encompassed broad Google searches, leading to the discovery of pertinent gray literature that holds significance in the field.

A combination of keywords and Boolean operators were used to retrieve relevant literature. For instance, phrases such as (“Adverse Childhood Experiences” OR “Childhood Adversity” OR “Child maltreatment” OR “Child Abuse”) AND (“Peer Bullying” OR “Youth Dating Violence” OR “Youth Violence” OR “Youth Aggression”) were used to help identify the relevant literature. Once studies were selected, a structured data extraction form was used to collect pertinent information from each study. This included details such as study design, sample size, methodology, and key findings. The extracted data was organized and summarized, and thematic analysis was employed to identify and categorize key themes and trends in the literature. Drawing from these themes, the report section of the review was organized into distinct headings.

In reporting the results, this review aims to present the findings in a clear and concise manner, providing insights into the existing body of literature on the association between Adverse Childhood Experiences and relationship violence among children. Furthermore, this review focuses on identifying research gaps to inform future research, policy development, and intervention and prevention programs.

Results

The search for related literature yielded a total of 154 works, encompassing a variety of topics related to relationship violence and children. 100 works were selected based on the predetermined criteria. These works were categorized into different themes, with 16 works dedicated to providing definitions and clarifications on relationship violence, 16 works exploring

the connection between Adverse Childhood Experiences (ACEs) and relationship violence among children, shedding light on the influence of early life adversity on later experiences of violence. Among the identified literature, 28 works delved into the various aspects of violence among children, addressing issues such as peer bullying, dating violence, and intimate partner violence in the context of child and youth relationships. Furthermore, 15 works examined the role of socioeconomic factors in relationship violence, emphasizing the impacts of economic and social disparities on the prevalence and dynamics of early experiences of relationship violence. Finally, the review identified 25 works that focused on intervention strategies and approaches aimed at preventing and addressing relationship violence, emphasizing the importance of proactive measures to mitigate its occurrence and what have been effective in promoting healthy relationships and reducing relationship violence among children.

Definitions

In this review, the definition of relationship violence used was developed by Gurm (2020), described as “any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone who has a bond or relationship with the offender” (Gurm, 2020, unpaginated). As noted by Gurm (2020), there are various forms and aspects of relationship violence, including but not limited to:

- Physical: “the intentional use of force against a person without that person's consent. It can cause physical pain or injury that may last a long time” (Canada Department of Justice, 2023, unpaginated).
- Emotional: “when a person uses words or actions to control, frighten or isolate someone or take away their self-respect” (Canada Department of Justice, 2023, unpaginated).
- Sexual: “sexual touching or sexual activity without consent, continued sexual contact when asked to stop, forcing someone to commit unsafe or humiliating sexual acts” (Canada Department of Justice, 2023, unpaginated).
- Financial: “when someone uses money or property to control or exploit someone else” (Canada Department of Justice, 2023, unpaginated).
- Neglect: when one “who has a duty to care for you, fails to provide you with your basic needs” (Canada Department of Justice, 2023, unpaginated).

- Cyberbullying: “the use of computers, smartphones or other connected devices to embarrass, hurt, mock, threaten or be mean to someone online” (Public Safety Canada, 2023, unpaginated).
- Harassment: “harassing behavior including repeatedly following, communicating with or watching over one’s dwelling home” (Canadian Resource Centre for Victims of Crime, n.d, unpaginated).
- Bullying: “willful, repeated aggressive behavior with negative intent used by a child to maintain power over another child” (Government of Canada, 2016, unpaginated).
- Negative Social Control: “systematic attempts to enforce norms –including in the family – that restrict individual freedom and rights under the law and the UN Convention on the Rights of the Child” (Nordic Co-Operation, n.d., unpaginated).

Relationship violence can occur in various contexts and settings, including domestic and intimate partner violence, as well as within familial relationships (e.g., parents, siblings, etc.), among neighbors, within: community, schools, workplaces, and in gang settings (Brubaker, et al., 2017; Cantor et al., 2019; Gurm, 2020; Voth Schrag, 2017). Violence can be experienced by everyone regardless of their sex, gender, sexual orientation, or other personal identity factors (Hine et al., 2022, Messner, 2016). Early encounters with relationship violence serve as significant Adverse Childhood Experiences.

Adverse Childhood Experiences (ACEs)

The influence of Adverse Childhood Experiences (ACEs) on individuals' physical and mental health and their role in the continuation of an intergenerational cycle of abuse is an emerging area of research. The term “ACEs” originated in a study conducted from 1995 through 1997 by Kaiser Permanente and the Centers for Disease Control and Prevention (Felitti et al., 1998). This study defined ACEs as various forms of childhood experiences of abuse and household dysfunction (Felitti et al., 1998). Centers for Disease Control and Prevention (2023) specifies that Adverse childhood experiences are potentially traumatic events that occur during the first 18 years of life. This may include being neglected, experiencing or witnessing abuse and violence, having suicide in the family, and growing up in an environment that challenges the child’s

sense of safety, stability, and bonding, such as caregiver mental illness and substance use, parental separation, or having a family member in prison (Centers for Disease Control and Prevention, 2023). It can also encompass socioeconomic challenges and disparities such as racism and poverty, and exposure to environmental toxicants (Shonkoff et al., 2021). Joshi et al. (2021) studied the prevalence of individual ACEs among middle-aged and older adults in Canada and the results show that 61.6% of the 44817 participants reported exposure to at least 1 ACE, indicating the high prevalence of ACEs among Canadians. In another study conducted in the U.S., approximately 64% of adults disclosed experiencing at least one type of ACE before reaching 18, with nearly 1 in 6 (17.3%) indicating exposure to four or more distinct types of ACEs (Centers for Disease Control and Prevention, 2023). Research indicates that ACEs have profound and enduring adverse effects on the health, well-being, and life opportunities of individuals (Centers for Disease Control and Prevention, 2023).

Shonkoff et al. (2021) state that Adverse Childhood Experiences lead to toxic stress and modifications in brain structure. The authors discuss that the development of children is characterized by continual adaptation, encompassing both physical and behavioral aspects. Children exhibit a remarkable degree of plasticity, particularly during the mid to late fetal stages, infancy, and toddlerhood, when foundational neural circuits are formed. These developmental stages mark periods of heightened plasticity, rendering the brain exceptionally receptive to the influences of systemic hormones, neural and immune feedback, as well as endogenous neurochemicals that modulate its circuitry and responsiveness to stimuli (Shonkoff et al., 2021). The child's interactions with caregivers, along with both prenatal and postnatal developmental processes, exert significant impacts, which can yield both positive and negative outcomes for the child's overall healthy development. Adverse Childhood Experiences have the potential to detrimentally impact and undermine the healthy development in children (Shonkoff et al., 2021). When a child faces adversity, it triggers the activation of their stress response. If this stress response is consistently strong, frequent, or prolonged, and lacks the protective support of nurturing relationships, it leads to toxic stress (Perrin et al., 2020, cited in Shonkoff et al., 2021). In cases where these biological disruptions persist during critical developmental periods, affecting not only the brain but also other biological systems, they can give rise to lasting structural alterations and physiological dysregulations. These changes can result in difficulties related to learning, behavior, as well as both physical and mental well-being (Shonkoff et al., 2021).

McEwen’s (2006) study illustrates the link between toxic stress and alterations in brain structure. This study explains that stress-induced hormones serve a protective role in the

immediate term and facilitate adaptation via allostasis. However, when the body experiences prolonged and chronic stress, these hormones, over time, may cause alterations within the body that potentially contribute to the development of disease. The brain plays a pivotal role in identifying stressors and deciding what is a suitable response. Specific brain regions like the hippocampus, amygdala, and prefrontal cortex undergo structural modifications in response to acute and chronic stress. These structural adaptations subsequently translate into changes in both behavioral and physiological responses (McEwen, 2006). Shonkoff et al. (2021) argue that toxic stress experienced due to higher plasticity in initial years of one's life, adversity in the prenatal period and the first few years after birth, profoundly affects the brain structure of the developing child and renders the body more vulnerable to physiological or psychosocial stressors (Shonkoff et al., 2021). Their study agrees with McEwen (2006) in that it states the time-limited activations of stress response systems exist to protect the body, but the lack of recovery after each activation and exposure to toxic stress leads to a maladaptive state for the brain (Shonkoff et al., 2021).

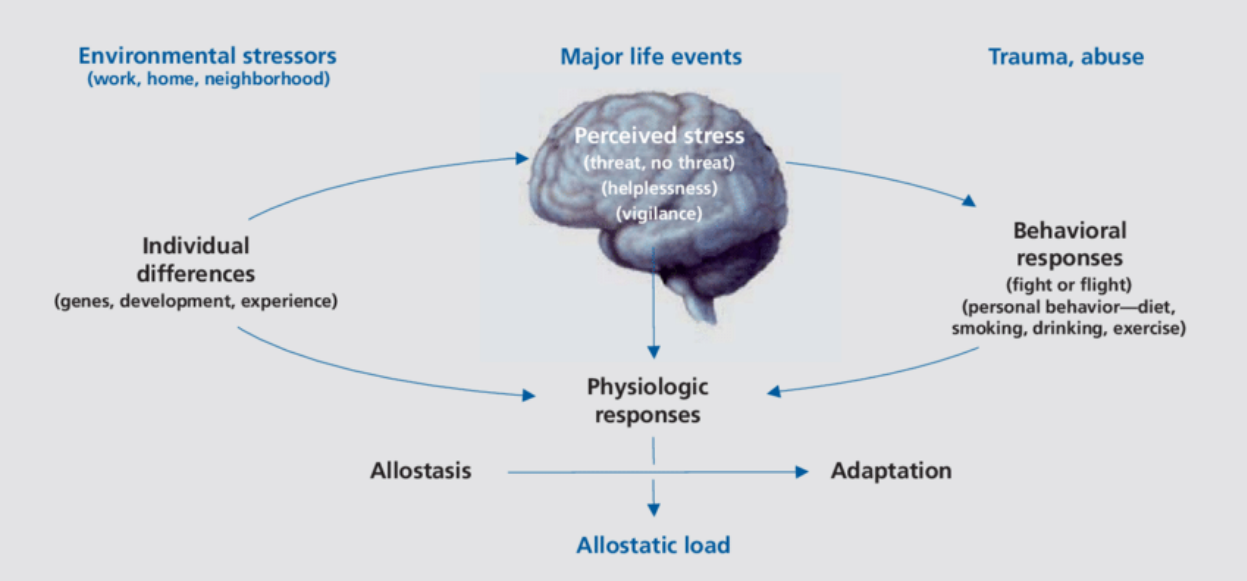

Figure 1. Central role of the brain in allostasis and the behavioral and physiological response to stressors. N Engl J Med. 1998;338:171-179. Copyright © Massachusetts Medical Society 1998. Cited in McEwen, 2006, Protective and damaging effects of stress mediators.

The association between ACEs and the resultant toxic stress with an elevated risk of a broad spectrum of health conditions in both children and adults is well documented. Karlen et al.

(2015) discuss the impacts of physiologic dysregulation due to stress in early years. The authors employed a questionnaire comprising 11 psychosocial items in the family during pregnancy. They also assessed the cumulative incidence of diagnoses in a group of 1876 children up to the age of 10 years. They measured cortisol levels in hair in those with sufficient hair samples at age 1, yielding a subsample of 209. Their study showed that those children who had undergone adverse experiences had higher infant cortisol levels in hair, and were significantly more often affected by the most common childhood diseases (Karlen et al., 2015). Miller et al. (2011) argue that being exposed to major psychological stressors in childhood is associated with elevated rates of morbidity and mortality from chronic diseases of aging. They argue that experiencing such stressors leads to chronic inflammation, which in turn causes adult chronic diseases (Miller et al., 2011).

Burke et al. (2011) reviewed medical charts of 701 subjects from the Bayview Child Health Center in San Francisco and coded medical chart documentation of ACEs as defined in previous studies in order to investigate the ACEs within low-income, urban communities and examined the relationship between the ACE score and two pediatric issues: learning/behavior problems and a Body Mass Index (BMI) equal to or greater than 85%, indicating overweight or obesity. This study illustrated that those exposed to four or more ACEs categories were at a higher risk of learning/behavior problems, as well as obesity (Burke et al., 2011).

A study conducted by Swedo et al. (2023) used 2016–2018 Pregnancy Risk Assessment Monitoring System population-based data from 5 states in the United States and included thirteen adverse childhood experience measures across 3 domains: abuse, neglect, and household challenges. They also examined Fourteen pregnancy- and infant health–related indicators, including unwanted pregnancy, adequate prenatal care, experiences during pregnancy (e.g., smoking, abuse, depression), gestational diabetes, hypertensive disorders of pregnancy, birth outcomes (e.g., preterm birth), and breastfeeding. After accounting for demographic factors, parity, health insurance status, and educational attainment, the study computed prevalence ratios and their corresponding 95% CIs to assess the connections between indicators related to pregnancy and infant health and adverse childhood experience scores. In this study involving a total of 14,510 participants, the majority of respondents were non-Hispanic White, aged between 25 and 34 years, married, privately insured, and had completed education beyond high school. Notably, a significantly higher proportion of participants who reported having three or more Adverse Childhood Experiences (ACEs) also reported experiences such as unwanted pregnancy, physical abuse during pregnancy, smoking during pregnancy, depression during pregnancy, and

hypertensive disorders of pregnancy (HDP) compared to participants without ACEs. The study argues that the impact of ACEs extends across a person's lifetime and can have lasting consequences that affect future generations. Child abuse, neglect, and other adversities often show intergenerational continuity, contributing to the cycle of violence. Furthermore, parental ACE scores strongly predict the ACE scores of their children, and ACEs can be experienced in utero even before a child's birth (Swedo et al., 2023).

Another study (Ashworth et al., 2023) reviewed 240 children and young people records in a pediatric Emergency Department in England who were experiencing suicidal crisis presented between March 2019 and March 2021. The study focused on various binary variables derived from clinicians' records. These variables encompassed Adverse Childhood Experiences (ACEs), including physical abuse, emotional abuse, sexual abuse, neglect, exposure to domestic violence, parental involvement in criminal activities, parental substance misuse, parental mental health issues, and parental separation. Additionally, demographic factors like gender, ethnicity, special educational needs, the presence of potential autism traits, mental health conditions, thoughts of suicide with or without self-harm, self-harm history, clinician-assessed risk to life, and the frequency of previous visits to the Emergency Department for suicidal crises were examined. The study found a significant association between suicidal crisis and experiencing ACEs such abuse, neglect, or violence, and ACEs related to parents such as parents' mental illness, criminality, or substance use.

Poletti et al. (2022) discuss the association between ACEs and the long-term changes in brain structure and the immune response. They investigate the interplay between ACE, inflammation, and white matter in bipolar disorder (BD) and major depressive disorder (MDD). 200 depressed inpatients (100 MDD and 100 BD) composed the sample of this study, and ACEs were measured using the 28 items Childhood Trauma Questionnaire (CTQ). The study detected a detrimental effect of ACEs on the microstructure of white matter exclusively in individuals with bipolar disorder with widespread effects across the brain, encompassing large tracts of the white matter skeleton. There was no observable effect of CTQ score on white matter microstructure in those with Major Depressive Disorder (MDD) despite ACE being a recognized risk factor for the development of this disorder.

Curran et al. (2018) argue that ACEs may increase vulnerability to many psychiatric disorders, or to a generalized liability to experience psychopathology. The study employed data from the US National Epidemiologic Survey on Alcohol and Related Conditions. They utilized

latent class analysis to identify profiles of childhood trauma and subsequently employed multinomial logistic regression to explore these profiles in connection with various demographic and household characteristics. The research showed that there is a significant connection between experiencing ACEs and developing psychopathological conditions (Curran et al., 2018). Similarly, McLaughlin et al. (2020) argue that experiencing childhood trauma is a significant risk factor for an increased likelihood of various forms of mental health issues throughout an individual's life. Furthermore, the authors argue that children who have undergone traumatic experiences frequently encounter challenges in establishing and sustaining positive and healthy relationships, as such experiences can shape patterns of social, emotional, and neurobiological development to enhance the detection of potential threats in the environment (McLaughlin et al, 2020).

On the topic of challenges in maintaining healthy relationships in those who have undergone ACEs, Kim et al. (2010) studied 215 maltreated and 206 non-maltreated children between the ages of 6 to 12 from low-income families. Through using Structural equation modeling analyses, the authors identified that experiencing neglect, physical and/or sexual abuse, various forms of maltreatment, and encountering maltreatment at an earlier age are connected to emotion dysregulation. Challenges in emotion regulation, in turn, are linked to higher externalizing symptomatology that contributed to later peer rejection, which in turn was related to higher externalizing symptomatology. Therefore, poor emotion regulation caused by abuse and maltreatment may lead to aggression or uncontrolled behaviors (Kim et al., 2010).

Teicher et al. (2016) discuss the relationship between maltreatment and emotion dysregulation further by arguing that childhood maltreatment, abuse, and neglect have a profound impact on the development of the child’s brain and affect sensory systems, network architecture and circuits involved in threat detection, emotional regulation and reward anticipation. Such experiences at an early age and the subsequent brain alterations are leading causes for mental illness, substance use, distress, impaired self-regulation, lack of emotional intelligence, mistrust of others, unhealthy lifestyle choices, emotional instability, and unstable relationships (Teicher et al., 2016, Miller et al., 2011; Shonkoff et al., 2009). Mayer et al. (2008) discuss the ways in which emotional intelligence is associated with social relations in children, adolescents, and adults. The authors define emotional intelligence as “the ability to carry out accurate reasoning about emotions and the ability to use emotions and emotional knowledge to enhance thought” (Mayer et al., 2008, p. 507). Emotional intelligence, emotion regulation, and emotional knowledge all lead

to positive social interactions, where lack of emotional intelligence is associated with engaging with bullying behavior or becoming a victim of bullying (Mayer et al., 2008).

More than half of the cases of violence perpetration, violence victimization, incarceration, and heroin/crack/cocaine use could be explained by ACEs.

Bellis et al. (2014) surveyed 3,885 English residents aged 18 to 69, and categorized individuals based on the number of Adverse Childhood Experiences they had experienced. Their modeling identified the proportions of health-harming behaviors, such as early sexual initiation, unintended teenage pregnancy, smoking, binge drinking, substance use, violence victimization, violence perpetration, incarceration, poor diet, and low levels of physical exercise, that were independently associated with ACEs at the national population level. The results highlight several key findings. First, 47% of participants had experienced at least one form of ACEs. Second, the modeling suggests that a considerable percentage of certain behaviors could be attributed to ACEs at the national level. For instance, ACEs were linked to 52.0% of violence perpetration. The authors discuss that the connections between behaviors and childhood experiences likely operate through the impacts of ACEs on the developing brain, such as structural and functional changes in the brain and its stress regulatory systems, affecting factors such as emotional regulation and fear responses. These biological changes may predispose individuals to engage in risky or antisocial behaviors. The authors state that more than half of the cases of violence perpetration, violence victimization, incarceration, and heroin/crack/cocaine use could be explained by ACEs. They also discuss the perpetuation of intergenerational transmission of ACEs and their related consequences by maintaining that these health-harming behaviors, when expressed in families, contribute to subsequent generations experiencing ACEs, creating a cycle that must be interrupted. As ACEs were also accountable for about one-third of participants reporting early sexual initiation and unintended teenage pregnancy, the authors argue that such pregnancies can result in individuals being born into environments not prepared to meet the needs of children and pose a higher risk of child abuse.

Early Experiences of Relationship Violence

Research on relationship violence victimization and perpetration in children is siloed, with separate discussions focusing on child abuse and neglect, peer bullying, youth dating violence, intimate partner violence, and family violence among children and youth. However, the association between Adverse Childhood Experiences and different types of violence among children is well established. Research maintains that experiencing childhood maltreatment and other adversities may lead to engaging in aggressive, violent, and risky behavior, bullying, and teen dating violence (Ahonen et al., 2016; Ashworth et al., 2023; Bellis et al., 2014; Curran et al., 2018; Kim et al., 2010; Mayer et al., 2008; Poletti et al., 2022; Swedo et al., 2023; Teicher et al., 2016; Wekerle et al., 2009). Comparably, those who are exposed to peer bullying and youth interpersonal violence are at a higher risk of young adult psychiatric disorders, childhood psychiatric disorders, family difficulties, and harmful behaviors (Copeland et al., 2013). These studies suggest a complex relationship where ACEs are risk factors for developing mental health disorders and exposure to interpersonal violence, while interpersonal violence, in turn, is an ACE, further increasing the risk of experiencing other types of ACEs and mental health problems.

Child Abuse

Child abuse constitutes a type of relationship violence and is an Adverse Childhood Experience that has long-lasting impacts on the physical and mental health of individuals (Centers for Disease Control and Prevention, 2022). The term “child abuse” refers to any form of harm or mistreatment to children under 18 years old (World Health Organization, 2021), which can take various forms including but not limited to physical abuse, psychological abuse, sexual abuse, emotional abuse, medical abuse, neglect, abandonment, exploitation, educational neglect, and cultural or religious abuse (Centers for Disease Control and Prevention, 2022; World Health Organization, 2021). In 2021, approximately one out of every five (19%) victims of family violence, as reported to the police, were children and youth aged 17 years and younger. Of these affected 24,504 individuals in this age group, a majority (64%) were girls. The rate of family violence incidents involving children and youth stood at 343 cases per 100,000 population, with girls experiencing almost twice the rate (447) compared to boys (242). In 2021, the occurrence of

family violence against children and youth was 9% higher than the pre-pandemic levels in 2019. When compared to 2020, there was a 13% increase in the rate of family violence involving children and youth. Examining longer-term trends, it becomes evident that family violence against this group has surged by 25% since 2009. Notably, this increase was more pronounced among girls, who experienced a 31% rise, while boys saw a 14% increase (Statistics Canada, 2022).

The complexities surrounding this form of abuse are exacerbated by various factors such as intersecting systems of oppression, socioeconomic disparities, cultural norms, and challenges in reporting and intervention. Apart from mortality, physical injury, and disability, violence against children can induce stress that impairs brain development and damages the nervous and immune systems. **As a result, the child may face delayed cognitive development, poor school performance and dropout, mental health problems, substance use, suicide attempts, increased health-risk behaviours, revictimization and the perpetration of violence** (World Health Organization, 2021; Public Health Agency of Canada, 2014; United Nation, 2006). Studies have demonstrated a link between child abuse and the likelihood of becoming a victim of violence in adulthood, such as exposure to intimate partner violence (Ashworth et al., 2023; Bellis et al., 2014; Curran et al., 2018; Kim et al., 2010; Mayer et al., 2008; Poletti et al., 2022; Swedo et al., 2023; Teicher et al., 2016). This association has been found to coincide with heightened psychological challenges and diminished physical well-being (Burczycka, 2017; Burke et al., 2011; Karlen et al., 2015; Miller et al., 2011).

Peer bullying

There is an extensive body of research on the adverse effects of peer bullying on physical and mental health of children. In an international comparative cross-sectional study in 28 countries (Due et al., 2005), 123,227 students who were 11, 13 and 15 years of age in 28 countries in Europe and North America in 1997–98 responded to a survey that measured their physical and psychological symptoms of bullying. The prevalence of bullying among students exhibited significant variations among countries. The lowest occurrence was noted among girls in Sweden, while the highest was among boys in Lithuania. The results underscore that as exposure to bullying increased, the likelihood of experiencing a high symptom load also rose consistently across all countries. A strong relationship between bullying and both physical symptoms (such as headaches, stomachaches, backaches, and dizziness) and psychological symptoms (like

irritability, nervousness, low mood, sleep difficulties, morning fatigue, feelings of exclusion, loneliness, and helplessness) was observed among adolescents in all 28 countries (Due et al., 2005).

Engaging in bullying behavior or bullying victimization may lead to psychological, social, and mental health problems such as agoraphobia, anxiety disorders, young adult depression, self harm, suicidality, antisocial personality disorder, substance use, criminality, and an increased risk of psychiatric hospitalization (Afifi et al., 2020; Copeland et al., 2013; Fisher et al., 2012; Olweus & Breivik, 2014; Takizawa et al., 2014; Tharp-Taylor et al., 2009; Sigurdson et al., 2015; Wolke & Lereya, 2015). Experiencing bullying in childhood is also associated with poor social relationships, poverty, and poor perceived quality of life later in adulthood (Takizawa et al., 2014). **The physical health impacts of bullying and the toxic stress it induces include headaches, inflammation, coronary artery disease, chronic pulmonary disease, cancer, and cardiovascular risk factors such as obesity, physical inactivity, and smoking** (Copeland et al., 2014; Gini et al., 2014; Shonkoff et al., 2009). Given that peer bullying is in itself an adversity that children and youth experience, it has the same negative consequences of ACEs for physical and mental health of individuals, as developmental and biological disruptions in early childhood lead to diseases later in adulthood (Shonkoff et al., 2009).

According to Canadian Health Survey on Children and Youth (CHSCY) (2019), **71% of Canadian youth aged 12 to 17 reported that they had experienced at least one form of bullying** (physical, verbal, social or relational, cyberbullying, etc.) in the past year. Of those who experienced bullying, approximately 42% disclosed that they experienced bullying on a monthly or even more frequent basis, while 58% reported facing it a few times a year. The most prevalent form of bullying reported was verbal, including instances of being made fun of, called names, or insulted, which accounted for 59%. This was followed by rumors being spread about them by others (34%) and instances of being excluded from various activities (32%). 72% of those who had experienced at least one type of bullying monthly or more frequently reported having stressful lives, compared to 59% of those who experienced bullying a few times a year and 44% of those who did not experience bullying (Statistics Canada, 2019). Furthermore, those who were exposed to bullying frequently were at a higher risk of developing sleep difficulties (73% vs. 41%), headaches (70% vs. 42%), stomach aches (60% vs. 31%), or backaches (56% vs. 27%) compared to those who did not experience bullying in the past 12 months (Statistics Canada,

2019). Furthermore, in 2019, 1 in 4 (25%) youth aged 12 to 17 reported being cyberbullied in the previous year (Statistics Canada, 2019).

A study conducted by Ramaiya et al. (2021) in three different cities in Indonesia examined the relationship between Adverse Childhood Experiences, gender norms, and peer bullying. The research involved 2,974 participants aged 10 to 14 years, with a distribution of 44.79% boys and 55.21% girls. The selection of three cities allowed for diversity of sociocultural and economic contexts. The participants completed a structured questionnaire through computer-assisted personal interview, providing insights on various aspects, including sociodemographic characteristics, family and peer relationships, school and neighborhood attributes, media usage, perceptions of gender norms and agency, as well as their physical, mental, and sexual health. The questionnaire also inquired about experiences of violence, both in the form of Adverse Childhood Experiences and peer-violence perpetration. The findings suggest that adolescents residing in impoverished urban communities in Indonesia encounter elevated instances of peer-violence perpetration, particularly when they have experienced poly-victimization in the form of having endured four or more ACEs. The results emphasize that experiencing Adverse Childhood Experiences is a risk factor for peer-violence perpetration.

Dating Violence

Similar to other adverse and stressful experiences in childhood, research points to a range of **negative consequences suffered by those who experience adolescent dating violence. Such issues include drug use, binge-eating, suicidal ideation and attempts, depression, anxiety, poor psychosocial functioning, poor cognitive functioning, risky sexual behaviors, delinquency, weight problems, and aggression** (Ackard et al., 2007; McNaughton et al., 2018; Wolfe et al., 2018). A study conducted in 2021 found that over one in three Canadian youth who had dated experienced adolescent dating violence in the past 12 months (Exner-Cortens et al., 2021). The prevalence of victimization was as follows: 11.8% for physical aggression, 27.8% for psychological aggression, and 17.5% for cyber aggression. The prevalence of perpetration was 7.3% for physical aggression, 9.3% for psychological aggression, and 7.8% for cyber aggression. Notably, both victimization and perpetration rates were highest among non-binary youth in comparison to cisgender men and women. In general, dating violence was most pronounced among youth who faced social marginalization, such as those living in poverty (Exner-Cortens et al., 2021).

Breslau et al. (2011) evaluated how Adverse Childhood Experiences are associated with physical violence in adolescent dating relationships. They surveyed 5130 adult respondents with at least one dating relationship before the age of 21 years. The findings indicate that 10 of the 12 childhood adversities were significantly associated with physical dating violence perpetration or victimization. Similarly, Fang and Corso (2007) analyzed the relationship between child maltreatment, youth violence perpetration or victimization, and young adult intimate partner violence perpetration or victimization. They matched data describing self-reported youth violence perpetration or victimization from Wave I of the National Longitudinal Study of Adolescent Health (1994–1995) with self-reported intimate partner violence perpetration or victimization in young adult sexual relationships and retrospective reports of child maltreatment collected during Wave III (2001–2002). **The results of this study show that those who have experienced child maltreatment were more likely to engage in violence in their adolescence, which may lead to high-risk behaviors and potential involvement with the criminal justice system.** Herrenkohl et al. (2004) explored the developmental pathways from childhood physical abuse and early aggression to intimate partner violence for young adult men and women at age 24. For men, the authors identified experiencing maltreatment early in life as a reliable predictor for later intimate partner violence, whereas for women, the quality of one's relationship with an intimate partner appeared to mediate the impacts of childhood abuse on later intimate partner violence.

Houston et al. (2007) used data from questionnaires completed by 181 low-income, adolescent mothers of African American descent after the birth of their first child and their own mothers. These questionnaires examined a history of physical abuse, conflict resolution skills, and the quality of romantic relationships with the child's father. The results suggest that families in which both the teenagers and their mothers had a history of maternal physical abuse were more prone to employing psychologically aggressive conflict resolution strategies compared to families with no reported instances of maternal physical abuse. Also, those adolescents who experienced physical abuse by someone other than their mothers were more likely to report emotional abuse with their intimate partners compared to those with no abuse history (Houston et al., 2007). Comparably, Ehrensaft et al. (2003) used a sample of 543 children followed over 20 years to analyze the impacts of parenting, exposure to domestic violence between parents, maltreatment, adolescent disruptive behavior disorders, and emerging adult substance abuse disorders on the risk of violence to and from an adult partner. This study maintains that there exists a transgenerational transmission of partner violence, as exposure to the domestic violence

between parents conferred the greatest risk of engaging in intimate partner violence- in the case of physical abuse (OR = 2.51, 95% CI = 0.95–6.59) and sexual abuse (OR = 1.62, 95% CI = 0.53–4.92) (Ehrensaft et al., 2003).

Socioeconomic Risk Factors

Studies show that there is a higher prevalence of ACEs observed among those who experience marginalization and oppression. ACEs and relationship violence exert a disproportionate impact on marginalized adolescents, including LGBTQ2SIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Two-Spirit, Intersex, Asexual, and other) individuals, racialized youth, persons with disabilities, and newcomers to Canada. Moreover, teenagers from economically disadvantaged backgrounds are at an increased risk of experiencing ACEs and relationship violence victimization (Exner-Cortens et al., 2021; Ramaiya et al., 2021). This vulnerability is multifaceted, stemming from the inherent adversity of marginalization itself, compounded by structural discrimination that begets additional life challenges, and reduced help-seeking and reporting among minorities due to socioeconomic barriers. The resulting imbalanced power dynamics and discriminatory belief systems further exacerbate the risk of relationship violence perpetration and victimization, with individuals internalizing stigmas and biases against themselves, consequently experiencing heightened victimization (Blake et al., 2012; Bradshaw & Johnson, 2011; Dank et al., 2014; Due et al., 2009; Earnshaw et al., 2018; Espelage et al., 2017; Garnett et al., 2017; Mittleman, 2019; Peguero, 2009).

A study conducted by Ruffolo et al. (2022) shows that among 184 children reviewed from 2011 to 2021 who were admitted for suspected physical abuse, those residing in the economically disadvantaged areas displayed more severe injuries. They exhibited higher area injury scores in the abdomen and extremities and were admitted to the intensive care unit more frequently. Children from less affluent neighborhoods were also more prone to being placed in the care of a different guardian upon discharge, as opposed to children from more affluent areas, where fewer experienced such caregiver changes (71% compared to 49%). Based on these findings, the authors suggest that efforts to reduce child abuse will benefit from providing additional support to families with fewer resources and limited social support systems. Furthermore, poverty, as an inherent adversity, can subject children to prolonged and chronic stress (Shonkoff et al., 2021; Miller et al., 2011). Studies show that children who are raised in poverty or those who experience

child abuse have more elevated inflammation levels and show more vulnerability to vascular disease, autoimmune disorders, and premature mortality, as parental maltreatment and socioeconomic disadvantage both induce early stress (Miller et al., 2011, Danese et al., 2010). For example, Miller et al. (2011) discuss how the rates of chronic heart disease by age 50 were 2.4 times higher in those who had been raised in poverty compared to those high in socioeconomic status.

Research has demonstrated that racial and ethnic disparities significantly influence the prevalence of Adverse Childhood Experiences (ACEs). Liu et al. (2020) used a sample of 30,668 Black (10.4%), Latinx (12.3%), and White youth (77.3%) ages 12–17 (52.5% male) who participated in the 2011–12 National Survey of Children's Health (NSCH) to explore the relationship between racial/ethnic differences, Adverse Childhood Experiences, and health disparities. The findings showed that white youth consistently reported fewer ACEs, had greater access to protective factors, and exhibited better overall health compared to their Black and Latinx peers. The authors argue that to enhance child well-being and address racial/ethnic disparities, it is crucial for research and practices to encompass an understanding of adversity, protective factors, and the systemic inequities encountered by youth from racial and ethnic minority backgrounds.

Maguire-Jack et al. (2020) examined whether clusters of ACEs are experienced regardless of racial differences. This study used a subsample of 43,711 Latinx, Black, and White children drawn from the National Survey of Children’s Health 2016 data release and employed descriptive and latent class analysis using the primary measure of 9 ACE indicators available in the survey. The findings revealed that exposure to ACEs varies by race and ethnicity, as white children had lower instances of specific Adverse Childhood Experiences (ACEs) and a lower total number of ACEs in comparison to non-Latinx Black and Latinx children.

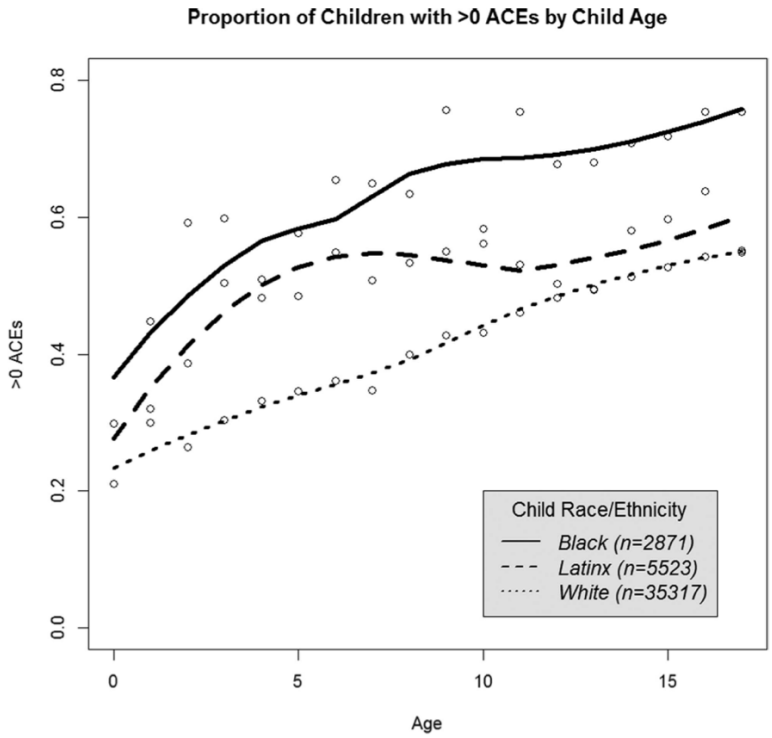

Figure 2. Proportion of children with 0 with adverse childhood experiences (ACEs) by child age. Maguire-Jack et al. (2020).

Between November 2012 and January 2013, Cronholm et al. (2015) reached out to participants from a previous large and representative community-based health survey conducted in Southeast Pennsylvania who were 18 years of age or older. They used ordinal logistic regression models to examine the relationship between ACEs scores and demographic characteristics. The results indicate that in a community-based sample primarily comprising African American individuals in an urban setting, there was a higher rate of experiencing ACEs in contrast to the predominantly white and fully insured population of the original Kaiser Sample.

Demographics	Philadelphia census (n=1,201,541), %	Philadelphia sample (n=1,784), %	Kaiser sample[a] (n=8,056), %
Race			
White	38.8	45.2	79.8
Black	36.1	43.6	4.8
Latino	11.4	3.6	5.4
Asian	6.2	3.7	6.3
Other[b]	7.4	3.9	3.7
Education			
Less than high school	20.0	10.3	6.0
High school graduate[c]	35.7	35.0	19.1
Some college	21.8	19.0	31.5
College graduate	22.5	35.7	43.4
Male	46.3	41.7	47.9
Age			
18–34	36.8	29.7	10.0
35–64	46.7	52.2	57.6
≥65	16.4	18.1	32.4

Figure 3. Demographics of the Philadelphia Census, Philadelphia Sample, and the Original Kaiser Sample. Cronholm et al. (2015).

Hayes-Greene and Love (2018) discuss how institutional/systemic/structural racism impacts non-white people's health, education, criminal legal status, child welfare, and finances. Examining the data from the corresponding federal agencies, the authors argue that African Americans are more likely to be incarcerated, suspended in K-12, be in foster care, be identified as victims by the child welfare system, be below proficient in reading in the 4th grade, be denied a loan, and less likely to own a home. Similarly, Jones and Neblett (2017) discuss the data indicating the high numbers of black children living in poverty, the high suspension rate for black preschool children, and higher mental health needs of African American children, including juveniles in prison and children in foster care. These discussions emphasize that systemic racism is a risk factor for experiencing other types of ACEs, including parental incarceration, community violence, and other socioeconomic disadvantages.

There is a substantial and extensive body of research examining the stress caused by racism and the effects of racism on mental health. Svetaz et al. (2018) discuss the ways in which Racism negatively impacts self-concept, health and well-being, and life trajectories of youth from nondominant racial–ethnic groups. In a comprehensive systematic review conducted by Priest et al. (2013), which encompassed 121 studies involving multi-ethnic youth, the findings revealed that the existing literature points to how racism-related stress negatively impacts the mental health of non-white youth, causing them to experience mental health issues such as depression, anxiety, behavioral problems, and aggression. The reviewed literature also showed how racism has negative impacts on youth's sense of self-worth and self-esteem (Priest et al., 2013).

In Canada, Indigenous communities continue to face the enduring impacts of intergenerational trauma, family disruptions, residential schools and overrepresentation in child welfare and criminal justice systems (Bombay et al., 2011; Ross et al., 2015). Toombs et al. (2022) state that ACEs are more prevalent among Indigenous populations compared to non-Indigenous communities. The authors suggest that the health disparities faced by Indigenous communities may be linked, in part, to the ways in which they are impacted by generational trauma and experience ACEs more often.

Gender and sexual identity serve as other bases for marginalization. LGBTQ2SIA+ young adults are at a higher risk for experiencing dating violence victimization and perpetration compared to heterosexual youth (Dank et al., 2014). Structural, interpersonal, and interpersonal stigma against LGBTQ2SIA+ youth lead them to experience more bullying compared to their heterosexual peers- parents of non-heterosexual children were 81% more likely to report their child was teased, and children aged 9 who would later report same- sex attraction were 18% more likely to report bullying, 33% more likely to report weekly bullying, and 66% more likely to report daily bullying (Earnshaw et al., 2018; Mittleman, 2019). Furthermore, female and transgender youth face elevated risk for experiencing most forms of abuse (Dank et al., 2014).

	Total[a] (%) (N = 3,745)	Male youth (%) (N = 1,768)	Female youth (%) (N = 1,956)	Transgender youth (%) (N = 18)	χ^2
Dating violence and abuse victimization					
Physical dating violence	29.9	35.9	23.9	88.9	93.53***
Psychological dating abuse	47.2	44.2	49.7	58.8	12.18**
Cyber dating abuse	26.3	23.3	28.8	56.3	20.95***
Sexual coercion	13.0	8.8	16.4	61.1	84.01***
Dating violence and abuse perpetration					
Physical dating violence	20.5	14.4	25.5	58.8	82.21***
Psychological dating abuse	25.7	18.8	31.7	29.4	76.14***
Cyber dating abuse	11.8	9.3	13.9	35.3	26.86***
Sexual coercion	2.6	3.9	1.2	17.6	41.352***

† $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$

[a] Includes youth who were in a current or recent relationship. Valid, non-missing data were present for 94–99 % of respondents. Three youth in a relationship (0.1 %) did not report their gender identity; these youth are included in the total but missing from the male, female, and transgender columns

Figure 4. Dating Violence Experiences of Lesbian, Gay, Bisexual, and Transgender Youth. Dank et al. (2014).

Intervention

Studies have shown the effects of intervention programs that focus on teaching conflict resolution and emotional regulation skills on reducing violence among school-age children. For example, a study by Wolfe et al. (2003) evaluated the efficacy of a community-based, 18-session intervention program (each session two hours) aimed at promoting healthy relationships for at-risk youth by studying 158 youth between 14 and 16 years old with histories of child maltreatment. These participants were randomly assigned to a preventive intervention group or a no-treatment control group. This intervention educated the youth on the differences between healthy and abusive relationships, communication and conflict resolution skills, and social action activities. Then participants were evaluated 4.7 times and were followed for 16 months post group. The findings revealed that those who participated in the program had significantly less instances of abuse and distress over time (reduction in physical abuse (**β**TIME –.008, *p* .01) and emotional abuse (**β**TIME –.006, *p* .05) against a dating partner, i.e., on average, youths' reported physical abuse decreased .008 points and their emotional abuse .006 points each month). The authors state that such interventions and involvement of youth is crucial in reducing the cycle of abuse (Wolfe et al., 2003). Similarly, Domino (2013) studied 323 students in seventh grade who participated in the program *Take the Lead*, which is a 16-session curriculum aimed at promoting

social skills and competencies, approximately 45 minutes per session, once per week for 16 weeks, designed to be taught by classroom teachers. The author employed a pre-test/post-test time-lag control group cohort study design. Participants anonymously completed a self-report survey before and after each intervention providing a sum score for bullying and victimization. These questionnaires were completed at 3 assessment points: commencement of fall 2009 intervention; completion of fall 2009 intervention, and completion of spring 2010 intervention. The results indicate that those who participated in the program reported reduced instances of bullying and victimization compared to the control group (reductions in bullying ($p < .001$), and victimization ($p < .001$), from pretest to posttest, compared to controls ($p < .001$)). Domino's findings also show that those in the control group experienced increased instances of bullying and victimization during the same time period, and reported a significant reduction of such experiences after they participated in the program (Domino, 2013).

Fonagy et al. (2001) evaluated the program *Creating a Peaceful School Learning Environment* (CAPSLE) by studying nine elementary schools. They assigned the schools to participate in either CAPSLE, psychiatric consultation, or to treat the bullying instances as usual as the control group. CAPSLE comprised four elements: 1) adopting a policy of complete intolerance towards behaviors like bullying, victimization, and passive observation of violent incidents, 2) implementing a disciplinary strategy to exemplify appropriate conduct, 3) introducing an education curriculum aimed at imparting self-regulation skills, and 4) instituting a mentoring initiative involving adults and children to guide the latter in steering clear of any of the mentioned roles (bully, victim, and passive observer). The findings indicate that after two years of implementing the program, 19% of those who participated in CAPSLE reported bullying victimization, compared to 25% of those who received psychiatric consultation and 26% of those in the control group. In another study, Berry and Hunt (2009) examined the cognitive-behavioral intervention program that focused on teaching skills related to managing anxiety, distress, and depression, low self-esteem, and using maladaptive coping strategies. A 3-month follow-up after the implementation of this program reveals that the intervention successfully reduced reports of aggression, anxiety, depression, and distress. Sahin (2012) found out that the *Empathy Training Program* designed to increase students' sense of empathy and to teach them emotion regulation skills was effectively able to reduce the instances of abusive and aggressive behavior among the participants.

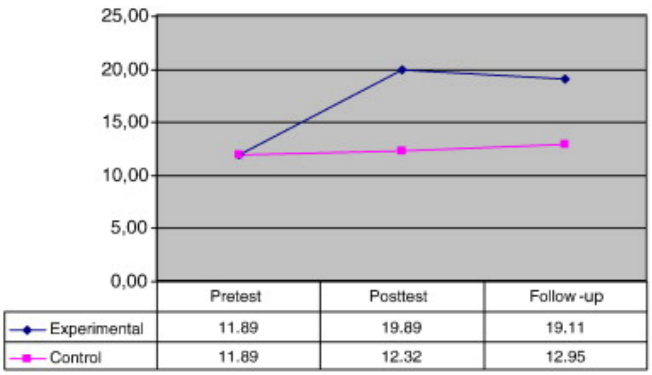

Figure 5. Time and intervention interaction on empathetic skills. Sahin (2012).

Parental and peer support are important factors in reducing instances of interpersonal violence among school-age children (Biswass et al., 2020). Violence does not only involve the abuser and the victim but also other peers can be passively or actively involved in their support of abusers or victims (Salmivalli, 2010). There are some programs that encourage peer support in cases of interpersonal violence in schools. Battey's study (2009) of the efficacy of The Bully Prevention Challenge Course Curriculum, a course that is focused on encouraging peer support, promoting self-esteem, and teaching communication skills in instances of bullying victimization in seventh grade middle school class, indicates that there was an increased perceived social support and improved feelings of self-worth among those who participated in the course.

Variable	Pretest		Posttest		Follow-up	
	Treatment	Control	Treatment	Control	Treatment	Control
Global Self-Worth	3.33 (.55)	3.27 (.66)	3.35 (.51)	3.27 (.65)	3.27 (.57)	3.18 (.63)
Male	3.28 (.53)	3.25 (.74)	3.27 (.47)	3.14 (.76)	3.20 (.56)	3.13 (.79)
Female	3.37 (.59)	3.25 (.66)	3.46 (.58)	3.23 (.67)	3.33 (.61)	3.11 (.59)
Scholastic Competence	2.95 (.73)	2.65 (.74)	2.92 (.72)	2.86 (.67)	2.93 (.73)	2.81 (.75)
Male	2.85 (.76)	2.72 (.83)	2.81 (.71)	2.89 (.78)	2.88 (.74)	2.86 (.79)
Female	2.97 (.77)	2.65 (.75)	3.03 (.71)	2.85 (.86)	3.01 (.72)	2.68 (.76)
Social Acceptance	2.97 (.75)	2.99 (.68)	3.04 (.77)	3.00 (.70)	2.91 (.81)	3.06 (.67)
Male	3.03 (.65)	2.94 (.88)	2.94 (.71)	3.02 (.80)	2.89 (.72)	3.03 (.88)
Female	2.94 (.83)	2.94 (.72)	3.01 (.81)	2.98 (.71)	2.93 (.89)	3.02 (.52)
Physical Appearance	2.84 (.78)	2.86 (.81)	2.95 (.75)	2.91 (.85)	3.03 (.70)	2.91 (.83)
Male	2.92 (.67)	2.98 (.88)	3.05 (.60)	2.99 (.83)	3.08 (.61)	2.99 (.94)
Female	2.77 (.87)	2.84 (.80)	2.94 (.87)	2.89 (.86)	2.97 (.77)	2.75 (.76)
Athletic Competence	2.94 (.68)	2.92 (.71)	2.96 (.64)	3.00 (.69)	2.86 (.69)	2.95 (.74)
Male	3.06 (.54)	2.99 (.68)	3.04 (.59)	3.06 (.73)	2.88 (.69)	2.98 (.81)
Female	2.71 (.80)	2.90 (.70)	2.79 (.72)	3.01 (.68)	2.85 (.68)	2.81 (.76)
Behavioral Conduct	3.14 (.61)	2.98 (.62)	3.22 (.61)	3.06 (.64)	3.06 (.73)	2.95 (.65)
Male	2.91 (.58)	2.90 (.67)	2.99 (.64)	2.98 (.69)	2.93 (.75)	2.81 (.70)
Female	3.38 (.60)	2.96 (.62)	3.46 (.54)	3.03 (.64)	3.19 (.68)	3.02 (.63)
Parental Support	3.52 (.52)	3.42 (.62)	3.46 (.58)	3.40 (.68)	3.35 (.68)	3.04 (.70)
Male	3.52 (.49)	3.52 (.58)	3.39 (.65)	3.45 (.71)	3.37 (.64)	3.45 (.70)
Female	3.52 (.59)	3.43 (.62)	3.52 (.55)	3.38 (.67)	3.32 (.73)	3.11 (.73)
Teacher Support	3.35 (.51)	3.23 (.62)	3.34 (.58)	3.26 (.65)	3.21 (.64)	3.21 (.64)
Male	3.35 (.50)	3.01 (.65)	3.21 (.60)	3.08 (.72)	3.10 (.66)	2.99 (.74)
Female	3.38 (.52)	3.22 (.63)	3.45 (.50)	3.23 (.66)	3.30 (.61)	3.40 (.54)
Classmate Support	3.17 (.63)	3.13 (.66)	3.13 (.67)	3.07 (.62)	3.04 (.67)	3.15 (.58)

Figure 6. Means and (Std) for Variables by Experimental Condition and Gender. Battey (2009).

Another study by Midgett et al. (2015) emphasizes the importance of putting an end to the ways in which violence is accepted and normalized by the community and other peers. The authors examined a stand-alone 90-minute psychoeducation program for middle-school students, a program that educated the participants on taking actions as peer advocates when observing violence. Through using pre- and post-tests, the study showed that completing this program has led to an increase in the participants' ability to identify different types of abuse, knowledge of intervention strategies, and confidence when intervening as peer advocates.

	Pre-Training		Post-Training				
Item	*M*	*SD*	*M*	*SD*	*t*(73)	*p*	Cohen's *d*
Identification of Bullying							
Verbal Bullying	3.44	.55	3.85	.36	6.23	< .001	.75
Social/Emotional Bullying	3.28	.70	3.78	.43	5.42	< .001	.68
Cyberbullying	3.43	.66	3.78	.49	4.77	< .001	.65
Physical Bullying	3.70	.49	3.84	.34	1.92	.06	.23
Knowledge of STAC Strategies							
Stealing the Show	2.97	.67	3.73	.50	8.50	< .001	.96
Accompanying Others	3.33	.58	3.80	.41	6.70	< .001	.84
Turning It Over	3.35	.63	3.66	.52	3.79	< .001	.44
Coaching Compassion	3.01	.69	3.74	.44	8.02	< .001	.96
Confidence Intervening							
Do Something	3.41	.59	3.76	.44	5.58	< .001	.74
Advocate	3.54	.57	3.74	.46	2.75	.008	.38
Make a Positive Difference	3.43	.51	3.64	.49	2.89	.005	.38
Total Scale (11 items)	3.35	.34	3.76	.31	9.77	< .001	.89

Figure 7. Means, Standard Deviations, and Contrast Between Pre- and Post-Training. Midgett et al. (2015).

Cross et al. (2011) examined the efficacy of the Friendly Schools program to reduce bullying, which is a two-year group randomized controlled trial with a one-year follow-up, conducted in over 90 classes drawn from 29 metropolitan government primary schools in Perth, Western Australia. The Friendly Schools program targeted the entire school, classroom, caregivers and family members, and all the students, and included lessons on peer discouragement of bullying, social support of victims, and family intervention. Of participants who completed questionnaires at baseline (1968 out of the 2068 Grade 4 students enrolled at the participating schools- 1046 students in the intervention schools and 922 students in the comparison schools) the ones in intervention schools showed a significant decrease in their exposure to bullying behavior and there was a higher chance that they would report it if they were being bullied (observing less bullying increased from 11% at posttest 1, to 16% in posttest 2, and then 21% at posttest 3). This research supports the idea that when youth receive support in their different social contexts, the instances of violence will be decreased significantly.

The Nurse-Family Partnership stands as an effective evidence-based program in the prevention of Adverse Childhood Experiences and early exposure to violence (Dawley et al., 2007; HealthLink BC., n.d.). Functioning as a free public health initiative, the Nurse-Family Partnership is specifically focused on supporting women who are anticipating their first child. It offers support throughout the stages of pregnancy and continues its assistance into the initial two years of the child's life. This program is particularly designed for individuals meeting specific criteria, including being pregnant with their first child, less than 29 weeks gestation, and aged 24 years or younger. Those aged 19 and younger are eligible, while individuals between 20 and 24 years qualify if they are facing social, financial, or housing challenges such as single parenting, educational limitations, low income, or homelessness. This initiative matches these women with nurses who have undergone specialized training. These nurses engage in home visits for approximately two and a half years, commencing prior to the birth of the child. The Nurse-Family Partnership aims to provide tailored support, addressing diverse challenges, and fostering a nurturing environment for both mother and child during these pivotal early years (HealthLink BC., n.d.). Randomized trials of this model and studies of the program emphasizes the efficacy of the program in reducing instances of violence against children and promoting healthy pregnancy and parenthood- 0.29 perpetrators of violence against children in the program participants versus 0.54 in the comparison group, and in the second year of life, nurse-visited children seen in the emergency department 32% fewer times, and 56% reduction in visits for injuries and ingestions (Dawley et al., 2007).

One study that examines the long-term effects of intervention programs is the work of Olweus et al. (2020). In a four-year follow-up period spanning from 2007 to 2010, involving 70 elementary schools (referred to as A-schools) that consistently and repeatedly administered the Olweus Bullying Questionnaire (OBQ), and which had originally implemented the Olweus Bullying Prevention Program (OBPP) two to eight years prior, it was evident that they displayed significantly more positive long-term progress in terms of issues related to being bullied. This progress was assessed using an entirely independent data source, the National Pupil Survey. In comparison, 102 similar schools (designated as B-schools) that did not conduct any OBQ surveys during the same timeframe did not exhibit the same favorable long-term development. A-schools that maintained the use of the Olweus Bullying Questionnaire (OBQ) had effectively transformed their "school culture" in a positive direction by enhancing their awareness, readiness, and proficiency in addressing and preventing bullying. The results imply that initiatives of this nature should not be regarded as isolated, time-limited "programs." Instead, they should be perceived

as a collection of guiding principles, strategies, and mechanisms aimed at establishing a secure and compassionate school atmosphere where issues related to bullying are consistently acknowledged, managed, and mitigated (Olweus et al., 2020). It is important to note that an assessment of the Olweus Bullying Prevention Program by Bauer et al. (2007) revealed its effectiveness for White students but not for students from racial and ethnic minority backgrounds, pointing to the importance of considering the imbalanced power structures affecting participants and the disadvantages and disparities marginalized groups endure in terms of their health and experiences of adversity and violence.

	B-schools	A-schools	Absolute difference	Relative difference	Chi^2 (df=1)	Odds ratios with 99% confidence intervals	
2007	8.7% (n = 5419)	6.8% (n = 4301)	1.9%	21.6%	11.80 [a]	OR = 1.30	1.09-1.56
2008	9.3% (n = 6640)	7.5% (n = 5526)	1.8%	19.7%	12.94 [a]	OR = 1.27	1.09-1.49
2009	9.8% (n = 6462)	7.2% (n = 5705)	2.6%	26.0%	24.84 [a]	OR = 1.39	1.19-1.62
2010	9.4% (n = 6789)	7.6% (n = 6180)	1.8%	19.1%	13.09 [a]	OR = 1.26	1.08-1.46
Mean 2007 -2010	9.2% (n = 6662)	7.1% (n = 5609)	2.2%	23.6%	18.58 [a]	OR = 1.33	1.14-1.56

Figure 8. Significance testing of differences between percentage bullied students in schools without continued use of the OBQ (B-schools) and schools with continued use (A-schools). Olweus et al. (2020).

Given the association between mental illness and interpersonal violence, early mental health interventions, if effective, have the potential to lessen the impacts of ACEs and the instances of youth violence. An effective early mental health intervention will educate children to recognize the signs of distress and reduced functioning, respond to their emotions and symptoms appropriately, and seek help when needed (Kelly et al., 2007). Early intervention has the potential to be effective in preventing adult-type mental disorders (McGorry & Mei, 2018). Research indicates that children are less likely to have adequate access to mental health services and their

mental illnesses are usually left untreated because of reasons such as inadequate structures in place, social stigma (Rickwood et al., 2007), and the barriers that marginalized children face when trying to access services (Alegría, et al., 2010; Bringewatt & Gershoff, 2010; Harrison et al., 2004; Yoshikawa et al., 2013). In order to improve services that promote healthy behaviors and mental well-being in young people, youth and their caregivers need to be able to be involved and engaged in all levels of policy and service development, leading to less barriers in accessing the mental health services and creating youth friendly services (Howe et al., 2011). Furthermore, services need to facilitate help-seeking behavior in youth, as it is sometimes a challenge to speak up and seek help particularly when one is under high levels of distress or is experiencing marginalization (Collin et al., 2011).

Collin et al. (2011) evaluated the online mental health service *ReachOut.com* and found multiple benefits. The online service effectively allows youth to seek help, engage with the website, learn the knowledge and skills necessary to appropriately respond to their emotions and seek help when needed. 84% of those who visited the website report an increase in their knowledge about mental health issues This points to the potential of using online services as early intervention programs, 74.3% view ReachOut.com as relevant, credible and trustworthy, and 60.3% report that they have visited ReachOut.com when they were going through a tough time.

Key stages in help-seeking	Awareness and appraisal of problem	Expression of symptoms and need for support	Availability of sources of help	Willingness to seek out and disclose to sources
ReachOut.com	**Online delivery:** anonymous, peer-based and embedded in everyday life **Participant involvement** in service design and delivery building service relevance and brand **Gateway to online tools and services** via links and partnerships			
	Resources (fact sheets, personal stories and online peer-based forums) that aim to increase mental health literacy to assist with recognising signs and symptoms of mental health problems, as well as understanding different sources of help available.	CBT-based single player online game, forums and blog, fact sheets and stories to help build young people's interpersonal and social skills to assist them in articulating their experience and need for help.	Resources on how to find the most relevant help and treatment available for different problems and scenarios.	Targets young people experiencing mental health issues AND whole population to promote cultural beliefs and attitudes to (a) affirm the message that help is effective, (b) combat stigma surrounding mental health and help-seeking and (c) give information, promote skills, provide informal support and referral.
	Facilitated and informal discussion via feedback, forum and blog facilities and via partner websites such as Habbo Hotel.	Facilitated and informal discussion via feedback, forum and blog facilities and via partner websites such as Habbo Hotel.		Proximity to service: awareness and sense of relevancy and connection to the service.

Figure 9. REACHOUT.COM Service Offerings at Each Stage of Help-seeking Process. Adopted from Rickwood et al. (2005), cited in Collin et al. (2011).

Another study by Schley et al. (2008) examined the effectiveness of intensive outreach models (e.g., assertive community treatment, assertive outreach, or intensive case management) in promoting youth mental health. The findings illustrate that those children who were exposed to Adverse Childhood Experiences and engaged in high-risk behaviors showed reduced risk to themselves and others after undergoing intensive outreach treatments. The authors state intensive outreach models as potentially an effective form of early intervention in this area (Schley et al., 2008).

Risk variable	At referral		At discharge		McNemar test	
	n	%	*n*	%	*n* *	*P*-value
Suicidal ideation	41	90.2	28	17.9	24	0.000
Deliberate self-harm	36	86.1	31	6.5	25	0.000
Violence	40	85.0	14	42.9	14	0.016
Crime	42	59.5	19	26.3	18	0.031
Substance abuse	40	77.5	30	70.0	29	0.453

Figure 10. Changes in prevalence of risk to self and others between referral to and discharge. Schley et al. (2008).

Rusch et al. (2019) studied the role of paraprofessionals in the Partners Achieving Student Success (PASS) program, a school-based prevention and early intervention program serving families in low-resource, high-poverty communities and found out that paraprofessionals can acts as liaisons in schools, promoting the collaboration between mental health providers and school staff. The study explains that paraprofessionals often have firsthand knowledge of the struggle that their communities face that is useful when acting as liaisons. They can also act as liaisons between school and families, given the importance of families to be involved and educated about the mental health of their children (Rusch et al., 2019). Studies show that if families play the role of trusted adults for their children, they can have profoundly positive impacts on the lives, behaviors, and well-being of young people (Campos-Castillo at al., 2021; Meltzer et al., 2018; Papanikolaou at el., 2011).

Embracing trauma-informed practices within educational institutions emerges as another recognized and effective approach to addressing violence against and among children, as indicated by the literature. Cultivating trauma-informed schools involves creating an environment that prioritizes understanding and addressing the impact of trauma on students. This approach goes beyond conventional disciplinary measures, emphasizing empathy, support, and tailored interventions to foster a conducive and safe learning atmosphere. By incorporating trauma-informed principles, schools can enhance student well-being, feelings of security, self-regulation, resilience, and academic success, recognizing the significant role that a nurturing educational environment plays in mitigating the effects of trauma on students' lives (Griffin et al., 2012; Wiest-Stevenson & Lee, 2016). Research in traumatology highlights that people commonly react in

similar ways to a variety of traumatic events, displaying responses such as traumatic reactions, posttraumatic stress responses, and the development of PTSD (Wiest-Stevenson & Lee, 2016). **Experiencing traumatic childhood events has been associated with violent offending and delinquent and antisocial behavior in adolescents and adults** (Black et al., 2012; Ford et al., 2006). However, there are numerous services and treatment interventions tailored for children that have not prioritized addressing the ways in which trauma affects the lives of their participants. Children undergoing traumatic stress often receive inaccurate labels within the educational system, such as being diagnosed with attention deficit disorder or oppositional-defiant disorder (Black et al., 2012). Trauma-informed therapeutic approaches hold the potential to understand the roots of children's behavior and mitigate instances of violence by demonstrating efficacy in alleviating symptoms associated with post-traumatic stress disorder (PTSD) and other psychosocial symptoms. These interventions, rooted in an understanding of trauma's profound impact, aim not only to address the immediate consequences of traumatic experiences but also to foster healing and resilience, contributing to a reduction in violent behaviors (Black et al., 2012; Baetz et al., 2019; Silverman et al., 2008).

Implications for Policy and Practice

1. Policymakers and practitioners should consider implementing trauma informed, culturally safe targeted intervention programs that focus on teaching conflict resolution, emotional regulation skills, and best practices when dealing with violence and bullying. These programs, especially those addressing marginalized groups, can contribute to reducing the instances of interpersonal violence among school-age children.

2. Embracing trauma-informed practices within educational institutions is recognized as an effective approach. Policymakers should explore strategies to integrate trauma-informed education to create a supportive environment that addresses the specific psychological and social needs of adolescents facing adversities and be prepared to offer services to help children address and heal from their trauma.

3. Given the association between mental illness and relationship violence, there is a need for early mental health interventions targeting children. Policymakers should prioritize the

development of accessible mental health services for children, addressing barriers such as social stigma, systems of oppression and discrimination, financial barriers, and inadequate structures.

4. The findings underscore the importance of providing additional support to families with fewer resources and limited social support systems, particularly those facing systematic marginalization or oppression. Policymakers should advocate for policies that address systemic inequities and provide resources to support marginalized youth.

5. Policymakers and practitioners should consider implementing educational programs that encourage peer support in cases of interpersonal violence in schools. These programs can play a crucial role in reducing violence by fostering a sense of social support among peers.

6. Policymakers should adopt a long-term perspective on intervention programs. For instance, the success of the Olweus Bullying Prevention Program suggests that initiatives should be viewed as guiding principles and mechanisms for establishing a secure and compassionate school atmosphere consistently addressing and preventing bullying.

7. The scoping review highlights the need for increased attention to the link between Adverse Childhood Experiences (ACEs) and relationship violence among school-age children. Policymakers should support research and practices that address this specific intersection to inform targeted interventions and prevention efforts.

8. Policymakers should prioritize the development and implementation of education and prevention programs that address the various forms of relationship violence, including dating violence, peer bullying, and family violence. These programs should be tailored to the unique needs and experiences of different demographic groups and be a part of school curriculums.

9. Policymakers should target primary prevention and work with religious organizations and primary health centers to screen and assist those wanting to have children.

Gaps in Literature

1. Diversity in Terminology and Understanding: The review highlights a need for standardization in the terminology related to relationship violence among adolescents, considering the varied

levels of intimacy, role expectations, and duration of noncohabitating relationships. Using the term Relationship Violence would be useful to refer to all different forms of violence and their similarities, while having in mind their differences.

2. Adolescent-Specific Program Development: There is a gap in the literature concerning the adaptation or creation of assessment tools tailored to the unique characteristics of adolescent relationships, accounting for their developmental stage and diversity.

3. Intersectionality and Marginalization: The literature emphasizes the disproportionate impact of ACEs and relationship violence on marginalized adolescents. However, further research is required to explore the interconnectedness of various forms of marginalization, such as race, gender identity, and socioeconomic status, and their impact on the prevalence and consequences of ACEs and relationship violence.

4. Effectiveness of Early Interventions in the long term: While the review mentions the potential of early mental health interventions, there is a gap in understanding the effectiveness of specific intervention programs in preventing or mitigating ACEs and relationship violence among school-age children in the long term.

Conclusion

In conclusion, the scoping review illuminates the intricate relationship between Adverse Childhood Experiences (ACEs) and relationship violence among school-age children. The findings underscore the necessity for targeted intervention programs that equip children with conflict resolution and emotional regulation skills, particularly addressing the heightened vulnerability of marginalized groups. Embracing trauma-informed practices within educational institutions emerges as a pivotal strategy to create supportive environments catering to the unique needs of adolescents facing adversities. The review advocates for early mental health interventions and emphasizes the importance of accessible services, breaking down barriers that hinder marginalized children's access to mental health support. Policymakers are urged to champion equity, acknowledging the disproportionate impact of ACEs and relationship violence on marginalized communities. The scoping review not only sheds light on existing gaps but also calls

for increased focus on long-term perspectives in intervention programs and sustained research efforts. Ultimately, the implications for policy and practice converge on the imperative of a holistic and proactive approach, ensuring the well-being and safety of all children.

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