Children's exposure to intimate partner violence: an overview


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Children’s exposure to intimate partner violence: an overview

Jill R. McTavish*, Jen C. D. MacGregor, C. Nadine Wathen and Harriet L. MacMillan

Departments of Psychiatry and Behavioural Neurosciences and of Pediatrics, McMaster University, Hamilton, ON, Canada; Faculty of Information & Media Studies, Western University, London, ON, Canada; Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, ON, Canada

ABSTRACT

Children’s exposure to intimate partner violence (IPV) is associated with significant emotional impairment and other harmful effects. It is increasingly recognized as a type of child maltreatment, with outcomes similar to other types of abuse and neglect. Children can experience harm from exposure to IPV, even when not directly involved in, or a witness to, the violence between caregivers. This review, based on a synthesis of best available evidence, addresses the epidemiology of children’s exposure to IPV, including prevalence, risk and protective factors, and associated impairment, as well as strategies for identification, and interventions for prevention of exposure and impairment. Strategies for ensuring children’s safety are also discussed. The article concludes with guidance specific to mental health clinicians.

INTRODUCTION

Children’s exposure to intimate partner violence (IPV) is associated with significant emotional impairment and other deleterious consequences. It is increasingly recognized as a type of violence exposure with outcomes similar to physical, sexual, and emotional abuse, and neglect. Clinicians have an important role in responding to children exposed to IPV—from assessment to intervention or referral—regardless of child protection service (CPS) involvement. Our aim in this paper is to provide a comprehensive overview by addressing questions about children’s exposure to IPV that are of relevance to psychiatrists and other mental health providers. To do so we summarized recent high-quality research evidence for children’s exposure to IPV. Although we did not do a formal systematic review, we relied on searches conducted as part of a guideline development process to identify recent systematic reviews, meta-analyses and randomized controlled trials, where available, with evidence from non-experimental designs included only if no higher level of evidence was available. The databases Medline, Embase, CINAHL, PsycINFO, Sociological Abstracts and ERIC were searched for citations up to September 2015 to identify key studies and evidence syntheses.

WHAT IS CHILDREN’S EXPOSURE TO INTIMATE PARTNER VIOLENCE?

IPV is defined as any physical, psychological, or sexual harm committed by a current or former partner or spouse (Centers for Disease Control and Prevention, 2015). Physical harm can include physical aggression, such as hitting, kicking, or beating; psychological harm can include controlling behaviours, such as isolation from family or friends, financial control, or restriction of access to services; and sexual harm can include forced intercourse or other sexual coercion (Feder & MacMillan, 2015). While children’s exposure to IPV was previously referred to as ‘witnessing’ IPV, it is now recognized that harmful outcomes can result from the mere awareness of violence or potential violence between caregivers; a child does not have to witness harm between caregivers for there to be harmful outcomes (MacMillan & Wathen, 2014). For this reason we refer to children’s exposure to IPV, except in reference to specific studies that refer to children’s witnessing of IPV. It is also important to recognize that, while children’s exposure to IPV can be considered a form of psychological harm (Gilbert, Widom, Browne, Fergusson, Webb, & Janson, 2009), it is increasingly recognized as a distinct form of child maltreatment, as evidenced by its inclusion in worldwide mandatory
reporting legislation (Dubowitz, 2014; Mathews & Kenny, 2008).

While dating violence could refer to any partner combination, the use of this term normally refers to teen dating violence (Centers for Disease Control and Prevention, 2016). In this paper we focus on children’s (aged 18 years and under) experiences of violence between caregivers, rather than peers. It should be recognized that children can have diverse family structures; however, violence experiences from the perspective of same-sex couples and gender-diverse individuals are under-researched, and so much of the current IPV research is based on studies of violence against women by men (Ard & Makadon, 2011; Finneran & Stephenson, 2013). It is challenging to estimate rates of prevalence in same-sex and trans* populations due to differences in sampling methodology and definitions; however, research estimates that between 26–33% of gay men, 32–44% of lesbian women, 37–87% of bisexual men, and 61–91% of bisexual women experience IPV during their lifetimes (Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016). Much less research has been conducted on trans* individuals (Langenderfer-Magruder et al., 2016). A study in Massachusetts found that 34.5% of transgender participants reported receiving partner-perpetrated threats (Landers & Gilsanz, 2009) and data from the Gender, Violence, and Resource Access Survey indicates that 50% of transgender and intersex participants had been raped or assaulted by their partners (Courvant & Cooks-Daniels, 2003). Emerging research also indicates that trans* individuals experience significantly higher rates of IPV than do cisgender people (Walker, 2015; Wathen, MacGregor, & MacQuarrie, 2015).

What is its prevalence/incidence?

One of the challenges associated with determining prevalence of different types of child maltreatment is the lack of clear definitions. Estimates vary according to the definition used as well as the study methods, including approaches to administering questions and sampling procedures, among others (MacMillan, Jamieson, Wathen, Boyle, Walsh, Omura, et al., 2007). For example, measuring the incidence of children’s exposure to IPV is possible, but estimates are limited to cases reported to CPS; community-based surveys can estimate prevalence by asking adults about their childhood exposure to IPV, but these retrospective designs may be subject to recall bias (Hardt & Rutter, 2004). Self-reported questionnaires by children and adolescents offer the most accurate estimate of victimization, but there are numerous methodological, legal, and ethical issues that must be addressed when designing and implementing such approaches (Finkelhor, Vandermininden, Turner, Hamby, & Shattuck, 2014; Knight, Smith, Dubowitz, Litrownik, Kotch, English, et al., 2006; McClinton Appollis, Lund, de Vries, & Mathews, 2015; Ybarra, Langhinrichsen-Rohling, Friend, & Diener-West, 2009). For this reason we present a range of estimates. Even when considering these various methods, it must be recognized that all current estimates of prevalence likely underestimate actual rates of IPV experienced by children.

One of the most comprehensive approaches to estimating children’s exposure to IPV is the National Survey of Children’s Exposure to Violence (NatSCEV), which is a cross-sectional, national telephone survey of children in the United States (US) who are 17 years of age and under (for children under 10 the interview was conducted with the caregiver who was most familiar with the child’s daily routine and experiences). This survey was completed first in 2008 (NatSCEV I) and a follow-up study was completed in 2011 (NatSCEV II) (Finkelhor, Turner, Ormrod, & Hamby, 2009; Finkelhor, Turner, Shattuck, & Hamby, 2013). In the more recent NatSCEV II study, which used a nationwide sample of 4503 children, 17.3% of children had witnessed a parent assault another caregiver in their lifetime, and 6.1% of children had witnessed a parent assault another caregiver in the past year (Finkelhor et al., 2013). A review of adult retrospective self-reports similarly indicates that, conservatively, at least 10–20% of children are exposed to IPV yearly (Carlson, 2000).

Most of our global estimates about children’s exposure to IPV come from studies about women’s exposure to IPV from a current or past male partner (World Health Organization, 2005). While it is now recognized that bilateral violence, or common couple violence, is a common form of IPV (Johnson, 2006; Kelly & Johnson, 2008), the overwhelming burden of morbidity and mortality results from IPV committed against women by men. For example, in a systematic review about estimates of the prevalence of intimate partner homicide, Stöckl, Devries, Rotstein, Abrahams, Campbell, Watts, et al. (2013) found that 13.5% of homicides were committed by an intimate partner, and that this proportion was six times higher for homicides committed by men against women than by women against men. Attempts have been made to distinguish bilateral violence, which is considered a less severe form of violence, from battering or intimate partner terrorism, where the ‘partner uses violence and other coercive control tactics to attempt to take general control over his or her partner’ (Johnson, Leone, & Xu, 2014, p. 187).
With respect to global estimates of women’s exposure to IPV, the World Health Organization (World Health Organization, 2005) conducted a landmark study where 24,000 women from 15 sites in 10 countries were interviewed about their experiences with IPV. Findings from this research indicate that the proportion of women who experienced IPV in their lifetime ranged from 15–71%. The ‘deeper impact’ of these high prevalence rates includes the ‘traumatic effect on those who witness it, particularly children’ (World Health Organization, 2005, p. vii).

**What are the risk and protective factors?**

Similar to our knowledge about prevalence rates, a lot of what is known about risk and protective factors of children’s exposure to IPV comes from literature about women’s experiences with IPV (MacMillan & Wathen, 2014). Much of the research about women’s exposure to IPV is based on cross-sectional studies, which precludes inferences about causation. There has been more research focused on factors that increase the likelihood of women experiencing IPV, rather than factors that protect against their exposure to IPV. Available research on protective factors suggests that women with higher education levels are less likely to experience IPV and that men with higher education levels are less likely to be perpetrators of IPV (World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Other factors that protect against women’s experiences of IPV include experiences of healthy parenting as a child; having a supportive family; living within an extended family or family structure; belonging to an association; and women’s ability to recognize risk of sexual violence (World Health Organization & London School of Hygiene and Tropical Medicine, 2010).

Many risks for women’s exposure to IPV have been identified, and these have been usefully summarized according to an ‘ecological model’ in the World Health Organization’s report Preventing Intimate Partner and Sexual Violence Against Women (World Health Organization & London School of Hygiene and Tropical Medicine, 2010). In this model, risk factors are broken down into individual factors related to biological mechanisms and personal history; relationship factors, which address close relationships with peers, intimate partners and family members; community factors, or the communities in which the relationships operate, including schools, workplaces and neighbourhood; and societal factors, which include larger, macro factors, such as religious or cultural belief systems, societal norms, and economic or social policies (see Table 1).

Most identified factors associated with perpetration of IPV or victimization are found at the individual level; the least have been found at the societal level (World Health Organization & London School of Hygiene and Tropical Medicine, 2010). This is likely because of limited research about societal level factors, rather than the absence of relevant factors at this level. Identification of these factors (and protective factors) is necessary for the development of effective interventions to prevent IPV and associated impairment for adult victims of IPV and their children. Research into these factors is ongoing. For example, a recent review on risk factors also suggests that infertility and sub-fertility is a risk factor for women’s exposure to IPV in

<table>
<thead>
<tr>
<th>Table 1. Risk factors for IPV.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perpetration by men</strong></td>
</tr>
<tr>
<td><strong>Victimization of women</strong></td>
</tr>
<tr>
<td><strong>Individual factors</strong></td>
</tr>
<tr>
<td>Demographics</td>
</tr>
<tr>
<td>- Low income</td>
</tr>
<tr>
<td>- Low education</td>
</tr>
<tr>
<td>Exposure to child maltreatment</td>
</tr>
<tr>
<td>- Sexual abuse</td>
</tr>
<tr>
<td>- Intra-parental violence</td>
</tr>
<tr>
<td>Mental disorder</td>
</tr>
<tr>
<td>- Antisocial personality</td>
</tr>
<tr>
<td>Substance use</td>
</tr>
<tr>
<td>- Harmful use of alcohol</td>
</tr>
<tr>
<td>- Illicit drug use</td>
</tr>
<tr>
<td>- Acceptance of violence</td>
</tr>
<tr>
<td>Relationship factors</td>
</tr>
<tr>
<td>- Multiple partners/infidelity</td>
</tr>
<tr>
<td>- Low resistance to peer pressure from friends</td>
</tr>
<tr>
<td><strong>Community factors</strong></td>
</tr>
<tr>
<td>- Weak community sanctions</td>
</tr>
<tr>
<td>- Poverty</td>
</tr>
<tr>
<td><strong>Societal factors</strong></td>
</tr>
<tr>
<td>- Traditional gender norms and social norms supportive of violence</td>
</tr>
</tbody>
</table>

**Demographics**
- Young age
- Low education
- Separated/divorced marital status

**Exposure to child maltreatment**
- Intra-parental violence

**Mental disorder**
- Depression

**Substance use**
- Harmful use of alcohol
- Illicit drug use
- Acceptance of violence

**Relationship factors**
- Multiple partners/infidelity
- Low resistance to peer pressure from friends

**Community factors**
- Weak community sanctions
- Poverty

**Societal factors**
- Traditional gender norms and social norms supportive of violence
low- and middle-income countries (LMICs) (Stellar, Garcia-Moreno, Temmerman, & van der Poel, 2015), and a recent multi-country survey of men (n = 7806) suggests that, in some LMICs, their witnessing parental violence in childhood was the strongest risk factor for their perpetration of IPV in adulthood (Fleming, McCleary-Sills, Morton, Levtov, Heilman, & Barker, 2015).

In addition to the impacts described above, research suggests that children’s exposure to IPV can contribute to intergenerational cycles of violence. A meta-analysis by Stith, Rosen, Middleton, Busch, Lundeberg, and Carlton (2000) examined the relationship between exposure to IPV as a child, and later IPV experiences. The authors reported weighted effect sizes for the relationship between childhood exposure to IPV, showing a small effect (r = 0.08) for men later becoming a victim of IPV, and a medium effect (r = 0.35) for men later becoming a perpetrator of IPV. In a prospective study of adolescents (n = 213), Cui, Durtschi, Brent, Lorenz, and Conger (2010) found that exposure to either physical or verbal aggression in adolescence was positively associated with perpetration of abuse and victimization in adulthood. These findings correspond with the results of an earlier 20-year prospective study of children (n = 543) by Ehrensaft, Cohen, Brown, Smailes, Chen, and Johnson (2003), which suggested that exposure to IPV is a strong predictor of perpetrating IPV by both men and women, second only to risk for conduct disorder.

More recent reviews concerning the relationship between childhood exposure to IPV and perpetration of IPV or victimization in adulthood are conflicting. Gil-González, Vives-Cases, Ruiz, Carrasco-Portino, and Álvarez-Dardet (2008) reviewed what is known about the association between men being physically abused during childhood, witnessing marital violence as a child within the family of origin, or having an absent or rejecting father and the perpetration of IPV against women. The authors found an association between men’s childhood experiences of being physically abused or witnessing marital violence and later perpetration of IPV. The authors, however, noted that most of the studies included in their review were limited methodologically, in terms of study design (e.g. cross-sectional designs and retrospective reports) and external validity. A systematic review by Wood and Sommers (2011, p. 232) similarly suggests that while ‘there is some support for intergenerational transmission of IPV, from the children who witness it to men who perpetrate it and women who experience it, direct causation is not supported by the research’. The authors suggest that there may be a dose–response effect, where children who are exposed to IPV and other forms of child maltreatment are especially at risk for becoming either a perpetrator or a victim of IPV in adulthood (Wood & Sommers, 2011). Finally, a systematic review by Capaldi, Knoble, Shortt, and Kim (2012) on risk factors for IPV concluded that there is a low-to-moderate association between childhood exposure to IPV and later perpetration or victimization of IPV; however, the authors cautioned that much of the evidence was based on retrospective reports, and suggested that the association might be mediated by more proximal factors, such as the individual’s antisocial behaviour or adult adjustment (Capaldi et al., 2012).

Children’s exposure to IPV is not only associated with later risks of violence in adulthood, it is also associated with exposure to other forms of family violence in childhood. Using data from the NatSCEV study, Hamby, Finkelhor, Turner, & Ormrod (2010) showed that the odds ratio, or the odds that the child will experience other forms of family violence if they witness IPV, is 3.88–9.15, even after controlling for demographics. The rates of witnessing IPV if a child had experienced another form of maltreatment varies: 70.9% of sexually abused children witnessed IPV; 62.6% of neglected children witnessed IPV; 55.7% of physically abused children witnessed IPV; and 50.6% of emotionally abused children witnessed IPV. These rates indicate the need for mental health clinicians to complete careful history taking for both children’s exposure to IPV and exposure to other forms of child maltreatment, a process that is discussed further below.

What are the consequences of exposure?

There is substantial evidence linking children’s exposure to IPV with a wide range of serious consequences, including emotional, behavioural, physical, social, and academic problems (Bair-Merritt, Blackstone, & Feudtner, 2006; Kitzmann, Gaylord, Holt, & Kenny, 2003; Lourenço, Baptista, Senra, Adriana Basilio, & Bhona, 2013; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). In extreme cases of IPV, for example, where children are ‘caught’ in the physical violence between caregivers, children face serious physical harm including death; they can also suffer the psychologically damaging experience of losing a parent to domestic homicide (Bourget, Grace, & Whitehurst, 2006; Jaffe, Campbell, Hamilton, & Juodis, 2012). As described in the previous section, children exposed to IPV are also at increased risk for other forms of child maltreatment, which may compound their risk of impairment (Park, Smith, & Ireland, 2012; Sternberg, Baradaran, Abbott, Lamb, & Guterman, 2006; Teicher, Samson, Polcari, &
McGreenery, 2006; Wolfe et al., 2003). It is important for mental health clinicians, among others, to recognize that children’s exposure to IPV can be as harmful as other forms of child maltreatment (Kitzmann et al., 2003; Sternberg et al., 2006).

Evidence regarding one or more of emotional, behavioural, social, and academic problems associated with children’s exposure to IPV has been reviewed in four meta-analyses. Kitzmann et al. (2003) examined 118 studies on the psychosocial outcomes of children exposed to IPV. They reported that children exposed to IPV had significantly worse outcomes compared to children not exposed to IPV and that effect sizes were similar across internalizing (d = 0.50), externalizing (d = 0.43), social (d = 0.38), and academic problems (d = 0.52). The average study level effect size in this meta-analysis was d = 0.34, which is considered to be small (Cohen, 1988). An effect size of this magnitude suggests that ‘about 63% of child witnesses were faring more poorly than the average child who had not been exposed to interparental violence’ (Kitzmann et al., 2003, p. 345).

Wolfe et al. (2003) examined the association between children’s exposure to IPV and emotional and behavioural problems using 41 studies published between 1985–2003. In all but one study, children’s exposure to IPV was associated with emotional and behavioural problems, and no difference in association was found between the two types of outcomes. Neither age nor sex moderated the strength of associations. The aggregate weighted mean for internalizing and externalizing disorders reported in Wolfe et al.’s (2003) study can be translated into an effect size of d = 0.38 for internalizing symptoms and d = 0.42 for externalizing symptoms (Evans, Davies, & DiLillo, 2008), which is similar to effect sizes found in other meta-analyses (Evans et al., 2008; Kitzmann et al., 2003).

Evans et al. (2008) analyzed the relationship between children’s exposure to IPV and internalizing, externalizing, and trauma symptoms across 60 studies published between 1990–2006. They reported an effect between children’s exposure to IPV and increased internalizing (d = 0.48) and externalizing (d = 0.47) symptoms, as well as an even stronger association with trauma symptoms (although due to study sample sizes and heterogeneity this stronger association should be interpreted with caution). Moderator analyses revealed that the association between exposure to IPV and externalizing symptoms was stronger for boys exposed to IPV than for girls, but no other moderating effects were found.

Chan and Yeung (2009) examined 37 articles on the adjustment outcomes of children exposed to family violence (including exposure to IPV, but also physical or psychological abuse of children by parents) published between 1995–2006. They concluded that their findings were largely consistent with Wolfe et al. (2003) and Kitzmann et al. (2003). Unlike Wolfe et al. (2003) and Kitzmann et al. (2003), they found some variation in effect sizes across outcomes. Specifically, PTSD, internalizing, and externalizing problems were more strongly associated with family violence exposure, whereas outcomes related to perception or cognition of family violence, interpersonal relationships, and competence were less strongly associated.

Considerably less research has examined the physical health consequences of children’s exposure to IPV. In their 2006 review, Bair-Merritt et al. (2006) examined 22 papers reporting associations between children’s exposure to IPV and physical health consequences (including intermediate outcomes that directly influence physical health). They concluded that children’s exposure to IPV is related to increased adolescent and adult risk-taking behaviour (e.g. substance abuse) and is ‘likely’ related to under-immunization, but that there is insufficient evidence to draw conclusions regarding overall health status, use of health services, breast feeding practices, and infant weight gain. More recent evidence suggests witnessing intimate partner violence, like other forms of child maltreatment (Teicher, Dumont, Ito, Vaituzis, Giedd, & Andersen, 2004), may also be associated with physical changes in the brain (Choi, Jeong, Polcari, Rohan, & Teicher, 2012).

Despite noteworthy methodological limitations in the existing evidence base (e.g. mostly cross-sectional designs) as well as some discrepancies across studies (e.g. strengths of association and moderating effects) and areas of insufficient evidence, children’s exposure to IPV is well-established as a form of child maltreatment with harmful and long-term consequences for health and well-being. Nevertheless, there is also evidence that many children exposed to IPV are resilient. For example, Kitzmann et al. (2003) found that 37% of children exposed to IPV had outcomes similar or even better than children who were not exposed to IPV.

What is the best strategy to identify children?

Screening adult women, including those in pregnancy (O’Reilly, Beale, & Gillies, 2010), for IPV in healthcare settings remains prevalent in spite of lack of evidence about its ability to reduce recurrence of IPV or to improve health outcomes among women. A number of systematic reviews and randomized trials have concluded that screening women for IPV when they visit healthcare settings is not warranted (Feder, Ramsay,
Clinicians, however, should be aware of the signs and symptoms of children’s exposure to IPV in children seeking care, as well as indicators of IPV among parents or caregivers (MacMillan, Fleming, & Jamieson, 2010). (Other professionals, such as teachers, may also need to be aware of the signs and symptoms of children’s exposure to IPV in order to perform their reporting duties—discussion of this is found below.) Much of the remainder of this section discusses good clinical practice related to assessment and first response to children exposed to IPV, more details of which can be found in MacMillan et al. (2010) and Feder & MacMillan (2015).

Assessment of children for emotional and behavioural problems, which is part of diagnostic assessment for these conditions, must also include evaluation for exposure to all forms of child maltreatment, including exposure to IPV. During interviews with children and parents as part of a diagnostic assessment for emotional or behavioural problems, safety of the child and the abused caregiver is paramount (MacMillan, Fleming, & Jamieson, 2010). Each child and caregiver must be interviewed separately. When asking any patient about IPV, it is the clinician’s responsibility to ensure that the abusive partner or the parent cannot overhear the discussion; otherwise, individuals may be put at further risk.

Once they are speaking in sentences, even very young children can provide important information about their experiences (Hibbard, Barlow, & MacMillan, 2012), but questions should be tailored to a child’s age and developmental stage. The following are examples of general questions that can identify children exposed to IPV:

1. discussion of how people in the family get along, including questions about relationships and roles; (2) inquiry about family members’ safety (for example ‘do you feel safe at home?’) and ‘what about other people in your family, are they safe in your home?’), specifically asking about the child, each parent, and all siblings; (3) asking the child about any worries he or she might have generally, or about any family members; and (4) general inquiry about how much ‘yelling, hitting, pushing’ happens in the home, including discussion of what happens when ‘someone gets in trouble’ (MacMillan & Wathen, 2014, p. 381).

Confidentiality should also be discussed with the child, for example: ‘I will not tell anyone what you and I talk about without you saying it’s all right, unless it has to do with someone’s safety. Do you know what safety means?’ (Often the child, depending on the age, can provide an explanation. It is still helpful to clarify what you mean by safety.) ‘If you, or someone you know, is hurting themselves or being hurt by someone else, then that’s a problem with safety’ (MacMillan et al., 2010, n.p.). The clinician should explain to the child that they will decide together what information will be discussed with parents. Themes, rather than specific comments, can often be shared with the child’s permission.

Disclosures of IPV, either by a caregiver or a child, can be complicated by mandatory reporting legislation (Douglas & Walsh, 2015; Humphreys, 2008), which is discussed further below. In jurisdictions where mandated reporting of IPV exists, the limits of confidentiality should be explained to patients before they are asked about their IPV experiences (Feder, Hutson, Ramsay, & Taket, 2006; Feder & MacMillan, 2015). Parents who disclose that their child is exposed to IPV should be informed that a report is being made, or be involved in a joint report, with a few exceptions (e.g. if IPV is being committed by both parents or there is concern that a caregiver may flee with the child) (Hibbard et al., 2012).

When asking parents or caregivers about exposure to IPV, confidentiality and immediate safety are the top priorities (Feder et al., 2006). An appropriate assessment of a victim’s safety should include at minimum asking if it is safe for the caregiver and his/her child to return home. Other examples of safety consideration include: ‘(1) Has the frequency or severity of the violence increased? (2) Is the partner or ex-partner obsessed with the patient? (3) How safe does she (he) feel? (4) Does the partner or ex-partner have a weapon or access to one? (5) Has she (he) been threatened with a weapon?’ (Feder & MacMillan, 2015, n.p.).

Healthcare providers should be prepared to respond to caregiver disclosures in a supportive way, including validation of the experience and affirmation that violence is not acceptable, and should be familiar with
appropriate services in the community for referral (Feder et al., 2006). The World Health Organization guidelines for responding to IPV (World Health Organization, 2013), along with their clinical handbook for women subjected to IPV or sexual violence (World Health Organization, 2014), are excellent resources that include specific patient-centred and safety-oriented responses based on the best available evidence.

Efforts have been made to develop and test standardized tools for assessment of children exposed to IPV. Edleson, Ellerton, Seagren, Kirchberg, Schmidt, and Ambrose (2007) reviewed five such assessment tools and concluded that overall the tools were inadequate. For example, in some cases their psychometric properties were unknown, and they generally did not capture the range of experiences that children exposed to IPV may encounter. Most were not specific to exposure to IPV, but rather included items for other types of violence exposure as well. Following their review, Edleson, Shin, and Armendariz (2008) established their own 46-item Child Exposure to Domestic Violence (CEDV) scale as a reliable and valid tool, although the utility of this and other standardized approaches for clinical (as opposed to research) purposes is unknown.

**What is the best strategy to prevent exposure?**

The best way to prevent children’s exposure to IPV is to prevent IPV itself. Primary prevention of IPV generally refers to educational programmes for teens (Whitaker, Morrison, Lindquist, Hawkins, O’Neil, Nesius, et al., 2006), which is beyond the scope of this review. Primary prevention could also refer to media campaigns that attempt to increase awareness or change attitudes about IPV, but very few media campaigns related to IPV have been conducted, and their effect on violence rates is unknown (Whitaker, Baker, & Arias, 2008).

To date there is also insufficient evidence about how to best prevent re-exposure to IPV. Screening, while a potentially useful way to identify asymptomatic diseases early, has been found to be ineffective to prevent IPV recurrence (MacMillan et al., 2009; O’Doherty, Taft, Hegarty, Ramsay, Davidson, & Feder, 2014; Taft, O’Doherty, Hegarty, Ramsay, Davidson, & Feder, 2013). A recent systematic review indicates that—for women in shelters who were already exposed to IPV—there is some evidence to show that intensive advocacy may improve their everyday life in the short-term and reduce physical abuse 1–2 years after the intervention; however, there is no clear evidence that it reduces sexual, emotional, or overall abuse, or that it benefits women’s mental health (Rivas, Ramsay, Sadowski, Davidson, Dunne, Eldridge, et al., 2015). Heterogeneous and otherwise under-powered study designs precluded a further understanding of the benefit of advocacy interventions, especially in relation to the type of advocacy offered, the place it was given, and its benefits for women experiencing varying abuse severity.

Couples counselling for IPV is extremely controversial for several reasons, including the fact that involving victims in treatment implies that they are partly to blame for their experiences of violence; its usefulness may only apply to clear cases of bilateral violence where there is no evidence of psychological abuse, intimidation, or fear (Whitaker et al., 2008). A recent systematic review suggests that cognitive behavioural therapy for victims of IPV may be effective at reducing physical and psychological IPV, but not sexual IPV; however, small sample sizes and heterogeneity of interventions do not allow for firm conclusions (Tirado-Muñoz, Gilchrist, Farré, Hegarty, & Torrens, 2014).

There is some evidence to suggest that permanent (12 months) but not temporary (2 weeks) restraining orders can prevent re-exposure to IPV (Wathen & MacMillan, 2003); however, victims often do not obtain a restraining order due to fear of or threats of harm (Jordan, 2004). A recent meta-analysis indicates that overall treatment of perpetrators has mixed results but is generally not efficacious; the authors allow that future research could find different results if programme designers better delineate treatment contents, techniques, and methods (Arias, Arce, & Vilarino, 2013). It is also recognized that interventions directed at perpetrators of IPV need to account for differences in severity of abuse (for example, between bilateral violence and intimate partner terrorism), as efficacious programmes may not be effective across levels of abuse severity (Whitaker et al., 2008). Given the paucity of effective strategies for preventing IPV, research about preventing victim’s—including children’s—impairment is urgently needed.

**What is the best strategy to prevent impairment?**

As children’s exposure to IPV is an exposure rather than a symptom or disease, not all children experience impairment (Kitzmann et al., 2003). Nevertheless, given the increased risk for emotional and behavioural problems (Evans et al., 2008), it is essential that all children exposed to IPV undergo a thorough diagnostic assessment to determine if intervention is needed, as the potential for impairment, as discussed above, is significant (MacMillan et al., 2010). It is also important...
to assess whether exposure to IPV is ongoing, as clinicians may assume that this is the sole responsibility of CPS. As with other forms of child maltreatment (Feng, Chen, Fetzer, Feng, & Lin, 2012), the clinician may have a legal responsibility to report children’s exposure to IPV (discussed further below), but this must be separated from the clinician’s moral duty to respond to the child in need. Responses should involve an understanding of exposure and associated impairment, but also treatment for any mental health concerns, as well as considerations of appropriate recreational and educational activities, and requirements for ongoing protection (MacMillan & Wathen, 2014).

Interventions that have shown benefits in child outcomes based on results of randomized controlled trials include psychotherapeutic interventions, parenting skills and training, and advocacy plus psychoeducation (Howarth, Moore, Welton, Lewis, Stanley, MacMillan, et al., in preparation). Psychotherapeutic interventions evaluated with a randomized controlled trial include child–parent psychotherapy (CPP), trauma-focused cognitive behavioural therapy (TF-CBT), and community-based group therapies. Lieberman, Van Horn, and Ippen (2005) report of CPP for preschoolers (ages 3–5 years) and their mothers shows a short-term benefit in post-traumatic stress disorder (PTSD) symptoms for children and a follow-up study shows that these results were still evident after 6 months (Lieberman, Ghosh Ippen, & Van Horn, 2006). Cohen, Mannarino, and Iyengar’s (2011) report of TF-CBT for children (ages 7–14 years) indicates a short-term improvement in anxiety and PTSD symptoms, but not depression. Community-based group therapies have also shown improvement in child mood and self-esteem (McWhirter, 2011).

A parenting skills and training intervention directed at children (4–9 years) and their mothers suggests that improvement by the end of the treatment may be seen for externalizing problems and the number of children who meet the criteria for problem behaviour and oppositional disorder (Jouriles, McDonald, Spiller, Norwood, Swank, Stephens, et al., 2001; Jouriles, McDonald, Rosenfield, Stephens, Corbitt-Shindler, & Miller, 2009). Howarth et al. (in preparation), however, suggest that the findings of these studies must be interpreted with caution due to potential risk of bias due to low participant numbers (Jouriles et al., 2001) and unclear allocation concealment (Jouriles et al., 2009), respectively.

Psychoeducational interventions, such as trauma-focused psychoeducation, show mixed results, but generally indicate no benefit for internalizing symptoms, depression, PTSD or externalizing problems (Howarth et al., in preparation). Advocacy offered to mothers plus psychoeducation for children showed improvement in child’s self-worth at the end of the treatment (Sullivan, Bybee, & Allen, 2002); however, these results must be interpreted with caution because of potential for bias in the study design (Howarth et al., in preparation).

Other treatment types that have not been evaluated with a randomized design, such as play therapy (Kot, Landreth, & Giordano, 1998), must be evaluated with more rigorous methods before conclusions can be drawn. In summary, there is some evidence for a few mother and child or child-focused therapies for children exposed to IPV that suggest improvement in child behavioural and mental health outcomes.

What are the best strategies to ensure children’s safety?

Research about children’s safety when exposed to IPV is under-developed (MacMillan et al., 2013). Safety, as conceptualized by the World Health Organization and collaborators, can be defined as ‘a state or situation devoid of physical, material, or moral threats, which must lead to a perception of being sheltered from danger’ (Maurice, Lavoie, Chapdelaine, & Bonneau, 1997, p. 181). This definition involves both an assessment of objective and behavioural safety, as well as a subjective assessment of safety, or an understanding of one’s perceived feeling of safety. Safety can be considered a fundamental right of individuals and a pre-requisite for maintaining and improving health (United Nations Development Program, 1994). Responses to threat have been observed in children as young as 3–4 months of age (Miller, 2014). Associated neural responses to threat may place children of all ages at risk of developmental psychopathology and other negative health outcomes (Miller, 2014), making considerations of safety an important concern for clinicians.

Safety planning can be implemented by trained professionals as part of an intervention to address children’s exposure to IPV (Rizo, Macy, Ermentrout, & Johns, 2011); alternatively, safety planning may be informally discussed with children by caregivers who are worried about their safety in a violent environment. Safety planning for caregivers and children that is professionally driven may be directed at caregivers only (Glass, Eden, Bloom, & Perrin, 2009; McFarlane, Groff, O’Brien, & Watson, 2005), caregivers and children (Peled & Edleson, 1992; Thompson, 2011), or children only (Cohen et al., 2011; Lieberman et al., 2005; Lieberman, Ghosh Ippen, & Van Horn, 2006). The effectiveness of safety planning that is primarily
intended for caregivers is unknown, and the applicability of these strategies for children is unclear (MacMillan et al., 2013). Some have suggested that safety planning for women exposed to IPV should be offered by clinicians trained in IPV advocacy (Liebschutz & Rothman, 2012); however, the tensions between strategies for supporting women exposed to IPV and their children must be considered. Where mandated reporting of children’s exposure to IPV is in place, women may avoid services for fear that their children will be reported to CPS (Douglas & Walsh, 2015). Mandated reporters may also refuse to make reports about children who have been exposed to IPV due to confusion about what is considered reportable (Davidov, Nadorff, Jack, Coben, & Team, 2012) or for fear of further victimizing mothers (Douglas & Walsh, 2015). In cases where protecting a child involves risks to a caregiver (for example, a mother exposed to IPV), some authors have suggested the need to include separate advocates for child(ren) and the abused caregiver to address the safety needs of all concerned (Douglas & Walsh, 2010; Zannettino & McLaren, 2014).

Examples of structured, professional-driven interventions directed at children that involve safety planning include CPP (Lieberman et al., 2005, 2006) and TF-CBT (Cohen et al., 2011). It is important to recognize that, even when safety planning has been designed specifically for children exposed to IPV, the potential for children to experience discomfort and other negative effects as a result of the intervention must be considered. Peled and Edleson (1992), for example, discuss a support and education programme designed for children who have been exposed to IPV that included a protection planning component. The authors discussed how the time required for the children to feel safe in the group varied, and that the protection planning component in particular caused discomfort among some children. The authors speculated that the ‘concreteness of the protection plan may have forced the possibility of future violence into the consciousness of some children’ who were not currently living in an abusive environment (Peled & Edleson, 1992, p. 337). Most interventions for children exposed to IPV are currently directed at children who are no longer exposed to the offending caregiver; many professionals recognize this as a gap in service provision but worry about putting children who are currently exposed to IPV at increased risk for victimization (Howarth et al., in preparation).

In the absence of clear evidence about specific safety strategies that are appropriate to children exposed to IPV, MacMillan et al. (2013) have proposed some child safety principles and practical strategies, such as ensuring safety planning is developmentally appropriate, expanding the concept of safety beyond physical safety, and ensuring that safety emphasizes the need for adults, and not children, to take responsibility for violence (see Table 2). These principles and strategies attempt to minimize conflicting messages across safety initiatives; they were created in part to begin a dialogue with practitioners, researchers, and policy-makers about approaches to children’s safety. The need for developmentally appropriate information about safety for children exposed to IPV has been echoed by a recent report on domestic violence from the National Institute for Health and Care Excellence (National Institute for Health and Care Excellence, 2014).

Table 2. Child safety principles and practical strategies*.

- School-based prevention efforts should not focus exclusively on sexual abuse and should emphasize that any violence in the home is unacceptable; this will also de-stigmatize the secrecy about family violence.
- Broader the concept of safety so that it is not just a focus on physical safety, but on emotional, spiritual, and cultural safety.
- Provide information based on the age and developmental stage of the child.
- Frame messages to children within the context of general safety; calling for help; seeking a place of safety outside the home if there is danger inside the home; telling a trusted adult.
- Emphasize the need for adults, not children, to take responsibility for any violence.
- Anticipate possible harms, including increasing self-blame, reinforcing acceptance of violence, and the misapplication of advice in a range of dangerous situations (e.g. going to a locked room during a fire).
- Anticipate that exposure to IPV occurs even when parents are not co-habiting (e.g. following separation, during visitation).

*Reproduced from MacMillan et al. (2013) with permission.
judicial representatives (Wathen & MacMillan, 2013). Mandatory reporting laws arguably detract from this moral responsibility when clinicians assume that the needs of a child can adequately be met by CPS alone (Worley & Melton, 2013). For example, CPS workers may fear for their own safety when responding to IPV in the home (Fusco, 2013; Stanley, Goddard, & Christopher, 2002); some may not perceive themselves to be adequately trained in terms of how to best identify and respond to these cases (Fusco, 2013); and some may unintentionally collude with IPV perpetrators by focusing on the abused caregiver’s responsibility to protect the child (Humphreys, 2008). While outside of the scope of this paper, it is also important for clinicians to recognize that CPS’s involvement in the abused caregiver’s life is fraught and that having a child removed from the home is a devastating experience that may cause adult victims to cope with destructive behaviours (Humphreys, 2008; Kenny, Barrington, & Green, 2015; Nixon, Radtke, & Tutty, 2013; Nixon, Tutty, Weaver-Dunlop, & Walsh, 2007). More broadly, CPS may also not have sufficient government investment to ensure adequate responses to children in these environments (Cross, Mathews, Tommyr, Scott, & Ouimet, 2012; Humphreys, 2008), which further emphasizes the need for the clinician’s involvement in these cases.

A recent qualitative meta-synthesis of mandated reporters’ experiences with mandatory reporting (McTavish, Kimber, Devries, Colombini, MacGregor, Wathen, et al., forthcoming) suggests that clinicians must be informed about jurisdiction-specific legislation on child maltreatment, including if children’s exposure to IPV is reportable and what degree of harm is reportable (e.g. threatened harm vs ‘serious’ harm). The level of evidence that CPS requires to substantiate a report varies across jurisdictions; acquiring this knowledge will likely require discussions with the clinician’s local CPS (McTavish et al., forthcoming). For example, the duty to report may only be activated when the reporter feels that the child has experienced direct harm or at the very least has witnessed IPV (Davidov et al., 2012), or it may fall under considerations for reportable emotional abuse or neglect (‘failure to protect’) (Nixon et al., 2007). Consultation with CPS or expert colleagues about reporting duties is advisable. Clinicians must also remember that it is important to communicate their specific knowledge of the child or family to CPS. For example, clinicians are ideally suited to be involved in safety assessments for children and family members and should communicate to CPS about children’s risk of experiencing violence in the home, as well as any potential for escalation in violence (if known) (Hegarty, Taft, & Feder, 2008).

As specified in a recent clinical statement from the American Academy of Pediatrics, collaboration between clinicians and CPS is ‘essential’ for formulating a management plan for the child and to ensure close follow-up (Hibbard et al., 2012). Similar to responses for other forms of child maltreatment (Feng et al., 2012), in situations where a child’s exposure to IPV is ongoing, advocacy by the clinician on behalf of the child can help to ensure that the child’s needs are prioritized; it is also important for the clinician to ensure that the needs of the abused caregiver are addressed, as ending their exposure to violence is important in ensuring the safety of the child (Wathen & MacMillan, 2013). Legal duties of mandated reporters require that, if the clinician is concerned about ongoing risk from exposure to IPV for the abused caregiver, and consequently the child, then it is important that this is communicated to CPS. In doing so, as mentioned above, the clinician must recognize the importance of emphasizing the need to reduce the risk of IPV for the adult caregiver, as well as the child’s exposure.

What are specific considerations for mental health clinicians?

Mental health clinicians, including psychiatrists, should be aware of their patients’ history of trauma exposure throughout the life course. During the past three decades, there has been an emphasis on inquiring about history of child maltreatment, especially sexual abuse, as part of the psychiatric assessment of adult patients. It is equally important to include questions about childhood exposure to IPV, as well as current exposure, and to determine whether the adult patient has children or functions in the role of caregiver. The mental health clinician should have knowledge about IPV and its implications for mental health, as well as skills in responding to patients who have experienced IPV, including assessment of safety. In addition, he/she should know about appropriate services for those experiencing IPV, including shelters, outreach services, and social and legal resources (Stewart, MacMillan, & Wathen, 2013). Just as mental health clinicians assessing and treating adult patients should be aware of any children in the lives of their patients, clinicians working with children should have knowledge about the behaviour of caregivers with whom children have contact. Psychiatric assessment should include inquiry about IPV in the family and specifically between caregivers, as well as children’s exposure. If IPV is identified, the clinician should be able to discuss the potential impact of such violence on children, and be familiar with appropriate referral pathways, not only for the adult patient, but also for children.
Conclusion

Children’s exposure to IPV is a prevalent form of child maltreatment that is associated with significant, deleterious health outcomes. Clinicians have an important role in responding to children exposed to IPV, beginning with careful history taking and diagnostic assessment in a safe and private environment. Clinical trials suggest the effectiveness of several interventions for preventing impairment, such as specific psychotherapeutic interventions, parenting skills and training, and advocacy plus psychoeducation. More research is needed to determine the effectiveness of these interventions in settings beyond those studied in the trials. Clinicians’ involvement in cases where children have been exposed to IPV is imperative, regardless if a report to CPS occurs.

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Disclosure statement

The authors have no disclosures to submit.

Notes

1. Note, however, that a review by Kitzmann et al. (2003) found no difference in adjustment problems between children with exposure to physical violence as well as exposure to IPV and children with only exposure to IPV.

2. An effect size, the standardized mean difference between two groups, is a way of quantifying the magnitude of an effect, and, unlike significance level, is not influenced by sample size. Cohen’s (1988) d statistic is a measure of mean difference between groups that is often used in meta-analyses. Cohen (1988) hesitantly defined effect sizes as small ($d = 0.2–0.3$), medium ($d = 0.5$), or large ($d = 0.8–1.0$).

ORCID

Harriet L. MacMillan http://orcid.org/0000-0002-1223-706X

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