

**ASSESSMENT OF SERVICES AVAILABLE FOR CHILDREN EXPOSED TO  
INTIMATE PARTNER VIOLENCE IN ANCHORAGE, ALASKA**

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SEPTEMBER 2015



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## **Introduction**

The Cook Inlet Tribal Council (CITC) plans to expand services provided under its Flourishing Child initiative, and requested an assessment of service needs for children in the Anchorage area that are exposed to intimate partner violence (IPV). Specifically, CITC wishes to know if the proposed expansion of Flourishing Child services will satisfy an unmet need in the community. This assessment includes a brief introduction and review of related concepts, and an assessment of services available within the Municipality of Anchorage.

### **Definition: Intimate Partner Violence**

“Intimate partner violence includes physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner” (Breiding, Basile, Smith, Black, & Mahendra, 2015, p. 11). Understanding of intimate partner violence (IPV) as a phenomenon, as a crime, and as a public health problem evolved over the last four decades. IPV was recognized as a major public health problem in 1970s, and is highly prevalent among the general population (approximately 30% of the relationships involve violence) (McHugh & Frieze, 2006). Considerable evidence of its negative consequences exists. Despite that, disagreements on definitions, measurement, and interventions to prevent or mitigate IPV abound. (Nicholls & Hamel, 2015)

Intimate partners typically identify as a couple, not necessarily cohabiting, and are familiar and knowledgeable about each other’s lives. They may be heterosexual or same-sex couples, may share emotional connectedness, regular contact, ongoing physical contact, and sexual intimacy. Examples of intimate partner relationships include current and/or former spouses, boyfriends and/or girlfriends, dating partners, and sexual partners.

IPV can vary in frequency and severity, and does not necessarily require sexual intimacy. The severity of IPV occurs on a continuum, ranging from one episode that might or might not have lasting impact to chronic and severe episodes over the years. IPV can take many forms. Four main types of IPV: are recognized: physical violence, sexual violence, stalking, and psychological aggression.

### **Exposure of children to IPV**

Approximately 10-20% of all children in the United States are exposed to IPV each year (Carlson, 2000). Children so exposed are often referred to as the “‘silent’ or ‘hidden’ victims of violence because their presence is often overlooked by the parents/caregivers or unknown by observers and professionals” (The National Child Traumatic Stress Network, 2015). Identifying children exposed to IPV improved in recent years. Police departments, early education centers, child care centers, schools, and hospitals routinely screen for domestic violence. In addition, once identified, service providers in most states are mandated to report such exposure to child protection services.

Exposure is far more complex than a simple dichotomy of whether the child observed/witnessed or overheard the violence. Ten categories of exposure are identified in the literature (Holden, 2003). Out of the ten categories identified in Table 1, children have first-hand exposure in the first six categories, and they are directly involved in the second, third, and fourth categories. Many times children may be exposed to the same incident in multiple ways or more than once.

Table 1: Types of children' exposure to intimate partner violence (Holden, 2003)

<b>Type of exposure</b>	<b>Definition</b>	<b>Examples</b>
Exposed prenatally	Real or imagined effects of dv on the developing fetus	Fetus assaulted in utero; pregnant mother lives in terror; mothers perceived that the dv during pregnancy had affected their fetus
Intervenes	The child verbally or physically attempts to stop the assault	Asks parents to stop; attempts to defend mother
Victimized	The child is verbally or physically assaulted during an incident	Child intentionally injured, accidentally hit by a thrown object, etc.
Participates	The child is forced or voluntarily joins in the assaults	Coerced to participate; used as spy; joins in taunting mother
Eyewitness	The child directly observes the assault	Watches assault or is present to hear verbal abuse
Overhears	The child hears, though does not see, the assault	Hears yelling, threats, or breaking of objects
Observes the initial effects	The child sees some of the immediate consequences of the assault	Sees bruises or injuries; police; ambulance; damaged property; intense emotions
Experiences the aftermath	The child faces changes in his/her life as a consequence of the assault	Experiences maternal depression; change in parenting; separation from father; relocation
Hears about it	The child is told or overhears conversations about the assault	Learns of assault from mother, sibling, relative, or someone else
Ostensibly unaware	The child does not know of the assault, according to the source	Assault occurred away from home or while children were away; or occurred when mother believed child was asleep

## **Prevalence of children exposed to IPV**

### *Nationwide*

Assessments and measures of prevalence of exposure of children to IPV are challenging to conduct for several reasons. Most available assessments of exposure are based on reported instances. The 1975 and 1985 National Family Violence Surveys reported almost identical results - approximately 10 million children each year witnessed physical assaults between their parents, and three times more witnessed any type of violence (Straus, 1992). Clinical, epidemiologic, and experimental studies confirmed these numbers over the years.

Prevalence data at the national level was sporadic and scattered until The National Survey of Children's Exposure to Violence (NatSCEV) conducted in 2008 (Hamby, Finkelhor, Turner, & Ormrod, 2011). A second wave of the same survey (NatSCEV II) in 2011 examined nationwide "incidence(s) and prevalence of children's exposure to violence" and confirmed "NatSCEV I's finding that children's exposure to violence is common; nearly 60 percent of the sample (57.7 percent) had been exposed to violence in the past year, and more than 1 in 10 reported 5 or more exposures. Exposure rates did not vary by much between genders or age groups except in the oldest age group (14-17 years). This exposure occurs across all age ranges of childhood and for both genders" (p. 5). Specifically, the second wave found that:

- 8.2 percent had witnessed a family assault, and 6.1 percent had witnessed a parent assault another parent (or parental partner) in the past year.
- Over their lifetimes, more than one in five children surveyed (20.8 percent) witnessed a family assault, and more than one in six (17.3 percent) witnessed one parent assault another parent or a parental partner.
- Among the oldest youth (ages 14–17), the lifetime rate of witnessing any family assault was 34.5 percent, and 28.3 percent of these youth had witnessed one parent assaulting another. There were few significant gender or age differences in the witnessing of family assaults.

### *Municipality of Anchorage*

Beginning in late 1990s, there have been a series of efforts to improve visibility of domestic violence as a public health issue and much work was done in collecting, compiling, and disseminating data and information on domestic violence in Anchorage. A long time partnership between several departments of the Municipality of Anchorage - Department of Health and Human Services (DHHS) Safety Links program, Anchorage Police Department (APD), Municipal Department of Law (DOL) – Anchorage Women's Commission (AWC), and Abused Women's Aid in Crisis (AWAIC).

MOA's *The Action Plan for Interpersonal Violence Prevention (APIVP)* prepared by the Anchorage Women's Commission (AWC) in 2001 reported that an initiative to "collect domestic violence data from existing court records including charges, dismissals, prosecutions, presence of children as witnesses, children in need of aid, etc." (Municipality of Anchorage, 2001). The above partnership yielded several reports over the years, and the Domestic Violence Action Plan (DVAP), leading to the formation of the Anchorage Domestic Violence Prevention Project (ADVPP). ADVPP is a partnership between all the above organizations, funded by a grant from Department of Justice, Office of Violence Against Women. Two phases of ADVPP (2002-2005; 2006-2009) were implemented. As part of the ADVPP project, the DOL maintained database of all DV cases, and DHSS analyzed and reported on the data. The series of reports used as primary sources of data in this report are products of ADVPP.

Data on prevalence of IPV and the number of children exposed to IPV in the Anchorage area was unavailable prior to 1993. Although the Anchorage Police Department began recording the presence of children while responding to domestic violence calls, a systematic collection and compilation of data on presence and role of child in domestic and intimate partner violence situations was not established until almost a decade later.

We relied on the following published reports rather than data sources to discuss incidence of children exposed to IPV:

- *Analysis of police action and characteristics of reported domestic violence in Anchorage, Alaska: Ten year study 1989-1998*  
Published by the Municipality of Anchorage in 2000, this report presents analysis of domestic violence<sup>1</sup> reports between 1989 and 1998. This report resulted in the Action Plan for Interpersonal Violence Prevention prepared by the Anchorage Women’s Commission. It is not clear if findings are based on a sample of cases or all cases of domestic violence reported to APD.
- *Domestic violence analysis: Incidents reported to police in Anchorage, Alaska. Fourteen Year Study 1989-2002*  
Published by the Municipality of Anchorage, Department of Health and Social Services (MOA-DHSS) in 2006, this report summarizing incidences of domestic violence (DV) reported over the phone to the Anchorage Police Department (APD) between 1989 and 2002. This report presents findings from a sample of 2,578 domestic violence reports during the period 1999-2002.
- *Anchorage Domestic Violence Prevention Project II: Summary of findings; 2010*  
Published by MOA-DHSS in 2010, this report summarizes DV report data in the Anchorage Municipality from May 2006 through October 2009.
- *Alaska Domestic Violence and Sexual Assault Intervention Program: Final Report FY 2013/14 – Summary of Findings*  
Published by MOA-DHSS in 2014, this report summarized data from October 2006 through October 2014 and has tracked roughly 16,556 DV cases involving 13,366 defendants, 22,522 victims, and 7,530 children.

Through the years from 1993 to 2002, approximately 40% of the cases of domestic violence each year in Anchorage had children present during the violent episode. However, there are more than half of the cases each year are missing data on the presence of children. Among those cases where data was available, approximately 81% had children present. Almost 70% of these cases identified children as witnesses or may have been witnesses. More than 15% of the cases identified children as being victims. About 14% of the cases identified children as suspects. Approximately 70% of the children who witnessed domestic violence are biological children of both the victim and the suspect of domestic violence. A large majority of the children are also identified as being children from a previous relationship. However, it is not clear if they are the children of the victim of the suspect.

Younger children are exposed to domestic violence at a higher rates. Age statistics are available for cases from 1999-2000 fourteen year study, and ADVPP II 2010 report. Children under the age of five are represented at a much higher rate. Data from the prosecutor’s office show approximately 53.8% of the children exposed to domestic violence were under the age of 5, in comparison to approximately 25% of children in the City’s general population. Children 1 year or younger are three times more compared to those in the general population.

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<sup>1</sup> Anchorage Municipal Code (AMC) does not identify intimate partner violence as a distinct punishable violation. However, it defines assault as a violation, and identifies exposure of children to assault in the family setting as family violence and the perpetrator is charged with Class A misdemeanor. Therefore, presence of children is recorded by the Anchorage Police Department (APD) as a misdemeanor.

The 2009 report from the Anchorage Domestic Violence Prevention Project II reported 41% of all victims (3,072 out of 7,551) were children. Of those child victims, 28% were White, 43% Alaska Native, 11% Black, 7% Asian/Pacific Islander, 1.2% Hispanic, and 9.6% race unknown. Victimization among children was evenly distributed across gender - 47% of victims were boys and 46.5% girls. The mean age of child victims was 6.2 years old although children age 5 years and younger made up approximately 54% of child victims.

Through all these reports, population that receive services from AWAIC differed in some characteristics. Victims and the children tended to be a few years older at AWAIC. Much of the population served by AWAIC do not report the DV incident to APD. Of the 1,264 victims assisted at the shelter between May 2006 and October 2009, nearly a third (30.2%) had not reported their most recent domestic violence incident to APD.

The AMDHSS released a 2014 summary report of the Alaska Domestic Violence and Sexual Assault Intervention Program (ADVSAIP) covering data from October 2006 through October 2014 and has tracked roughly 16,556 DV cases involving 13,366 defendants, 22,522 victims, and 7,530 children as summarized in Table 6. A third of the victims in each year since 2006 were children under the age of 18.

Figure 1: Child and adult victims of domestic violence reported by the Anchorage Municipal Prosecutor’s Office (2006 – 2014)

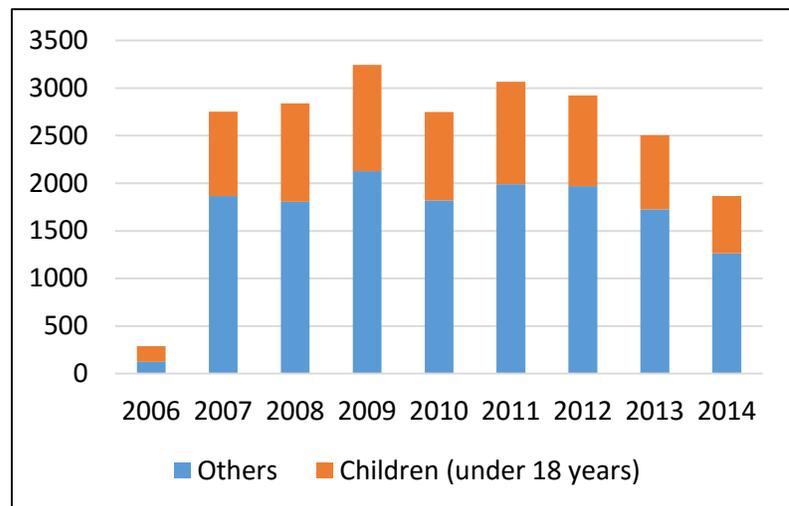


Table 2: Cases, defendants, and victims in domestic violence cases reported by the Municipal Prosecutor’s Office

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Cases	386	1,784	1,975	2,306	2,404	2,289	2,154	1,897	1,361
Defendants	355	1,493	1,580	1,856	1,690	1,883	1,765	1,566	1,178
Victims	288	2,750	2,837	3,242	2,748	3,066	2,921	2,504	1,866

### Effects of exposure of children to IPV

Effects of such an exposure are diverse and complex, can last for a short term or a life time, and depend on the age of the child at the time of exposure. Effects on children are not well understood, but extant evidence includes externalizing behavior problems, socioemotional problems, interpersonal skill deficits, and cognitive difficulties.

Many factors influence the ways in which exposure to IPV effects children. Content of the dispute and if it is resolved, frequency and duration of violence, and nature of abuse witnessed are most influential factors.

Table 3: Effects of witnessing intimate partner violence by developmental level (Carlson, 2000)

<b>Effect type</b>	<b>Infants/Toddlers</b>	<b>Preschoolers</b>	<b>School Age</b>	<b>Adolescent</b>
Behavioral	Being fussy	Aggression, behavior problems	Aggression, conduct problems, disobedience	Dating violence, delinquency, running away
Emotional		Fear and anxiety, sadness, worry about mother, post-traumatic stress disorder, negative affect	Fear and anxiety, depression, low self-esteem, guilt, shame, post-traumatic stress disorder	Depression, suicidality, post-traumatic stress disorder
Physical	Distress, problems sleeping, eating	Highly active, demanding, whiny, clinging, regression		Substance abuse
Cognitive	Inability to understand	Limited understanding, self-blame	More understanding than young children, self-blame, academic problems, proviolent attitudes	provioleat attitudes
Social		Trouble interacting with peers and adults, ambivalent relationships with caregiver	Fewer and lower quality peer relationships	Violent dating relationships

Children exposed to domestic violence qualify as maltreated because “they are living in an environment that is psychologically abusive” (Holden, 2003, p. 156). There is significant overlap between domestic violence and both child physical abuse and child neglect (Hartley, 2002). Between 30 and 60% of the children of battered women are physically abused and exposure to domestic violence is arguably one of the best risk indicators available of physical child abuse (Black, Heyman, & Slep, 2001).

Despite the well-documented adverse consequences of IPV exposure and a growing discussion of the appropriate policy responses to IPV exposure (Jaffe, Crooks, & Wolfe, 2003; Nixon, Tutty, Weaver-Dunlop, & Walsh, 2007), surprisingly little information is available about how often such exposure occurs in the general population. Such information is important for determining the extent of the problem, assessing the need for services, and establishing a baseline for evaluating progress.

## Interventions and services for children exposed to IPV

It is important to recognize the complex set of conditions and diverse medical and behavioral challenges experienced by children exposed to IPV. While many treatments and interventions are available for individual psychological conditions and disorders among children, interventions for children exposed to IPV are often comprehensive in nature, coupled with parallel services to their parents, and attempt to address multiple individual and contextual factors. Thus, collaboration across institutions and disciplines is necessary.

Despite strides described below in serving the needs of children exposed to IPV, it has been a concern that “services for children remain largely inconsistent. Some programs are restricted by financial constraints to the provision of only basic services, perhaps only having one staff member who provides occasional childcare. Other programs are able to hire child advocates and counselors to oversee a wide variety of counseling and advocacy services for child clients” (National Resource Center on Domestic Violence, 2002, p. 14)

Futures Without Violence, formerly Family Violence Prevention Fund recommended the following sixteen approaches based on a review of core components of evidence-based therapeutic intervention models for children exposed to IPV (DeBoard-Lucas, Wasserman, Groves, & Bair-Merritt, 2013):

1. Understand that children of all ages, from infancy through adolescence, are vulnerable to the adverse impact exposure.
2. Establish a respectful and trusting relationship with the child’s mother.
3. Let mothers and children know that it is OK to talk about what has happened *if the child would like to engage in this type of discussion*.
4. Tell children that violence is not their fault; if children say that the violence is their fault or that they should have stopped it, tell them directly that they are not responsible for violence and that it is not their job to intervene (or coach their mothers to do so).
5. Foster children’s self-esteem by showing and telling them that they are lovable, competent and important.
6. Help children know what to expect.
7. Model and encourage good friendship skills.
8. Use emotion words to help children understand how others might feel during disagreements.
9. Recognize that when children are disruptive, they are generally feeling out of control and may not have the ability to use other strategies to express themselves.
10. Incorporate the family’s culture into interventions, and support mothers and children to explore the values, norms, and cultural meanings that impact their choices and give them strength.
11. Actively teach and model alternatives to violence.
12. Involve mothers in conversations with their children about the children’s views of the abuse.
13. Discuss child development with mothers.
14. Help mothers teach their children how to label their emotions.
15. Address mothers parenting stress.
16. Work with mothers to help them extend both their own and their child’s social support network.

A fundamental aim of most interventions is to provide the children a sense of safety, stability, and predictability in their life and their relationships. Interventions can be broadly classified into individual approaches, group approaches, and combination approaches:

*Individual approaches:*

Jaffe, Crooks, and Wolfe (2012) identify four commonly used individual-level interventions: Psychoeducation, art and relaxation therapy, trauma and grief specific cognitive behavioral therapy, and debriefing strategies. “The primary focus when providing individual treatment is to allow children and youth to talk about their feelings regarding the violence, and for someone to validate those feelings. Many children are not expecting immediate solutions to longstanding family problems, but rather an opportunity to talk to an adult who understands and listens to their fears, worries, and concerns about themselves and their family” (p. 34).

*Group treatments*

Group treatments are cost effective and provide support and sharing opportunities that help realize the shared experiences and common issues faced by children exposed to IPV. Most treatment models are a series of group sessions a week or so apart. Each session may have up to eight or ten children, last up to an hour or a little longer, and often facilitated by one or two adult facilitators. Facilitation that models adult and gender roles, and allows safe space for children to share their experiences is extremely important and is often tailored to suit the developmental stages of various children in the group.

*Other types of services*

Other models include a combination of parent groups and children groups, home visitation, joint-child parent sessions, and shelter-based group intervention with mothers and children (Chamberlain, 2014).

**Services available in Anchorage, Alaska**

The State of Alaska Violent Crimes Compensation Board identifies seventeen shelters and victim advocates in the Anchorage area<sup>2</sup> that serve victims of domestic violence. There are at least 14 agencies Apart from these agencies, at least 30 private practice counselors in Anchorage area specifically address trauma and practice Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children exposed to IPV.

While all of them provide some form of service to women and child victims, comprehensive services for child victims are almost non-existent. The Cook Inlet Tribal Council (CITC) Flourishing Child program is a unique program available for children (and their families) that attend the Cook Inlet Native Head Start program in Anchorage. A consulting psychotherapist is located at the Head Start and children are referred to the psychotherapist by the teachers at the Head Start.

None of the 9 other Head Start or Early Head Start locations in Anchorage operated by either Kids’ Corps, Inc. (8 locations), or the Rural Alaska Community Action Program, Inc. (Rural CAP) (1 location) offer similar services. While the CITC Flourishing Child services are necessary, the need for such services in the Anchorage area is much greater as demonstrated by the numbers of victims in the area. The Abused Women’s Aid in Crisis (AWAIC) shelter provided services to 424 women and 302 children at

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<sup>2</sup> Retrieved on September 20, 2015. <http://doa.alaska.gov/vccb/VictimServices/sheltersAdvocates.html>

imminent risk for a total of 18,228 shelter safe nights with an average 25-day length of stay in FY 2013 (Municipality of Anchorage, 2014).

The Children's Program at AWAIC prioritizes keeping children safe and providing a stable, fear-free environment and targets children that have witnessed violence in the home. "Staff members helped 352 residential and non-residential children and provided 2,322 group hours and organized outside outings for 154 children. In FY 14, the shelter provided services to 461 women and 317 children at imminent risk due to domestic violence for a total of 19,756 shelter safe nights. AWAIC staff assisted 4209 non-residential women and children at risk for DV.

These numbers are a clear indication that there is much unmet need for services to children exposed to IPV in Anchorage. In addition, there is considerable overlap between population served by CITC Flourishing Child through the Cook Inlet Native Head Start and AWAIC.

### **Conclusion**

With much of the need identified in the prevalence section above unmet, and with the considerable overlap between CITC Flourishing Child program and AWAIC programs, the plan to expand Flourishing child program to serve children and families at AWAIC in addition to the current CITC Native Head Start location will be an important next step in meeting the current needs.

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