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ORIGINAL RESEARCH

Impact of a Second-Stage Domestic Violence Shelter on Children's Resilience, from Staff Perspectives

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Purpose: Understanding how protective processes support resilience following domestic violence is important for developing effective interventions. While existing research has examined children's risks and resilience after domestic violence exposure, less is known about how second-stage shelters support resilience. Drawing on staff perspectives within a biopsychosocial framework, this study explored how the second-stage shelter context was perceived to shape children's resilience.

Methods: This study followed a directed qualitative content analysis methodology. Data were collected through semi-structured interviews with fifteen staff members at a second-stage shelter in Canada, incorporating open-ended questions and a reflective art-based activity to enhance depth of insight.

Results: Findings demonstrated that children's resilience was understood as emerging through interconnected physical, psychological, and social-environmental processes, with psychological and social-environmental processes featuring most prominently in participants' accounts. Professional support emerged as a cross-domain protective factor connecting multiple areas of children's wellbeing, alongside maternal mental health, parenting capacity, children's self-regulation, and safety. Key opportunities included shelter safety, accessible services, and sustained duration of support. Children's adjustment within the second-stage shelter context was perceived as involving transitions over time, with resilience developing through the ongoing interaction of protective processes and evolving experiences.

Conclusion: This study extends understanding of children's resilience following domestic violence exposure by illustrating how staff perceived resilience to develop within a second-stage shelter setting. Findings highlight resilience as a relational and context-dependent process emerging through interconnected protective processes, with implications for trauma-informed and developmentally responsive practice.

Keywords: domestic violence, protective factors, children resilience, biopsychosocial, second-stage shelter

Introduction

Domestic Violence

Domestic violence (DV), often used as an umbrella term, encompasses both family violence (FV) and intimate partner violence (IPV). FV refers to abusive behavior occurring within a family or household context, while IPV specifically involves abuse directed toward a current or former romantic partner. Such abuse can take many forms, including physical, verbal, psychological, sexual, financial, cultural, and spiritual abuse, as well as neglect, coercive control, harassment, and cyber violence.[1]

Globally, domestic violence occurs at alarming rates, representing a serious public health concern. According to the World Health Organization (WHO), nearly one-third (27%) of women aged 15–49 who have ever been in a relationship report experiencing some form of physical and/or sexual violence by an intimate partner worldwide.[2]

In Canada, police-reported data identified 142,724 victims of family violence and 128,175 victims of intimate partner violence in 2024, corresponding to rates of 349 per 100,000 population and 356 per 100,000 population aged 12 years

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and older, respectively.[3] Although these data provide important estimates of the burden of violence, police-reported statistics likely underestimate the true extent of violence because many incidents may not be reported to authorities.[4]

Physical, Psychological, and Social Impact of Domestic Violence on Children

Research demonstrates that domestic violence can have wide-ranging and multidimensional effects on children's physical, psychological, and social development.

There is strong convergence in the literature that DV exposure is associated with a range of adverse physical health outcomes. These include increased risk of low birthweight,[5] reduced intrauterine growth, prematurity, and neonatal mortality.[6] Additional studies similarly report associations with impaired child growth,[7] incomplete immunizations, respiratory conditions, increased healthcare utilization,[8] and asthma,[9] alongside broader dysregulation of nervous, endocrine, cardiovascular, and immune systems.[10] Findings are increasingly aligning around biological embedding mechanisms, with evidence indicating that childhood violence exposure is associated with telomere erosion, impacting chromosomal health.[11] Importantly, this biological embedding may not be limited to directly exposed children, as maternal histories of adversity have also been linked to shorter telomere length in offspring,[12] suggesting potential intergenerational transmission of stress-related biological effects. Collectively, these findings support the view that DV-related stress may be biologically incorporated across generations through both direct and indirect pathways.

Moving from biological to psychological outcomes, the literature again shows strong consensus, with consistent evidence linking DV exposure to elevated risks of internalizing problems (e.g, anxiety and depression), externalizing behaviors (eg, aggression and hostility), and post-traumatic stress symptoms.[13–16] These findings are complemented by evidence of early emotional regulation difficulties in infancy and early childhood,[17,18] suggesting that psychological impacts may emerge early and persist over time. However, across studies there is important variation in how these outcomes are explained, particularly regarding whether child adjustment is primarily driven by direct exposure to violence or indirectly through caregiving environments. While direct exposure to violence can negatively affect children, a substantial body of research suggests that its impact is also mediated through relational processes, including maternal mental health difficulties, disruptions in parenting, and attachment insecurity.[19–22] This indicates that children's outcomes are shaped not only by exposure itself, but also by changes in the caregiving environment and parent–child relationships.

These relational pathways may be especially consequential when examining children's social outcomes over time. Multiple lines of evidence suggest that DV exposure is associated with long-term social disadvantage, including reduced educational attainment, income, and employment opportunities in adulthood.[23,24] During childhood and adolescence, DV exposure has also been linked to poorer social competence,[25] impaired peer relationships,[26] and an increased risk of bullying victimization.[27] These social difficulties have been associated with disruptions in caregiver–child attachment,[28] which attachment theory suggests may have enduring implications for relational functioning across the lifespan.[29,30] Such relational disruptions may also have broader implications for later interpersonal functioning, including patterns of relationship formation and conflict across development.[31] However, a key divergence in the literature concerns the stability of these pathways, with contemporary evidence emphasizing that developmental outcomes are not fixed but are shaped by later experiences and contextual factors, rendering trajectories probabilistic rather than deterministic.[32,33]

Taken together, the literature provides strong evidence that exposure to domestic violence is associated with risk across multiple physical, psychological, and social domains. However, a consistent finding across studies is the substantial heterogeneity in children's outcomes. This variability suggests that exposure to domestic violence alone is insufficient to explain developmental trajectories, underscoring the importance of moderating, mediating, and buffering processes that influence whether, how, and to what extent adverse outcomes emerge over time.

Protective Factors and Resilience

Developmental trajectories appear to be shaped by a complex interplay of risk, protective, and contextual factors that moderate the impact of domestic violence exposure and contribute to children's adaptation and resilience over time. Building on the documented heterogeneity in children's outcomes, research has increasingly focused on identifying protective factors (PF) that may explain why some children exposed to domestic violence demonstrate resilience despite

significant adversity. Protective factors are generally defined as resources or characteristics that reduce the impact of risk and support adaptive functioning.[34,35] Resilience, in turn, is understood as a dynamic process of positive adaptation in the context of adversity.[36] From a theoretical perspective, these processes can be understood within a biopsychosocial resilience framework,[37] which conceptualises adaptation as the product of interacting biological, psychological, and social systems, consistent with Engel's broader biopsychosocial model of health.[38] In this sense, resilience is not the sum of separate factors, but the product of their continuous mutual interaction.

Across the literature, there is general agreement that protective factors operate at multiple levels, typically distinguished as internal (individual-level) and external (family, school, and community-level) resources.[35]

At the individual level, evidence converges on self-regulation as a key protective mechanism, suggesting that internal regulatory capacities may buffer stress exposure across domains.[35,39,40] Related characteristics such as adaptive temperament, higher self-esteem, and stronger cognitive functioning have also been linked to more positive adjustment,[39,41] indicating that individual-level protective processes are consistently associated with improved emotional, behavioral, and academic outcomes.

At the external level, findings consistently highlight relational and contextual supports, indicating that protective processes are embedded within caregiving and environmental systems, although the mechanisms through which these operate vary across studies. Maternal mental health and wellbeing are repeatedly identified as critical protective factors,[39,41,42] given their central role in shaping caregiving quality and emotional availability, which in turn influences multiple domains of child adjustment. Similarly, positive parenting practices,[43,44] school-based support,[35,40] peer relationships,[16,45] and broader social support networks[46–48] collectively function as interconnected systems that promote more adaptive outcomes. Across studies, reduced ongoing exposure to violence is also consistently identified as a key condition for improved adjustment,[39] underscoring the importance of safety as a foundational protective context. Collectively, these findings suggest that external protective factors operate not in isolation but as interacting systems that jointly shape children's developmental trajectories across domains.

Integrating these findings, meta-analytic evidence provides a clearer synthesis of the most robust protective systems. Yule et al identified self-regulation, school support, peer support, and family support as the strongest and most consistent predictors of resilience in DV-exposed populations.[40] Self-regulation is associated with improved emotional and social functioning and academic achievement.[35,40] School support has been linked to better wellbeing, self-worth, academic performance, and reduced risk of later violent behavior.[35,40] Peer support is associated with fewer internalizing and externalizing symptoms, reduced PTSD, and improved social competence.[16,40,45] Family support, particularly through maternal mental health and caregiving quality, remains one of the most influential protective systems, shaping attachment security and child adjustment across multiple domains.[37,41,42,49]

In addition, literature emphasizes interaction effects across levels of influence. For example, maternal mental health functions not only as a direct protective factor but also shapes parenting quality and attachment relationships, which subsequently influence children's emotional, behavioural, and social adjustment.[42,49,50] Similarly, broader social contexts, including caregiver support networks and social connections, may indirectly promote adaptive outcomes by reducing isolation and strengthening perceived safety and support.[46–48]

Although reducing or ending exposure to domestic violence is consistently associated with improved child outcomes, particularly when safety is restored,[39] the separation process itself may introduce additional psychosocial stressors. Changes in family relationships, living circumstances, and established routines can contribute to experiences of grief, loss, and adjustment difficulties for children and families.[51,52] These findings highlight the complexity of recovery following domestic violence and reinforce the importance of early, developmentally sensitive intervention and support.[53]

Overall, the literature demonstrates that protective factors operate across multiple levels, however, a biopsychosocial perspective highlights that these levels are functionally interdependent rather than independent. Supporting this integrated perspective, Cameranesi et al[37] identified co-occurring psychological and physical health difficulties among children exposed to intimate partner violence who demonstrated resilience challenges. This finding illustrates how developmental outcomes may emerge across interconnected domains rather than through isolated processes. Consequently, improvements within one domain may influence functioning in others, reinforcing the importance of

understanding resilience as an interaction among psychological, physical, and social-environmental processes. Examining protective factors across these interconnected domains is therefore essential for informing targeted and context-sensitive prevention and intervention approaches.

Domestic Violence Shelters

In Canada, women and children affected by domestic violence can access a continuum of shelter-based support services, most notably emergency and second-stage shelters. While second-stage shelters serve women both with and without children, families with children represent the majority of residents. A Canadian provincial study by the Alberta Council of Women's Shelters (ACWS) found that 87% of women accessing second-stage shelters were caring for at least one child, and 60% had two or more children in their care.[54] These services represent a key component of the domestic violence response system, providing safety, stabilization, and transitional support within broader networks of housing and social services.[55,56] It is estimated that approximately 415 emergency shelters and 149 second-stage shelters operate across Canada.[55]

These shelters operate within provincial and territorial housing and social service systems and are typically delivered by community-based non-profit organizations, collectively forming a regionally distributed network of services across Canada.[55] Access to shelter services is generally guided by referral pathways and assessments of safety needs, with programs supporting women and children who continue to require protection and transitional support following experiences of domestic violence.

Existing literature and policy reports describe emergency shelters as providing immediate, short-term accommodation for women and children fleeing domestic violence.[55,56] These services are designed to address urgent safety needs and support crisis stabilization while connecting families with essential resources, including legal, financial, housing, and healthcare supports.[55,56] As crisis-response settings within the broader continuum of care, emergency shelters primarily focus on immediate protection and stabilization following experiences of violence.

In contrast, second-stage shelters provide longer-term transitional housing and continued support for women and children who require ongoing safety and stability following emergency shelter stays.[55,56] These settings typically provide independent, apartment-style accommodation alongside structured professional supports, enabling families to develop greater autonomy while continuing to access services throughout the recovery process.[56] Second-stage shelters are commonly conceptualized as a transitional bridge between emergency accommodation and permanent housing, supporting families as they move from crisis toward longer-term stability.[56]

The second-stage shelter context therefore provides an important setting for examining how children's resilience processes are perceived to occur within the interaction of relationships, environments, and ongoing adjustment following domestic violence exposure.

The Current Study

Although existing literature has extensively documented the biopsychosocial impacts of children's exposure to domestic violence and identified protective factors associated with resilience, less is understood about how children adjust and develop resilience within second-stage shelter environments. Policy and system-level literature have described the structure, purpose, and role of second-stage shelters within the broader domestic violence response system, however, empirical research examining children's developmental and psychosocial experiences specifically within these longer-term residential contexts remains limited. In particular, limited empirical attention has been given to the perspectives of shelter staff who provide ongoing support to children and families and offer valuable insights into children's adjustment processes within these settings. This gap is particularly important within second-stage shelters, where extended residential support, relational continuity, and access to integrated services create a distinct context for understanding how children's resilience processes unfold following domestic violence exposure, including the protective factors, challenges, and contextual conditions that shape adjustment.

The present study advances understanding of children's resilience within second-stage shelters through three contributions. First, it provides a staff-informed account of children's resilience within a second-stage domestic violence shelter, offering insight into how professionals perceive children's adjustment within this context.

Second, it draws on a biopsychosocial lens to examine how physical, psychological, and social-environmental processes interact to shape children's resilience. Third, it extends existing research by adopting a process-oriented perspective on resilience, examining it as a dynamic and context-dependent process that evolves through interactions between individuals and their social and environmental contexts, rather than viewing it solely as an individual outcome.

The main research question guiding this study is to explore how staff in a second-stage domestic violence shelter perceive the ways in which the shelter context influences children's resilience, including protective factors, challenges, opportunities, and potential areas for improvement. By exploring these dimensions, this study contributes to a deeper understanding of how second-stage shelter environments may support children's adjustment, adaptation, and recovery following domestic violence exposure.

Method

Methodology

This study adopted a qualitative approach grounded in the interpretivist/constructivist paradigm, which emphasizes participants' perspectives and the co-construction of knowledge.[57] Several qualitative methodologies were considered, including grounded theory,[58] interpretative phenomenological analysis,[59] and qualitative content analysis.[60]

Grounded theory was considered less appropriate because the aim of this study was not to develop a new explanatory theory inductively from participants' accounts. Rather, the study sought to examine staff perspectives on children's resilience within an existing biopsychosocial framework and to extend understanding of resilience processes in the context of second-stage domestic violence shelters. Accordingly, a deductive analytic approach was considered more appropriate than an inductive design. Interpretative phenomenological analysis was also not selected because its emphasis on the in-depth exploration of individuals' lived experiences did not align with the study's objective of examining resilience processes within a service context and advancing understanding within an established conceptual framework.[59]

Instead, this study employed directed qualitative content analysis, a method used to systematically interpret textual data through the identification of categories, themes, and patterns.[61] Directed qualitative content analysis is particularly well suited to well-established areas of inquiry because it draws upon existing theory and empirical evidence to guide analysis while remaining open to the emergence of novel findings.[62] Initial coding categories are informed by prior conceptual frameworks and research but may be refined, expanded, or supplemented as new insights emerge throughout the analytical process.[60] This approach allows researchers to both validate existing theoretical understandings and generate contextually grounded knowledge.

The study was guided by a biopsychosocial framework, which conceptualizes resilience as a dynamic process arising from the interaction of physical, psychological, and social factors. The biopsychosocial framework provided a priori conceptual structure for analysis by identifying theoretically derived domains relevant to children's resilience within second-stage shelter settings. This theoretical scaffolding justified the use of directed qualitative content analysis, as the methodology is specifically intended for studies seeking to apply, refine, and extend existing conceptual frameworks.[60] Initial coding categories were therefore informed by biopsychosocial constructs, allowing for the systematic examination of resilience-related processes across physical, psychological, and social dimensions while remaining responsive to patterns and themes emerging from participants' accounts.

This study followed the 16-step directed qualitative content analysis approach proposed by Assarroudi et al[61] (see Table 1). Directed qualitative content analysis was therefore considered the most appropriate methodology, as it enabled the systematic application, refinement, and extension of existing theoretical understandings while remaining sensitive to the unique contextual realities of second-stage shelter settings for children exposed to domestic violence.

Table 1 Sixteen-Step Process for Directed Qualitative Content Analysis

Preparation Phase	Organization Phase	Reporting Phase
1 - Develop skills	**8 -** Formative categorization matrix	**16 -** Report findings
2 - Sampling strategy	**9 -** Main categories and subcategories	
3 - Content analysis (manifest and/or latent)	**10 -** Coding rules	
4 - Interview guide	**11 -** Categorization matrix pre-test	
5 - Interviews	**12 -** Anchor samples	
6 - Unit of analysis	**13 -** Data analysis	
7 - Immersed in data	**14 -** Inductive abstraction	
	15 - Generic and main categories links	

Note: Adapted from reference [61].

Study Location

This study was conducted in a second-stage domestic violence shelter located in an urban area in Alberta, Canada.

Sample

The research was undertaken within a single second-stage domestic violence shelter. The site was selected purposively because it reflects key characteristics of second-stage shelter provision in Canada, including longer-term transitional housing and structured, family-centred supports for women and children following experiences of domestic violence. As a single-site pilot study, the aim was to generate in-depth, contextually grounded insights into children's resilience within this service setting rather than to compare experiences across multiple sites.

This study used a purposive sample of fifteen female staff members working in the shelter. Participants were selected to represent multiple professional roles that work directly with clients, ensuring a broad range of perspectives on children's and mothers' experiences within the shelter context (see Table 1, Step 2). Inclusion criteria encompassed all staff members whose roles involved ongoing, face-to-face interaction with clients. Participants held frontline service positions, including counsellors, case managers, child development specialists, and client liaisons, representing approximately 65% of the frontline staff.

Seven participants had direct responsibility for working with children, including counsellors and child development specialists who focused specifically on supporting children's developmental and emotional needs within the shelter. The remaining participants primarily worked with mothers. Participants' professional backgrounds included social work, psychology, and related disciplines.

Information on participants' age and years of professional experience was not collected, as the study focused on professional roles and experiential knowledge of working within a second-stage domestic violence shelter rather than demographic profiling. Given the small and specialized nature of the workforce, limiting demographic detail also supported participant anonymity.

The sample size of fifteen was considered appropriate for this qualitative study as it allowed for the inclusion of diverse professional perspectives while remaining manageable for in-depth data collection and analysis. The range of roles represented provided diverse perspectives across different areas of shelter practice, contributing to the richness and depth of the dataset.

Data collection continued until saturation was reached, indicated by the recurrence of key categories and redundancy in participant responses.[63]

The majority of eligible staff invited to participate agreed to take part, with only a small number declining due to scheduling conflicts or personal reasons, further supporting the comprehensiveness of the sample.

Data Collection

Data were collected through semi-structured interviews, each lasting approximately one hour, over a two-week period, and the content analysis was based on the manifest transcribed text (see Table 1, Step 3). Interviews were scheduled sequentially based on staff availability, with intervals between interviews determined by shift patterns and participant scheduling constraints. Given the single-timepoint, interview-based nature of the study, data collection was limited to individual interviews.

The interview guide (see Table 1, Step 4) included both open-ended questions and a creative art activity in which participants were invited to draw a landscape of mountains symbolically representing their perceptions of the relevance of protective factors within the shelter context (see Figures 1 and 2). This activity was designed to support reflection by allowing participants time to organize their thoughts and identify what they considered most meaningful prior to verbal discussion.[64] The drawings were not analysed as data, coded, or incorporated into the development of categories or themes. Instead, they functioned solely as reflective elicitation tools intended to facilitate deeper engagement with the interview topics. While they were not subject to formal analysis, they indirectly enhanced the richness and clarity of participants' verbal accounts, which formed the sole basis of the transcription and subsequent content analysis.

Interviews were conducted via Zoom, which enabled recording and automatic transcript generation (see Table 1, Step 5). Given participants' access to electronic devices and internet connectivity, Zoom provided a flexible and accessible platform for scheduling interviews at convenient times and locations. Research suggests that Zoom is a suitable tool for qualitative data collection due to its ease of use, cost-effectiveness, and efficiency in managing research time and resources.[65]

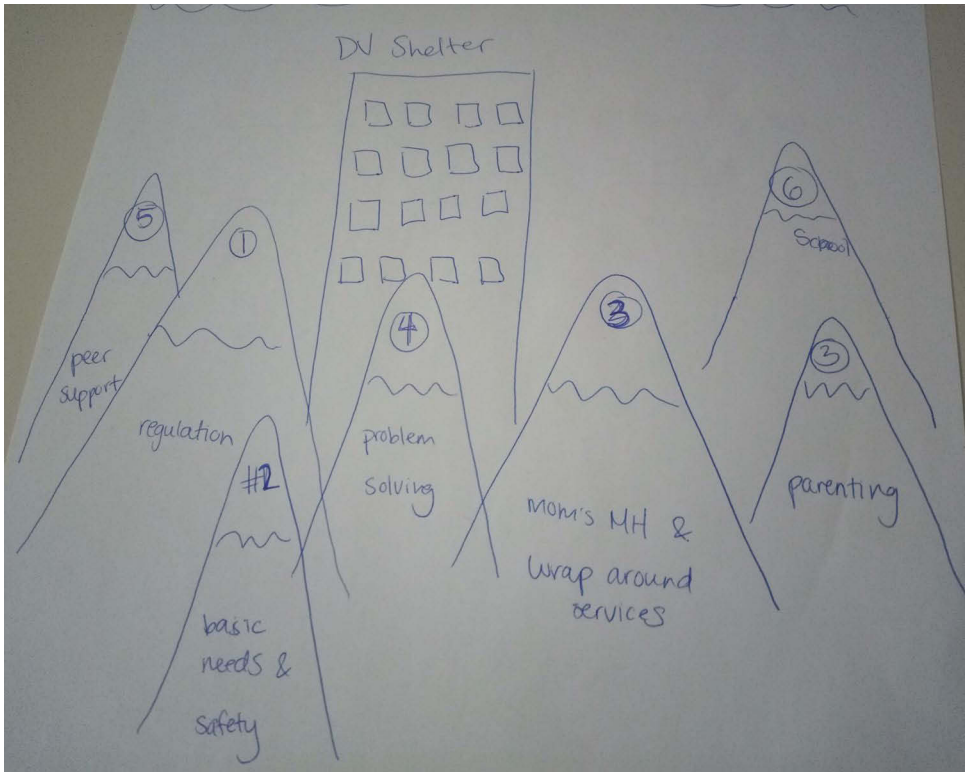

Figure 1 Art activity example 1.

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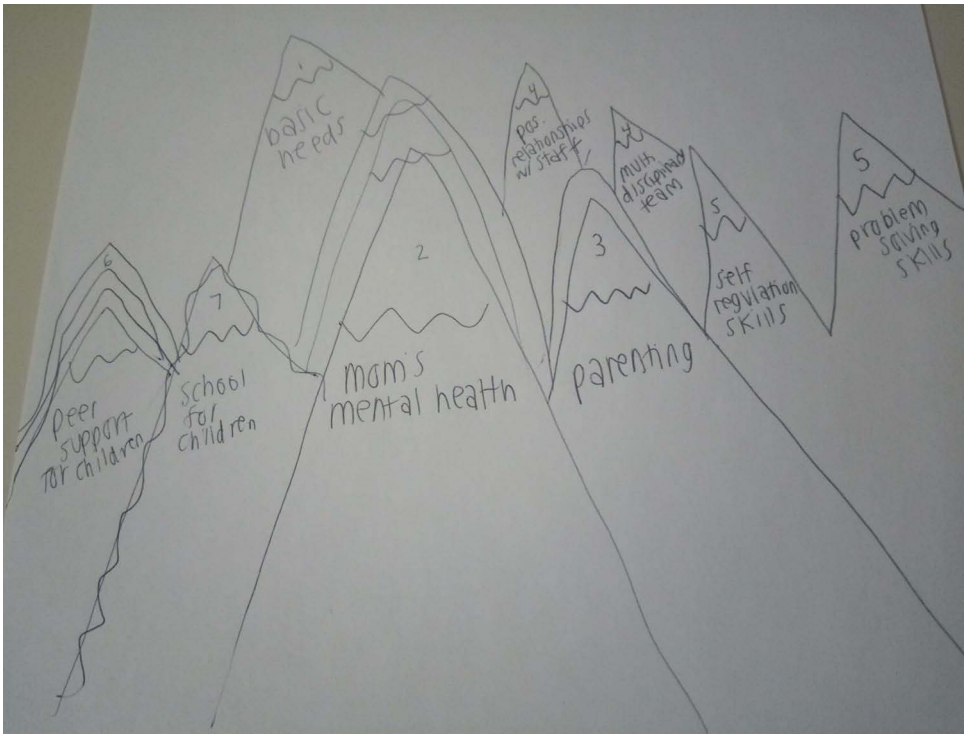

Figure 2 Art activity example 2.

Data Analysis

The transcriptions of interviews are considered the primary units of analysis in interview-based qualitative research (see Table 1, Step 6).[61] Following transcription, all interviews were reviewed, and the researcher engaged in repeated reading of the data to become immersed in the content (see Table 1, Step 7). During this stage, the data were explored using guiding questions (who, where, when, what, why) to support familiarisation and initial interpretation.[61,66]

A formative categorization matrix was then developed (see Table 1, Step 8), and initial categories and subcategories were defined deductively according to the biopsychosocial framework (see Table 1, Step 9). As Mayring notes, the category system constitutes the central instrument of analysis in directed qualitative content analysis.[67] Coding rules were subsequently established to reduce ambiguity and ensure consistency in category application (see Table 1, Step 10), and the categorization matrix was pretested to enhance analytical rigour (see Table 1, Step 11).[68] Anchor examples were then identified for each main category to guide consistent interpretation of the data (see Table 1, Step 12).[61,67]

The full coding process was then conducted (see Table 1, Step 13), during which meaning units were assigned to predefined categories. Codes were subsequently grouped based on similarities and differences to form generic categories.[61] A constant comparison process was used to examine relationships between generic and main categories, allowing refinement of the analytical structure throughout the process (see Table 1, Step 15). Finally, findings were systematically organised and reported according to the established category system (see Table 1, Step 16).

Rigor

Trustworthiness was enhanced through multiple strategies across the research process. Although qualitative research acknowledges that researcher subjectivity is inherent and cannot be fully eliminated,[69] reflexivity was maintained throughout the study using a reflective journal to document assumptions, decisions, and interpretative considerations.[70,71]

During data collection, participant validation strategies were used to enhance credibility. These included summarising participants' responses during interviews to confirm meaning, clarifying interpretations during the creative drawing activity, and conducting follow-up clarification when necessary.[72] These steps supported analytic triangulation by ensuring that participants' intended meanings were accurately captured.

During data analysis, credibility was strengthened through the use of a predefined coding framework, clearly defined coding rules, and anchor examples to ensure consistency in category application. To further enhance dependability, multiple researchers reviewed segments of the data to reduce the risk of selective perception and interpretive bias.[72] While variation in perspectives was observed, no directly contradictory accounts were identified. Where variation occurred, recurring patterns were prioritised within the analytical framework.

Finally, during the writing phase, reflexive journaling continued to support transparency in linking emerging findings with researcher assumptions and interpretations, thereby strengthening confirmability of the analytic process.

Results

Overview of Findings

Formative categorisation matrix subcategories, codes, and themes were organised within a biopsychosocial framework encompassing three domains: physical, psychological, and social-environmental factors (see Tables 2–4). These domains provided an initial structure for the analytic process, with findings presented hierarchically, whereby primary themes represented higher-order conceptual categories and secondary themes reflected more specific contextual expressions within each domain. Although domains are presented separately for clarity, participants' accounts demonstrated substantial overlap across categories, with several themes functioning as cross-cutting constructs that reflected the integrated nature of children's experiences within the second-stage domestic violence shelter context.

Across the dataset, psychosocial processes were most prominent, particularly within the social-environmental domain, which encompassed both structural and relational aspects of the shelter environment. Structural conditions, including secure building access, confidentiality of location, onsite services, routines, school support, and community resources, were consistently described as foundational features shaping children's daily experiences. These environmental conditions were closely linked to psychological processes, including emotional safety, adjustment, stigma, self-regulation, and feelings of stability. Participants frequently described how secure and predictable environments enabled children to feel "at home" and supported emotional regulation and expression, whereas disruption, including relocation and school transitions, was associated with experiences of loss and difficulty adjusting.

The psychological domain captured emotional, cognitive, and identity-related experiences, including children's perceptions of safety, experiences of stigma or feeling different, emotional adjustment, and relational loss associated with transitions into and within the shelter. Participants varied in the extent to which they engaged with different domains, however, psychological and social-environmental processes were more consistently elaborated across interviews. This pattern reflects the distribution of emphasis within the data rather than the relative importance of domains.

Across participants, the most consistently reported themes included professional support, safety, stability, transition, and loss. Maternal mental health, parenting, safety, self-regulation, and professional support were frequently identified as important contextual protective factors, although they were not uniformly prioritised across all accounts. Participants' narratives also revealed both convergence and divergence, as well as tensions within and across domains, particularly in relation to safety and stigma, transition and loss, and continuity of care and adjustment over time.

The physical domain, conceptualised as child health and developmental factors, was less frequently represented within participants' accounts and was generally discussed in relation to broader wellbeing and developmental processes rather than as a standalone focus. This suggests that participants primarily understood children's wellbeing through environmental, relational, and emotional pathways, while recognising that physical health remained embedded within these interconnected experiences.

Shelter Protective Factors

Biopsychosocial factors were reflected across the shelter protective factor themes (Table 2), encompassing physical, psychological, and social-environmental domains. Although these domains provide a useful framework for organising the findings, participants described them as highly interconnected, with protective factors interacting dynamically rather than functioning as discrete or independent influences.

Table 2 Shelter Protective Factors Themes and Illustrative Quotes

Domain	Codes	Primary Theme	Secondary Theme	Quotes
Physical	Development	Professional support	Developmental support	"the structure of the brain when during development, our services being able to be that buffer". (P3)
	Needs	Basic needs	Provision of essential resources	"basic needs met" *(P8)*
Psychological	Support	Professional Support	Therapeutic support	"kids to be able to express themselves (…) and not feel like they're judged" (P12); "intensive, comprehensive, therapeutic, healing support" (P10); "we offer so much support" (P1); "makes it easier for them to grow and heal slowly from the traumatic incident" (P11); "we offer more ongoing, consistent mental health support" (P14)
		DV Programming	Cycle disruption	"programs increase the knowledge in order to make different choices, to increase their confidence" (P10); "So that abuse doesn't continue" (P2); "that cycle is broken, and children hopefully with the ability to set boundaries or to have healthier self-esteem" (P13)
Social-environmental	Support	Community resources	Community partnerships	"we are very well connected with different community partners and resources" (P7)
	Building	Safety	Security	"safety and security with our physical building" (P8); "the safety nest" (P11).
	Relationships	Mother, peers, professional relationships Sense of community Parenting	Healthy relationships Belonging Nurturing relationships	"being able to form healthy relationships" (P1); *"sense of community* (P11); "positive relationships with adults in their life" (P14)
	Routine	Stability	Predictability	"ensuring that they are in some sort of routine" (P15)
	Building	DV Programming	Accessibility	"they have a home in the same building as the programming" (P5)
	School	School support	School attendance	"we're making sure kids are going to school" (P8)
	Support	Professional support	Multidisciplinary support	"We have highly trained staff with specialties that are relevant in serving our children" (P10); "our staff are specialized in different areas" (P7); "a variety of professional supports" (P14)

Within the social-environmental domain, prominent themes included safety, stability, professional and community support, parenting support, school engagement, and nurturing relationships that fostered children's sense of belonging. Within the psychological domain, participants highlighted emotional regulation, maternal mental health, therapeutic support, and children's adjustment and recovery processes following domestic violence. The physical domain, comprising the provision of basic needs and developmental support, was discussed less frequently but was consistently described as a foundational component that enabled psychological recovery, social connection, and overall wellbeing.

Key Contextual Protective Factors and Cross-Domain Processes

When participants were asked to reflect on both the shelter protective factors they had identified and those reported in the literature (eg, self-regulation and problem-solving skills, parenting, maternal mental health, school, and peer support), several contextual protective factors consistently emerged as particularly important within the second-stage domestic violence shelter environment. Professional support, maternal mental health, parenting, self-regulation, and safety were most frequently emphasized as central to supporting children's wellbeing and resilience.

Professional support emerged as a cross-cutting protective process operating across the physical, psychological, and social-environmental domains. Participants described it as both a stabilising resource during periods of transition and a mechanism for promoting children's longer-term development, recovery, and resilience.

Maternal mental health was also consistently recognised as an important influence on children's emotional and behavioral functioning. As P14 explained, "when the mom's mental health is not good or declining, that's when I personally see the most behaviors being reflected on the child". Alongside professional support, parenting capacity, children's self-regulation, and safety, maternal mental health emerged as one of the protective factors most consistently emphasized across participants' accounts. While participants identified different factors as particularly central in their reflections, these five areas represented the most consistently relevant protective factors within the second-stage shelter context.

While school and peer support were widely acknowledged as valuable protective resources, they were less consistently identified as central compared with the factors described above. As P12 noted, "school and peer support, they are extremely important too, but I feel that the other things are just a little bit more important". This suggests that the salience of protective factors shifts according to children's immediate circumstances, with different supports becoming more influential at different stages of adjustment and recovery within the shelter environment.

Overall, participants demonstrated broad agreement regarding the importance of professional support, maternal mental health, parenting, safety, and self-regulation, while differing in the relative priority assigned to individual factors. As P2 stated, "I have parenting and maternal mental health at the top", whereas P8 explained, "I still kept regulation skills is number one for kids", and P3 emphasized, "I put the safety and the support team kind of overarching everything…to create a safe space for mental health". Rather than indicating disagreement, these differing perspectives reflect the dynamic, interconnected, and context-dependent nature of resilience. Together, they illustrate that protective factors and processes interact across physical, psychological, and social-environmental domains, with their relative influence shifting according to children's developmental needs, recovery trajectories, and the broader shelter context.

Protective Factors, Opportunities and Challenges

Opportunities

Opportunities emerged across psychosocial domains as interconnected environmental and relational supports facilitating children's adjustment (see Table 3).

Key opportunities included safety and secure building, accessibility of services, and duration of support. A safe building was conceptualized within both the social-environmental and psychological domains. Its secure features and restricted access contributed to the social-environmental context, while also serving as an emotional resource that fostered children's sense of safety and security. Accessibility and sustained duration of support were highlighted as important for continuity, particularly in contexts of instability and transition.

Challenges

Challenges reflected disruptions across psychosocial domains and were primarily associated with transitions, relational loss, and emotional adjustment (see Table 4).

Table 3 Opportunity Themes and Illustrative Quotes

Domain	Codes	Primary Theme	Secondary Theme	Quotes
Psychological	Building	Safe building	Emotional safety	"environment that cares for them (…) it's a safe place for them to explore their emotions" (P15); "they know that they're safe when they're home here" (P8)
Social-environmental	Building	Accessibility	Onsite support	"all of the supports are in the building (…) the advantage here is having staff on site" (P5); "it's easily accessible" (P9)
		Safe building	Restricted access	"no one can access the building other than the people who live here" (P5)
	Support	Time, duration of support	Sustained support	"we have the luxury of time" *(P1);* "we see people on a regular basis" *(P2)*

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Table 4 Challenges Themes and Illustrative Quotes

Domain	Codes	Primary Theme	Secondary Theme	Quotes
Psychological	Building	Feeling different	Stigma	"feeling different living in a second-stage shelter (…) make them feel a little alienated (…) usually people don't have security guards and security cameras all around where they live" (P8); "stigma with the children living in second-stage". (P13)
	Moving	Transition	Adjustment and loss	"I have to explain to them this is just a chapter in your story (…) is just difficulty to end their relationship at the end" (P14)
Social-environmental	Moving	Transition	Adjustment and disruption	"it can feel like a very new adjustment and a new transition" (P7); "challenge would be moving away" (P6); "they don't understand why they're suddenly living somewhere different" (P12); "having to move schools is a big detriment" (P9)

Within the social-environmental domain, challenges included moving homes, changing schools, and adjusting to new environments, which were associated with disruption in routines and continuity of support.

Within the psychological domain, participants described experiences of stigma, feeling different, emotional distress, and loss. Importantly, there was variation in how strongly participants emphasized stigma, with some describing it as central to children's experience and others focusing more on emotional adaptation and relational disruption.

Improving Support Ideas

Participants' suggestions for improving support reflected psychosocial processes across psychological and social-environmental domains, highlighting the need for coordinated, continuous, and developmentally sensitive systems of care.

Within the psychological domain, ideas centred on the supportive closure of professional relationships. Participants varied in emphasis, with some focusing on emotional continuity while others prioritised structured endings in relational work. As P14 noted, "having those conversations (…) Just offering that support, but we have to flip the page". P13 described, "meeting from once a week…every two weeks, to once a month …a very gradual process".

Within the social-environmental domain, participants highlighted strengthening community partnerships, outreach, and service coordination. As P7 stated, "more conversations with child serving agencies", while P2 noted "improving our ability to complete outreach work with families", and P10 highlighted "making sure that those community connections happen soon while they move in with us".

Contextual Protective Processes and Inherent Tensions Shaping Children's Resilience

Participants highlighted several tensions inherent within the second-stage shelter context, where protective environments, relationships, and supports could also create challenges requiring careful navigation. These tensions reflected the complexity of resilience as a dynamic process shaped by both protective resources and the changing circumstances surrounding children's adjustment.

Safety and Stigma

Although safety was consistently identified as a central protective factor, participants also highlighted a tension between the protection provided by a secure shelter environment and the potential for shelter involvement to contribute to experiences of stigma or feeling different among some children. This reflected the dual nature of safety within the shelter context, where environments designed to promote protection may also influence children's experiences of adjustment and belonging.

Transition and Loss

Transitions were described as both protective and distressing. While moving to a safer environment represented an important protective response following experiences of violence, participants also identified associated losses, including disruptions to familiar relationships, environments, routines, and community connections. The ending of the program and

transition out of the shelter environment, while representing readiness to return to the community, were also recognised as involving new forms of loss, including the conclusion of newly established relationships and changes in familiar sources of support. This duality highlights the complexity of transition as both a pathway to safety and stability and an emotionally disruptive process requiring sensitive support.

Continuity of Care and Adjustment Over Time

Participants highlighted a tension between the importance of sustained emotional and professional support and the need to adapt support over time as children and families' circumstances change. While ongoing support was viewed as essential for children's stability and recovery, participants recognised the challenge of gradually adjusting services, relationships, and support networks while maintaining a sense of continuity. This tension was conceptualised as a developmental and relational adjustment process shaped by the balance between consistent support and evolving needs within the shelter context.

Summary of Key Patterns

Across the dataset, findings demonstrated both convergence and variation in participants' accounts. While participants consistently highlighted the importance of safety, stability, and professional support, the relative emphasis placed on specific protective processes differed across circumstances.

The biopsychosocial domains were understood as interconnected rather than discrete categories, with psychological and social-environmental processes most prominently represented within participants' accounts. Although less frequently discussed, the physical domain remained a foundational component of children's overall wellbeing.

Importantly, findings highlighted tensions across domains, particularly between:

- safety and stigma
- transition and loss
- continuity of care and adjustment over time

Collectively, these tensions demonstrate that protective processes are not inherently or uniformly experienced as beneficial, rather, their influence depends on children's needs, individual circumstances, and the broader physical, psychological, and social-environmental context. This reinforces a biopsychosocial understanding of resilience as a dynamic, relational, and context-dependent process and highlights the importance of interventions that remain responsive to children's and families' changing circumstances throughout recovery.

Discussion

Existing literature has consistently demonstrated elevated risks of physical, psychological, and social difficulties among children exposed to domestic violence,[8,13,31] while also highlighting the importance of protective processes in supporting resilience and adaptive functioning.[34,35] Within a biopsychosocial framework, resilience is understood as emerging through dynamic interactions among physical, psychological, and social-environmental processes rather than through isolated protective factors.[36,37] However, less is known about how these processes are understood and supported within second-stage domestic violence shelters, where children experience both increased safety and ongoing adjustment following separation from violence.

This study contributes to understanding children's resilience within this context by demonstrating that staff perceived resilience as developing through interconnected protective processes embedded within relationships, environments, and changing circumstances. Although protective processes were identified across all three biopsychosocial domains, psychological and social-environmental processes were substantially more prominent within participant accounts.

This pattern reflects the relational and contextual focus of second-stage shelter work, where children's adjustment is closely connected to experiences of safety, stability, caregiving relationships, emotional regulation, and access to responsive supports. Importantly, the lower visibility of physical processes within staff accounts does not indicate that physical health was considered less important, rather, physical processes were often embedded within broader

understandings of wellbeing, basic needs, and developmental support. These findings highlight the importance of maintaining a comprehensive biopsychosocial perspective while recognising how specific contexts may shape the processes that receive greater attention.

Protective Factors and Cross-Domain Resilience Processes

Across participant accounts, several protective factors emerged as particularly central within the second-stage shelter environment. Professional support, maternal mental health, parenting capacity, children's self-regulation, and safety were consistently identified as important contributors to children's wellbeing and resilience. These findings align with existing evidence linking caregiver wellbeing, supportive caregiving relationships, and children's regulatory capacities with improved adjustment following adversity.[35,39,42] However, this study extends previous work by illustrating how these protective factors operate in an interconnected manner within the specific context of second-stage shelter care.

A key contribution of this study is the finding that staff perceived professional support as a cross-domain protective factor. Rather than functioning solely as a discrete service intervention, professional support was perceived as operating across physical, psychological, and social-environmental domains by promoting stability, facilitating access to resources, strengthening caregiver capacity, and supporting children's adjustment during periods of transition. In this way, professional relationships functioned as an organizing mechanism through which multiple resilience processes were connected and sustained over time. This extends understandings of shelter-based support by suggesting that professional involvement represents not only the delivery of services but also a relational and contextual pathway through which multiple areas of need can be recognised, coordinated, and supported.[56]

The prominence of professional support also reinforces the relational and context-dependent nature of resilience following domestic violence exposure. Participants' accounts positioned resilience as emerging through ongoing interactions among children, caregivers, professionals, and the broader shelter environment. Professional relationships contributed to resilience by creating conditions in which children and caregivers could experience safety, strengthen relationships, develop coping strategies, and navigate transitions over time.

Similarly, maternal mental health, parenting capacity, and children's self-regulation were not described as independent protective factors but as interconnected processes that influenced one another across multiple domains of wellbeing. Participants' accounts highlighted how caregiver wellbeing shaped parenting, parenting supported children's emotional security, and supportive relationships and environments fostered children's developing capacity for self-regulation. Together, these findings underscore the biopsychosocial nature of resilience within second-stage shelters, where protective processes operate dynamically across individual, relational, and environmental levels.

Importantly, the contribution of this study extends beyond identifying individual protective factors, many of which have been well established in previous research. More significantly, the findings demonstrate how staff understood resilience within the second-stage shelter context as emerging through the dynamic interaction of protective processes. This perspective shifts attention from identifying which protective factors matter to understanding how they operate together within that context, framing resilience as a dynamic process that develops through children's relationships, everyday experiences, and the environments in which they live.

Psychological and Social-Environmental Processes

Within the psychological domain, participants elaborated on how these interconnected protective processes shaped children's adjustment following domestic violence exposure. Maternal mental health, parenting capacity, children's self-regulation, emotional wellbeing, and relational experiences emerged as central influences on children's recovery. Consistent with previous research, participants described children's emotional adjustment as closely connected to caregiver wellbeing and caregiving relationships.[39,41,42] Importantly, maternal mental health was not viewed as an isolated influence but as part of a broader relational system that shaped children's experiences of safety, connection, and emotional regulation.

Participants also identified parenting support and caregiver–child relationships as important pathways for promoting children's recovery. Strengthening parenting capacity and supporting relational repair were described as contributing to children's emotional security and greater stability following experiences of violence and disruption. These findings

reinforce the importance of family-centred approaches within domestic violence interventions, recognising that children's adjustment is closely connected to the wellbeing and caregiving capacity of their primary relationships. Second-stage shelters may therefore provide an important context for supporting both children and caregivers as they rebuild relational patterns and establish greater stability following violence exposure.

Children's self-regulation and coping capacities were similarly understood as developmental processes rather than fixed individual characteristics. Participants described these capacities as supporting children's ability to manage emotional distress, respond to uncertainty, and adapt to changes associated with relocation and family transitions. Rather than developing in isolation, self-regulation was perceived as being fostered through predictable environments, responsive relationships, and opportunities to practise coping strategies within the shelter context. This interpretation is consistent with resilience frameworks that recognize the reciprocal relationship between children's internal capacities and the external environments that support adaptive functioning.[36]

Social-environmental processes were highly prominent across participant accounts and represented a defining feature of how children's resilience was understood within second-stage shelters. Safety, stability, predictable routines, professional support, community connections, and nurturing relationships were described as creating the conditions necessary for children and families to move beyond immediate crisis and engage in longer-term recovery. These findings further illustrate the interconnected nature of resilience, with children's adjustment emerging through interactions among individual, relational, and environmental processes.

Safety and stability were particularly central within descriptions of the shelter environment. Participants described safety as extending beyond protection from ongoing violence to encompass predictability, emotional security, and opportunities for children to engage in everyday developmental experiences. Unlike emergency shelters, which primarily provide immediate crisis response, second-stage shelters offer longer-term residential support that enables families to establish routines, build relationships, and engage with integrated services over time. Participants viewed this continuity of care as an important strength of the shelter model, reducing barriers to support and allowing children's emotional, relational, developmental, and social needs to be addressed in a coordinated manner. These findings highlight how second-stage shelters provide not only physical protection but also the relational and environmental conditions that support children's adjustment and recovery through interconnected biopsychosocial processes.

School and peer relationships were recognised as valuable developmental resources. However, they were less consistently prioritised than more immediate protective processes within the shelter context. This should not be interpreted as suggesting that external relationships are less important for resilience. Rather, participants' accounts reflected the changing priorities of children and families during periods of transition, when safety, stabilisation, emotional adjustment, and rebuilding routines become more immediate concerns. As families establish greater stability, supporting children's reconnection with educational settings and peer networks may represent an important pathway for strengthening longer-term resilience and community integration.

Overall, the prominence of psychological and social-environmental processes reflects the realities of second-stage shelter work, where recovery occurs within a relational and transitional context. Children are not only adapting to the effects of past violence exposure but are also navigating changes in living environments, family structures, routines, relationships, and expectations for the future. Resilience within this setting is therefore shaped through ongoing interactions between children's developing capacities and the environments and relationships surrounding them, illustrating how changes within one domain have the potential to influence functioning across others.

Challenges, Transitions, and Tensions Within Children's Adjustment

Although the second-stage shelter environment was consistently described as protective, participants also highlighted challenges associated with children's adjustment throughout the shelter trajectory. Transition emerged as a central process shaping children's experiences, both when entering the shelter and when preparing to leave. These transitions involved changes in physical environments, routines, relationships, family structures, and expectations for the future. While movement into shelter represents an important protective response by reducing exposure to ongoing violence, participants emphasized that adjustment requires children to navigate multiple simultaneous changes.

Entry into shelter was described as a period of adaptation in which children became familiar with new environments, routines, and relationships while also processing experiences associated with domestic violence exposure and family disruption. Thus, movement toward safety did not necessarily eliminate distress, rather, it marked the beginning of a new adjustment process. Children may experience relief from violence alongside grief associated with leaving familiar homes, communities, schools, and relationships. This highlights the complexity of recovery following domestic violence, where protection and loss may occur simultaneously.

Similarly, transition out of shelter was described as an important developmental process involving both progress and adjustment. While leaving shelter may represent readiness to return to the community and increased stability, participants also identified potential challenges associated with changes in established routines, relationships, and sources of support. In particular, professional relationships developed within the shelter environment were described as meaningful sources of safety, connection, and consistency. Their planned ending may therefore represent another relational transition requiring preparation, developmentally sensitive communication, and attention to continuity of care.

The Complexity of Protective Environments: Safety, Stability and Change

A central interpretive finding of this study is that protective processes were not perceived as uniformly beneficial across all circumstances. Rather, the same conditions that supported children's resilience could also introduce new challenges requiring careful navigation. This was particularly evident in relation to safety, stability, and continuity of support.

Safety was consistently identified as a foundational protective process within the shelter environment. Secure buildings, restricted access, and confidentiality measures were essential in protecting children and families from ongoing violence. However, participants also identified a tension between safety as protection and safety as a socially visible aspect of shelter involvement. For some children, awareness of being in a shelter environment could contribute to feelings of difference, stigma, or disrupted belonging. This finding highlights that safety is not solely a matter of protection from harm but also a psychological and social experience. The same environmental features that create protection from external threats may shape children's perceptions of identity, normalcy, and connection. Importantly, this does not suggest that safety measures should be reduced, instead, it highlights the importance of considering how protective environments are experienced by children. Developmentally responsive shelter practices may therefore involve balancing necessary security with opportunities for children to experience belonging, inclusion, and everyday normalcy.

A similar tension was evident in relation to stability. Participants identified that predictable routines, consistent relationships, and a secure environment were essential foundations for children's recovery. However, stability within second-stage shelters is inherently temporary, requiring children and families to eventually adapt to new environments and support systems. Stability should therefore not be understood as permanence, but as a developmental foundation that enables children to regain security, strengthen coping capacities, and prepare for future transitions.

This perspective shifts understanding of resilience away from the idea that recovery occurs through the removal of adversity alone. Instead, resilience within second-stage shelters involves supporting children as they experience both protection and change. Sustained support, relational continuity, and gradual transitions may help children navigate these changes while maintaining a sense of security and connection.

Continuity of Care and Adjustment Over Time

Participants further highlighted the importance of balancing sustained support with the evolving needs of children and families throughout and beyond shelter residence. While ongoing emotional and professional support was viewed as essential for stability and recovery, participants also recognised that children must navigate changes in services, relationships, and support networks over time.

This tension reflects the developmental and relational nature of adjustment within second-stage shelters. Professional relationships may provide important sources of safety and connection, yet these relationships exist within a context where transitions and changes are inevitable Supporting children through these changes therefore requires attention not only to the availability of support, but also to how transitions are introduced, communicated, and experienced.

Together, these findings demonstrate that resilience within second-stage shelters is not simply a product of protective resources being present. Resilience emerges through the ongoing interaction between protective environments, supportive relationships, children's developing capacities, and the transitions they encounter over time.

Implications for Biopsychosocial Service Enhancement

Findings highlight the importance of strengthening integrated approaches that address children's physical, psychological, and social-environmental needs throughout the shelter trajectory. Rather than focusing on individual protective factors in isolation, service models may benefit from recognising that resilience emerges through interactions among multiple processes that shift in importance according to children's developmental needs, circumstances, and stages of adjustment.

Although physical processes were less prominent within participant accounts, they remain an important component of children's overall wellbeing. The limited visibility of physical health considerations may reflect the strong relational and psychosocial orientation of second-stage shelter work, where immediate priorities often involve safety, emotional adjustment, caregiving relationships, and family stabilization. However, given the established physical health impacts associated with domestic violence exposure, opportunities exist to further highlight the role of physical health within shelter-based models of care. Continued attention to physical health and wellbeing alongside existing relational and psychosocial supports may further enhance comprehensive biopsychosocial approaches to children's resilience.

Within psychological and social-environmental domains, findings reinforce the importance of continued investment in maternal mental health support, parenting interventions, children's self-regulation skills, and sustained professional relationships. Given the cross-domain role of professional support identified in this study, consistent and responsive relationships with shelter staff may represent an important mechanism through which children experience safety, connection, and continuity during periods of significant change. As these relationships often become an important source of security, services may benefit from intentionally preparing children for changes in these connections and providing opportunities for meaningful closure when support comes to an end. Findings also highlight the need for services to remain attentive to the tensions inherent within protective processes. While safety and structured support provide essential stability, they may also involve experiences of uncertainty, loss, and adjustment as children navigate new routines, living environments, and interpersonal relationships. Supporting children through these experiences may require developmentally sensitive approaches that help them understand the purpose and features of the shelter environment, adapt to changing circumstances, and make sense of their experiences through supportive conversations. Particular attention may be given to acknowledging and supporting experiences of grief and loss associated with changes in family relationships, transitions into and out of shelter, and the planned ending of important relationships with shelter staff. Ensuring continuity throughout the shelter trajectory may further strengthen these efforts. In addition to supporting children's adjustment within the shelter, coordinated planning for transition out of shelter, strengthened community partnerships, integrated service pathways, and gradual changes in service intensity may reduce disruption and help sustain supportive relationships and access to resources beyond the shelter environment.

Together, these findings suggest that resilience-oriented shelter practice requires attention not only to which protective resources are available, but also to how children experience and interpret those resources over time. Protective processes may be strengthened when they are responsive to children's developmental needs, relational contexts, and evolving experiences, recognising that the same supports that promote safety and recovery may also involve periods of adjustment, loss, and transition.

Conclusion

This study examined staff perceptions of how a second-stage domestic violence shelter supports children's resilience through a biopsychosocial lens. Findings indicate that staff understood children's resilience within this context as emerging through interconnected physical, psychological, and social-environmental processes, with psychological and social-environmental processes most prominently represented within participant accounts. Professional support, maternal mental health, parenting capacity, children's self-regulation, and safety emerged as central protective factors supporting children's adjustment and wellbeing.

A key contribution of this study is the identification of professional support as a cross-domain resilience process that connects multiple areas of children's wellbeing. Rather than functioning as an isolated service component, professional relationships were perceived as mechanisms through which children and families access resources, experience stability, strengthen relationships, and navigate changes. These findings extend understanding of resilience within second-stage shelters by demonstrating that protective processes operate through dynamic interactions among children, relationships, environments, and transitions over time.

Importantly, this study highlights that protective processes are not experienced as uniformly beneficial or independent from context. Safety, stability, and supportive relationships may provide essential foundations for recovery while also requiring children to navigate visibility, transition, relational change, and adjustment. Understanding these tensions is critical for developing trauma-informed and developmentally responsive approaches that support children not only during periods of shelter residence but also as they move through transitions beyond the shelter environment.

This study also highlights opportunities for strengthening biopsychosocial approaches within the second-stage shelter context. While psychological and social-environmental processes were most prominent within staff accounts, continued attention to physical health and developmental needs remains important for comprehensive support. Integrating physical health considerations alongside psychological and social supports may further strengthen biopsychosocial approaches to supporting children's resilience within shelter-based services.

Overall, this study advances understanding of children's resilience following domestic violence exposure by demonstrating that resilience within the second-stage shelter context is a dynamic, relational, and context-dependent process that develops through interactions among children, their relationships, environments, and experiences of adaptation. Importantly, the findings highlight that protective processes are not experienced in uniform ways. Conditions that promote safety, stability, and recovery may also involve adjustment, loss, and relational change as children navigate transitions within and beyond the shelter environment. Rather than reflecting the presence of protective factors alone, resilience emerges through the ways in which biopsychosocial processes interact and are experienced within a specific context. Recognizing this complexity may inform more integrated, developmentally responsive, and resilience-oriented approaches to supporting children and families following domestic violence exposure.

Several limitations should be considered. Findings reflect the perspectives of professionals working within a -single second-stage shelter and do not capture the experiences of children or mothers. Additionally, this study examined staff perceptions of resilience-related processes rather than directly assessing children's resilience, developmental outcomes, or changes in functioning over time. To protect organizational confidentiality, contextual characteristics such as shelter size, capacity, duration of operation, organizational structure, and its specific position within the regional service continuum were intentionally generalized or omitted, which may limit assessment of transferability to other settings. Nevertheless, the resilience processes identified may provide relevant insights for other second-stage shelters supporting children and families affected by domestic violence, while future research incorporating children's and caregivers' perspectives and diverse shelter contexts remains important.

Ethics Approval and Informed Consent

Ethical approval was granted on February 9, 2023, through the Sheffield Hallam University Faculty Research Ethics Committee (FREC) process which does not assign a number due to the volume of master's dissertations approvals annually.

For ethical scrutiny, a UREC2 Research Ethics Proforma for students undertaking low risk projects with human participants was completed. Moreover, a data management plan and a project safety plan (risk assessment) were concluded. Study commenced after the organization authorization and UREC2 approval.

Participants were priorly informed about the aims, methods, benefits, and risks of the study. Participants were also informed that they were free to withdraw at any time. Free, voluntary, and informed consent to participate was obtained from all individual participants included in the study.

Consent for Publication

The participants' informed consent included the publication of anonymized responses and direct quotes.

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References

1. Government of Alberta. 2023. Available from: https://www.alberta.ca/recognize-family-violence. Accessed July 27, 2026.
2. World Health Organization. *Violence Against Women*. WHO; 2024. Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women. Accessed July 27, 2026.
3. Statistics Canada. Trends in police-reported family violence and intimate partner violence in Canada, 2024: Statistics Canada; 2024. Available from: https://www.statcan.gc.ca/en/reference?MM=1. Accessed July 27, 2026.
4. Statistics Canada. Victims of police-reported family and intimate partner violence in Canada, 2021. Statistics Canada; 2022. Available from: https://www150.statcan.gc.ca/n1/daily-quotidien/221019/dq221019c-eng.htm. Accessed July 27, 2026.
5. Do HP, Tran BX, Nguyen CT, et al. Inter-partner violence during pregnancy, maternal mental health and birth outcomes: a systematic review. *Child Youth Serv Rev*. 2019;96:255–265. doi:10.1016/j.childyouth.2018.11.039
6. Costa Leite FM, Gabira FG, Freitas PA, et al. The consequences of violence during pregnancy for both fetus and newborn: a systematic review. *Rev Pesqui Cuid Fundam*. 2019;11(2):533–539. doi:10.9789/2175-5361.2019.v11i2.533-539
7. Chai J, Fink G, Kaaya S, et al. Association between intimate partner violence and poor child growth: results from 42 demographic and health surveys. *Bull World Health Organ*. 2016;94(5):331–339. doi:10.2471/BLT.15.152462
8. Holmes MR, Berg KA, Bender AE, et al. Effect of IPV on children's medical system engagement. *J Fam Violence*. 2022;37(8):1221–1244. doi:10.1007/s10896-021-00291-4
9. Wang E, Zahid S, Moudgal AN, et al. IPV and asthma. *Ann Allergy Asthma Immunol*. 2022;128(4):361–378. doi:10.1016/j.anai.2021.12.018
10. Berg KA, Evans KE, Powers G, et al. Exposure to intimate partner violence and children's physiological functioning: a systematic review. *J Fam Violence*. 2022;37(8):1321–1335. doi:10.1007/s10896-022-00370-0
11. Shalev I, Moffitt TE, Sugden K, et al. Childhood violence and telomere erosion. *Mol Psychiatry*. 2013;18(5):576–581. doi:10.1038/mp.2012.32
12. Esteves K, Jones C, Wade M, et al. Adverse childhood experiences: implications for offspring telomere length and psychopathology. *Am J Psychiatry*. 2019. doi:10.1176/appi.ajp.2019.18030335
13. Abordo P, Anastasov A, Bridgeman C, et al. Living through family violence in Australia: an integrative literature review of children's mental health outcomes. *Couple Fam Psychol Res Pract*. 2023. doi:10.1037/cfp0000243
14. Yetter AM. Mothers' IPV victimization and depression. *J Interpers Violence*. 2022;37(21–22). doi:10.1177/08862605211056731
15. Levendosky AA, Bogat GA, Martinez-Torteya C. PTSD symptoms in young children exposed to IPV. *Violence Against Women*. 2013;19(2):187–201. doi:10.1177/1077801213476458
16. Mishra AA, Christ SL, Schwab-Reese L, Nair N. PTSD symptom development and peer relationships. *Child Abuse Negl*. 2018;81:332–342. doi:10.1016/j.chiabu.2018.05.013
17. Edhborg M, E-Nasreen H, Kabir ZN. Impact of intimate partner violence on infant temperament. *J Interpers Violence*. 2020;35(21–22):4779–4795. doi:10.1177/0886260517717489
18. Geyer C, Ogbonnaya IN. Maternal domestic violence and infant emotional regulation. *J Interpers Violence*. 2021;36(3–4):1029–1048. doi:10.1177/0886260517739891
19. Roopnarine JL, Ong'ayi DMM, Krishnakumar A, et al. Maternal depression and IPV in families. *Am J Orthopsychiatry*. 2023;93(3):236–244. doi:10.1037/ort0000671
20. Silva EP, Emond A, Ludermir AB. Depression in childhood and IPV exposure. *Child Abuse Negl*. 2021;122:105305. doi:10.1016/j.chiabu.2021.105305
21. Chung G, Jensen TM, Parisi A, Macy RJ, Lanier P. Impact of intimate partner violence on parenting and children's externalizing behaviors: transactional processes over time. *Violence Against Women*. 2021;27(14):2576–2599. doi:10.1177/1077801220985125
22. Juan SC, Washington HM, Kurlychek MC. Breaking the intergenerational cycle of partner violence. *J Interpers Violence*. 2020;35(5–6):1158–1181. doi:10.1177/0886260517692996
23. Liu Y, Croft JB, Chapman DP, et al. Adverse childhood experiences and unemployment. *Soc Psychiatry Psychiatr Epidemiol*. 2013;48(3):357–369. doi:10.1007/s00127-012-0554-1
24. Liu M, Luong L, Lachaud J, et al. Adverse childhood experiences and homelessness outcomes. *Lancet Public Health*. 2021;6(11). doi:10.1016/S2468-2667(21)00189-4
25. Bender AE, McKinney SJ, Schmidt-Sane MM, et al. Childhood exposure to intimate partner violence and effects on social-emotional competence: a systematic review. *J Fam Violence*. 2022;37(8):1263–1281. doi:10.1007/s10896-021-00315-z
26. Bowen E. The impact of intimate partner violence on preschool children's peer problems: an analysis of risk and protective factors. *Child Abuse Negl*. 2015;50:141–150. doi:10.1016/j.chiabu.2015.09.005
27. Nicholson J, Chen Y, Huang C. Children's exposure to IPV and peer bullying. *Child Youth Serv Rev*. 2018;91:439–446. doi:10.1016/j.childyouth.2018.06.034

28. Boeckel MG, Wagner A, Grassi-Oliveira R. Effects of intimate partner violence exposure on the maternal bond and PTSD symptoms of children. *J Interpers Violence*. 2017;32(7):1127–1142. doi:10.1177/0886260515587667
29. Bowlby J. *Attachment and Loss. Vol 1: Attachment*. New York, NY: Basic Books; 1969.
30. Hazan C, Shaver P. Romantic love conceptualized as an attachment process. *J Pers Soc Psychol*. 1987;52(3):511–524. doi:10.1037/0022-3514.52.3.511
31. Kimber M, Adham S, Gill S, et al. Association between child exposure to IPV and perpetration in adulthood. *Child Abuse Negl*. 2018;76:273–286. doi:10.1016/j.chiabu.2017.11.007
32. Fraley RC, Roisman GI. Development of adult attachment styles. *Curr Opin Psychol*. 2019;25:26–30. doi:10.1016/j.copsyc.2018.02.008
33. River LM, O'Reilly Treter M, Rhoades GK, Narayan AJ. Parent-child relationship quality and later functioning. *Fam Process*. 2022;61(1):259–277. doi:10.1111/famp.12650
34. Alaggia R, Donohue M. Take these broken wings and learn to fly: applying resilience concepts to practice with children and youth exposed to intimate partner violence. *Smith Coll Stud Soc Work*. 2018;88(1):20–38. doi:10.1080/00377317.2018.1404282
35. Benavides LE. Protective factors in children and adolescents exposed to intimate partner violence: an empirical research review. *Child Adolesc Soc Work J*. 2015;32(2):93–107. doi:10.1007/s10560-014-0339-3
36. Masten A. Pathways to integrated resilience science. *Psychol Inq*. 2015;26(2):187–196. doi:10.1080/1047840X.2015.1012041
37. Cameranesi M, Shooshtari S, Piotrowski CC. Investigating adjustment profiles in children exposed to intimate partner violence using a biopsychosocial resilience framework. *Child Abuse Negl*. 2022;125:105453. doi:10.1016/j.chiabu.2021.105453
38. Engel GL. The need for a new medical model: a challenge for biomedicine. *Science*. 1977;196(4286):129–136. doi:10.1126/science.847460
39. Spearman KJ, Hoppe E, Jagasia E. Protective factors mitigating IPV exposure. *J Adv Nurs*. 2023;79(5):1664–1677. doi:10.1111/jan.15638
40. Yule K, Houston J, Grych J. Resilience in children exposed to violence: a meta-analysis. *Clin Child Fam Psychol Rev*. 2019;22:406–431. doi:10.1007/s10567-019-00293-1
41. Fogarty A, Wood CE, Giallo R, Kaufman J, Hansen M. Factors promoting resilience in children exposed to IPV. *Aust J Psychol*. 2019;71:375–389. doi:10.1111/ajpy.12242
42. Fong VC, Hawes D, Allen JL. Risk and protective factors for externalizing problems in children exposed to IPV. *Trauma Violence Abuse*. 2019;20 (2):149–167. doi:10.1177/1524838017692383
43. Molina AP, Skowron EA, Hackman DA. Maternal IPV exposure and parenting. *J Interpers Violence*. 2022;37(3–4):997–1022. doi:10.1177/0886260520922514
44. Skafida V, Devaney J. Risk and protective factors for children's psychopathology. *Child Abuse Negl*. 2023;135:105991. doi:10.1016/j.chiabu.2022.105991
45. Nam B, Kim JY, Bright CL, Jang D. Exposure to family violence and adolescent behavior. *J Interpers Violence*. 2022;37(7–8). doi:10.1177/0886260520960109
46. Miller LE, VanZomeren-Dohm A, Howell KH, et al. Social networks and adjustment in children witnessing IPV. *J Fam Issues*. 2014;35 (4):462–480. doi:10.1177/0192513X13478597
47. Ravi KE. Exposure to IPV and emotional-behavioral disability. *J Child Adolesc Trauma*. 2021;14(4):587–597. doi:10.1007/s40653-021-00367-9
48. Riina EM. IPV and child adjustment. *J Fam Psychol*. 2021;35(6):756–766. doi:10.1037/fam0000893
49. Erickson N, Julian M, Muzik M. Perinatal depression, PTSD, and trauma: impact on mother–infant attachment. *Int Rev Psychiatry*. 2019;31 (3):245–263. doi:10.1080/09540261.2018.1563529
50. Gentz S, Zeng C, Ruiz-Casares M. Role of resilience in children exposed to violence in Namibia. *Child Abuse Negl*. 2021;119:105087. doi:10.1016/j.chiabu.2021.105087
51. Auersperg F, Vlasak T, Ponocny I, Barth A. Long-term effects of parental divorce on mental health: a meta-analysis. *J Psychiatr Res*. 2019;119:107–115. doi:10.1016/j.jpsychires.2019.09.011
52. Brooke M. The effects of parental divorce and separation on children. *Can J Fam Youth*. 2023;15(2):139–145. doi:10.29173/cjfy29926
53. Howell K, Miller L, Lilly M, Graham-Bermann S. Fostering social competence in preschool children exposed to IPV. *J Aggress Maltreat Trauma*. 2013;22(4):425–445. doi:10.1080/10926771.2013.775986
54. Alberta Council Women's Shelters. *Building Informed Service Delivery in second-Stage Shelters*; 2017.
55. Women's Shelters Canada. *ShelterSafe*. 2021.
56. Maki K. Breaking the cycle of abuse and closing the housing gap: a mixed methods community-based study on second-stage shelters. *Can J Nonprofit Soc Econ Res*. 2023;14(2):7–29. doi:10.29173/cjnser619
57. Mackenzie N, Knipe S. Research dilemmas: paradigms, methods and methodology. *Issues Educ Res*. 2006;16(2):193–205.
58. Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine Publishing Co; 1967.
59. Smith JA, Flowers P, Larkin M. *Interpretative Phenomenological Analysis: Theory and Research*. London, England: SAGE Publications; 2009.
60. Hsieh HF, Shannon S. Three approaches to qualitative content analysis. *Qual Health Res*. 2005;15(9):1277–1288. doi:10.1177/1049732305276687
61. Assarroudi A, Heshmati Nabavi F, Armat MR, Ebadi A, Vaismoradi M. Directed qualitative content analysis: description and elaboration of its underpinning methods and data analysis process. *J Res Nurs*. 2018;23(1):42–55. doi:10.1177/1744987117741667
62. Del Rosso J. Researching the US politics of torture using qualitative content analysis. *SAGE Res Meth Cases*. 2018. doi:10.4135/9781526436795
63. Holloway I, Wheeler S. *Qualitative Research in Nursing and Healthcare*. 3rd ed. Wiley-Blackwell; 2009.
64. Gauntlett D. *Creative Explorations: New Approaches to Identities and Audiences*. London, England: Routledge; 2007.
65. Labinjo T, Ashmore R, Serrant L, Turner J. Use of zoom for qualitative data generation. *J Biogeneric Sci Res*. 2021. doi:10.46718/JBGSR.2021.10.000238
66. Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs*. 2008;62:107–115. doi:10.1111/j.1365-2648.2007.04569.x
67. Mayring P. *Qualitative Content Analysis: Theoretical Foundation, Basic Procedures and Software Solution*. Klagenfurt, Austria: Social Science Open Access Repository; 2014.
68. Elo S, Kääriäinen M, Kanste O, et al. Qualitative content analysis: a focus on trustworthiness. *SAGE Open*. 2014;4(1). doi:10.1177/2158244014522633
69. Singhal M. Being a traveller in qualitative research. *Psychol Stud*. 2014;59:316–320. doi:10.1007/s12646-014-0271-9
70. Ortlipp M. Reflective journals in qualitative research. *Qual Rep*. 2008;13(4):695–705. doi:10.46743/2160-3715/2008.1579
71. Sirris S. Researchers' role reflexivity. In: *Researching Values*. Palgrave Macmillan; 2022. doi10.1007/978-3-030-90769-3_12
72. Patton MQ. Enhancing the quality and credibility of qualitative analysis. *Health Serv Res*. 1999;34(5 Pt 2):1189–1208.

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