Children's exposure to intimate partner violence: Impacts and interventions

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Exposure to intimate partner violence is increasingly being recognized as a form of child maltreatment; it is prevalent, and is associated with significant mental health impairment and other important consequences. The present article provides an evidence-based overview regarding children's exposure to intimate partner violence, including epidemiology, risks, consequences, assessment and interventions to identify and prevent both initial exposure and impairment after exposure. It concludes with specific guidance for the clinician.

Key Words: *Behaviour therapy; Child abuse; Child welfare; Mental disorders; Spouse abuse*

L'exposition des enfants à la violence exercée par un partenaire intime : les répercussions et les interventions

L'exposition à la violence exercée par un partenaire intime est de plus en plus reconnue comme une forme de maltraitance de l'enfant. Elle est prévalente, s'associe à une atteinte importante de la santé mentale et a d'autres conséquences importantes. Le présent article contient un aperçu fondé sur des données probantes de l'exposition des enfants à la violence exercée par un partenaire intime, y compris l'épidémiologie, les risques, les conséquences, l'évaluation et les interventions en vue de déterminer et de prévenir à la fois l'exposition initiale et l'atteinte après l'exposition. Il se termine par des conseils détaillés pour le clinicien.

Exposure of a child or adolescent to any incident of violent or threatening behaviour or abuse between adults who are, or have been, intimate partners or family members is defined as a form of child maltreatment (1), and is associated with increased risk of psychological, social, emotional and behavioural problems. Intimate partner violence (IPV) includes not only physical aggression, such as hitting, kicking and beating, but also emotional abuse, through behaviours such as humiliation, intimidation and controlling actions (eg, isolation from family and friends). Previously, children were described as 'witnessing' IPV, but more recently, 'exposure to' is preferred because 'witnessing' was perceived by some to focus on direct observation. Children can experience the harms associated with IPV through awareness of violence between caregivers, even if they have never directly observed any acts of violence.

EPIDEMIOLOGY AND RISK FACTORS

In 2008, the Canadian Incidence Study of Reported Child Abuse and Neglect (2) found that 25,259 (34%) of the >85,000 substantiated investigations (weighted estimates) of child maltreatment were specific to exposure to IPV. However, as with IPV itself, official reports are known to underestimate the actual prevalence and incidence of this form of child maltreatment. A review of United States community studies estimated a yearly prevalence of 10% to 20% (3), similar to other reviews that put the range of adults who report having been exposed to IPV during childhood at 8% to 25% (1). Again, the type of reporting methods used in these studies has a significant impact on reported prevalence and incidence.

Risks for exposure to IPV are complex, involving the interplay of child-specific indicators as well as family and community factors. The Canadian Incidence Study of Reported Child Abuse and Neglect (2) reports the following factors, specific to the child's primary caregiver, as being associated with all forms of child maltreatment, including IPV: being a victim of IPV (ie, 46% of substantiated cases of child maltreatment occurred in situations in which the primary caregiver was a victim of IPV); having few social supports (39%); having mental health issues (27%); alcohol (21%) and drug abuse (17%); being a perpetrator of IPV (13%); physical health issues (10%); history of foster care/group home (8%) and cognitive impairment (6%). Household-level risk factors include: social assistance, employment insurance or other benefits (33% of substantiated cases of child maltreatment occurred in situations in which the household was in receipt of these income supports); one move in the past 12 months (20%); at least one household hazard (ie, drugs or drug paraphernalia, unhealthy or unsafe living conditions, weapons in the home) (12%); public housing (11%); and two or more moves in the past 12 months (10%) (2).

Although the present review focuses on information that is most relevant for clinicians practising in Canada, it is important to understand that IPV, and children's exposure to it, is a global health problem. The 10-country WHO study of women's health and IPV (4) identified a lifetime prevalence of one or more acts of physical or sexual violence as ranging from 15% to 71%. This study focused on women's health and, therefore, did not provide information about men's exposure to IPV. The most recent Canadian data indicate self-reported five-year prevalence of spousal violence against women to be 6%, and police-reported spousal violence against women to be 542 incidents per 100,000 women, almost four times higher than the rate for men (5).

HEALTH CONSEQUENCES OF CHILDREN'S EXPOSURE TO IPV

Adverse outcomes that result from exposure to IPV in childhood include an increased risk of psychological, social, emotional and behavioural problems including mood and anxiety disorders, post-traumatic stress disorder (PTSD), substance abuse and school-related problems in children and adolescents (6,7).

Children exposed to IPV are also at increased risk for physical, sexual and emotional abuse and neglect (8). In extreme cases,

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children face acute harm and even death, with up to 20% of filicide (especially paternal) cases involving a history of domestic violence (9); children experience significant loss and harm in the context of interparental domestic homicide (10).

The co-occurrence of exposure to IPV and other types of child maltreatment is high: 60% to 75% of families with abused women have children who are also abused (7). These children are more likely to have subsequent problems parenting and to maltreat their own children (11).

In addition to these direct consequences of children's exposure to IPV, there is also evidence that IPV in the home can attenuate positive effects of a specific nurse home-visiting program for first-time mothers (the Nurse Family Partnership), otherwise shown to be effective in reducing child maltreatment (12).

These negative effects may continue into adulthood and become part of an intergenerational cycle of violence (7), as outlined above (11). In addition, children exposed to IPV are more likely to experience violent dating and intimate relationships as adults (either as victims or perpetrators) (13).

IDENTIFICATION OF IPV AND CHILDREN'S EXPOSURE TO IPV

Two large randomized controlled trials (RCTs), one from the United States and one from Canada, demonstrate that universal screening of women presenting to health care settings does not reduce subsequent violence or improve their quality of life or health outcomes (14,15). While clinical guidance conflicts (16,17), current Canadian evidence-based practice guidelines do not recommend universal screening, focusing instead on a clinical case-finding approach to identifying women exposed to IPV (18). There are well-established demographic, and relationship- and partner-specific indicators associated with IPV, including: being young, being in a common-law (versus legally married) relationship or being separated; substance abuse by male partners, or unemployment/underemployment in male partners; and controlling behaviours by male partners. In Canada, being Aboriginal is also significantly associated with IPV exposure (5).

As with other types of child maltreatment, there is no evidence to justify screening children for exposure to IPV; however, as with IPV generally, it is important for clinicians to be alert to the signs and symptoms that children exposed to IPV may exhibit, as well as any indicators (as above) of IPV among their caregivers. Despite the lack of evidence for universal screening, assessment of children for emotional and behavioural problems needs to include evaluation of their exposure to all types of child maltreatment, including IPV. This is not screening, but rather specific history-taking that is part of the diagnostic assessment for these conditions (described below).

INTERVENTIONS

In this section, we review the available evidence regarding interventions that address identifying and preventing children's exposure to IPV, updating a previous review (19).

Assessment

When interviewing parents and children as part of a diagnostic assessment for emotional or behavioural problems, as well as when assessing injuries to the child, each caregiver must be interviewed separately, and general questions for the child about various exposures, including IPV, should be used (20). It is essential when asking any patient about IPV, even a general question about violence in the home, to do so with no one else present – overhearing any discussion about IPV by an abusive partner or parent could put the individual at risk. It is not uncommon for clinicians to interview parents together in taking their child's history about exposure to adverse experiences; however, this also is potentially risky and these interviews should be conducted individually. When asking caregivers about IPV, the clinician needs to be prepared to respond if IPV is disclosed, including showing support and inquiring about immediate safety. The clinician should also have some knowledge about appropriate community- and hospital-based referral services. Disclosure of violence in the home also has ramifications for mandatory reporting obligations (discussed below) and child protection professionals can provide information about referral services.

Further information regarding inquiring about children's exposure to violence as part of history-taking during a diagnostic assessment can be found in MacMillan et al (20). It is important that such questions be tailored to a child's age and developmental stage.

Evidence for preventing exposure to IPV

The most direct way to prevent children's exposure to IPV is through preventing or ending the IPV itself. Unfortunately, the field of IPV research is less evolved in terms of high-quality empirical studies evaluating interventions in adequate and generalizable samples, than that of other types of maltreatment. Several systematic reviews highlight the lack of evidence for preventing IPV (21,22) and, while advocacy-based interventions show promise in reducing IPV recurrence and improving quality of life, replication in larger and more diverse samples using rigorous methods is required (23,24). Similarly, evidence regarding interventions for common couple violence or female-perpetrated IPV is weak, and while there is some United States-based evidence that approaches, such as permanent restraining orders against abusive partners, may prevent recurrent abuse, programs for abusive partners have had mixed, but generally negative, results (25). Thus, the evidence for reducing children's exposure to IPV by reducing IPV itself is limited, and the relative benefits of women moving themselves and their children to escape IPV (into shelters, for example) is an area urgently in need of evaluation.

Evidence for preventing impairment from exposure to IPV

As reviewed above, few interventions directed at victims, couples or abusive partners have been proven to be directly beneficial in reducing IPV in population-based samples. The studies reviewed below provide recent clinical trial-level evidence of promising interventions for children exposed to IPV.

Lieberman et al (26) evaluated the effectiveness of child-parent psychotherapy (CPP) in mother-preschooler dyads in which the mother was a victim of IPV and had confirmed that the child had been exposed to this violence. The 36 dyads in the intervention group received weekly 60 min CPP sessions for 50 weeks, while the 29 control dyads received usual care. There was a significant improvement for the CPP group across time and, compared with controls, on the Child Behavior Checklist measures, reduced exposure to community violence and fewer diagnoses of PTSD. The positive effects of CPP on child outcomes persisted at the six-month follow-up (27).

While this was a well-conducted RCT with persistent positive effects at an initial follow-up assessment (six months), the sample was relatively small and was largely low and very low income. A subsequent reanalysis to examine whether the treatment was effective in the subsample of children exposed to four or more traumatic or stressful life events found CPP to benefit these high-risk children (28). These results, along with those of an initial efficacy trial comparing child-only to child-mother therapy

(versus controls) in a non-RCT (29), indicate that these forms of mother-child therapy in families in which children are exposed to IPV are promising and warrant further evaluation in larger and more diverse samples.

Jouriles et al (30) examined the effectiveness, among 66 families (mothers and children) recruited from women's shelters, of Project Support, an intervention addressing conduct problems in IPV-exposed children. In six assessment periods over 20 months following their shelter stay, children in the intervention group, which involved teaching mothers child-management skills and providing them with instrumental and emotional support, demonstrated greater reductions in conduct problems. Mothers in the intervention group also showed improvements, compared with controls, in parenting behaviours and psychiatric symptoms.

In a more recent trial, Cohen et al (31) evaluated a community-based trauma-focused cognitive behaviour therapy (TF-CBT) intervention, compared with usual community treatment, in 124 children with IPV-related PTSD symptoms. The TF-CBT group received enhanced combined child-parent sessions, in addition to the client-centred therapy model provided to the comparison group, including strategies such as psychoeducation, relaxation skills, cognitive coping skills and safety enhancement. These sessions also emphasized developing and sharing a narrative about the child's IPV experiences during joint child-parent sessions. Results indicated that TF-CBT improves children's IPV-related PTSD and anxiety symptoms.

In summary, there is emerging evidence that various forms of mother-child and child-focused therapies for children exposed to IPV show promise in improving children's behavioural and mental health outcomes. Similarly, emerging evidence regarding interventions to prevent youth from using violence in their relationships also show promise (32,33).

GUIDANCE FOR THE CLINICIAN

All clinicians working with children need to be familiar with the child protection laws about mandatory reporting when any form of maltreatment is suspected. Such laws are determined at the provincial and territorial levels, and the majority of Canadian jurisdictions include exposure to IPV in reporting requirements (34). When clinicians are uncertain whether specific behaviours between caregivers warrant reporting to a child protection agency, the clinician can contact the agency and anonymously discuss the case before making a decision about reporting. This is important because, with a few exceptions (such as concern that the caregiver may flee with the child), the parent who discloses that his/her child is being exposed to IPV should be informed that a report is being made. Ideally, such a report can be made jointly with the nonoffending parent, but sometimes the IPV is committed by both parents and, in such cases, the report needs to be made separately from the caregivers.

Mandatory reporting may raise concern that involvement of child protection could increase violence from the abusive partner. Over the past decade, child protection agencies have developed protocols and procedures that take into account the potential risk to children and the nonoffending partner of such investigations, and sometimes have a special team with expertise assisting families (34). It is important that clinicians communicate to child protection workers their knowledge of, and concerns about, any risk to the child and other family members regarding violence in the home, and potential for escalation in violence (if known) related to the involvement of child protection (35). For example, a clinician working with children is often best situated to work closely with child protection professionals in assessing older children independently regarding their safety and level of support. It is also important for clinicians to encourage parents who are experiencing IPV to consider the effects of such exposure on their parenting and assist them in accessing appropriate resources such as referrals to advocacy services.

As outlined in a recent clinical statement from the American Academy of Pediatrics about responding to psychological maltreatment of children (36), clinicians working with children at risk of, or exposed to, IPV need to ensure there is close collaboration among health care and child protection professionals. A management plan needs to be formulated that ensures close follow-up; when a child's exposure to IPV is ongoing, the clinician needs to advocate on behalf of the child(ren) to ensure those needs are prioritized. If the clinician becomes aware that a nonoffending parent has been unable to protect the child(ren) from exposure to IPV, it is important that this be reported to the child protection agency.

Box 1: Key messages

1. Children's exposure to intimate partner violence (IPV) is:
   - a prevalent form of child maltreatment, and includes being exposed in the home, directly or indirectly, to violent or threatening behaviour between caregivers (including physical but also emotional abuse, through behaviours such as humiliation, intimidation and controlling actions [eg, isolation from family and friends])
   - associated with increased risk of psychological, social, emotional and behavioural problems
2. Risks for exposure to IPV are complex, involving the interplay of individual as well as family and community factors. Individual-level risks include having few social supports, having mental health issues, and alcohol and drug abuse. Household-level risks include social assistance, employment insurance or other benefits, public housing, household moves and the presence of household hazards (ie, drugs or drug paraphernalia, unhealthy/unsafe living conditions, weapons in the home).
3. There is no evidence to support universal screening of women or children for IPV exposure; however, clinicians should be alert to signs and symptoms, as well as any indicators (as above) of IPV among their caregivers and, in such assessments, include questions regarding IPV and safety at home. Assessment must prioritize child and family safety.
4. The evidence for reducing children's exposure to IPV by reducing IPV itself is limited.
5. There is evidence that mother-child and child-focused therapies for children exposed to IPV show promise in improving behavioural and mental health outcomes.
6. Clinicians working with children at risk of or exposed to IPV need to ensure there is close collaboration among health care and child protection professionals, including regarding issues of mandatory reporting obligations.

CONCLUSION

Understanding IPV and being prepared with appropriate responses are essential skills for health care professionals caring for families. Evidence regarding the epidemiology, risk indicators and consequences of children's exposure to IPV establish it as a significant form of child maltreatment, with harmful and potentially long-lasting impacts on child health (Box 1). Emerging evidence on specific forms of mother-child and child-focused therapies in families where IPV is present offers hope that referrals from the clinic can improve the health and well-being of these children.

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