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Preventing and Responding to Children's Exposure to Intimate Partner Violence

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Introduction

In every country across the world, millions of children and young people (CYP) are being exposed to intimate partner violence (IPV) involving one or more of their caregivers or parents. IPV is a form of family violence, that refers to any behaviour by an intimate partner or ex-partner that results in physical, sexual or psychological harm, and includes physical aggression, psychological abuse and controlling, coercive behaviours. It can occur in any relationship regardless of gender or sexual orientation, although women, transgender and gender non-binary persons are at increased risk of experiencing IPV.[1]

Children's exposure to IPV has high human and economic costs. Children living in abusive households are at increased risk of negative physical and emotional health and educational outcomes across their lifespan.[2-4] The pain and suffering experienced by Canadian children as a result of IPV committed in one year (2009) was estimated to be associated with an economic cost of $235.2 million,[5] although the costs of the impact on children are likely to be much higher when the financial impact of responding to children and families is taken into consideration. More

recent data from the US estimates the lifetime costs associated with children's exposure to IPV in any given year as $55 billion, related to increased costs due to higher use of healthcare, increased crime and lost productivity.[6]

The scale and impact of this issue necessitates an effective response for children and their families. A comprehensive response includes prevention of IPV from occurring in the first place, detection of and early response to children's exposure to IPV to prevent recurrence, and support to limit or prevent ill effects once a child has experienced it.[7] Below is a summary of what is known in relation to each part of the response to children, as well as gaps in knowledge, evidence, and practice.

Subject

Awareness of a child that the caregiver on whom they rely for protection and comfort is experiencing IPV, can be extremely stressful for a child. Such exposure, even if not observed directly, is increasingly considered as a form of maltreatment, either as a form of emotional abuse or as a separate type of exposure.[7,8] It is important to understand that children can be exposed to IPV in many ways (e.g., seeing the aftermath of IPV, being told about IPV by a sibling, experiencing diminished parenting as a result of IPV); they do not need to directly see or overhear IPV to be impacted by its presence in their lives.[9-11]

Children exposed to one incident of IPV are more at risk of repeated exposure to the same type of violence,[12] and are at greater risk of experiencing multiple different types of victimisation. This is known as poly-victimisation.[13] One study found that of the children and young people who had witnessed IPV in the past year, 33.9% had experienced other types of maltreatment; among those who had been exposed to IPV sometime during their childhood, more than half (56.8%) had experienced other child maltreatment types. Children exposed to multiple types of victimization are more likely to experience negative outcomes than children experiencing none or one form of maltreatment.[14]

Problems

Children exposed to IPV are two to four times more likely to exhibit clinically significant mental health (MH) problems.[3] These include internalizing symptoms (e.g., anxiety, depression), externalizing behaviours (e.g., aggression) and trauma symptoms. While problems may not be severe enough to meet diagnostic criteria for a mental health disorder, they can cause significant

distress and functional impairment for CYP and their families.[3,15] It is well established that exposure to IPV in childhood and adolescence is associated with negative outcomes in adulthood, [16] which is mediated in part by early adjustment difficulties, particularly behaviour problems.[17]

Importantly, a number of studies have found that around 30% of children demonstrate resilient outcomes in the short to medium term, meaning they showed successful adaption in the face of significant adversity.[3] Differences in children's adaptation may in part be explained by the presence or absence of other adversities in children's lives, as well as children's, parents' and family strengths and resources.[18]

Research Context and Recent Findings

To avoid or reduce the distress and difficulties associated with exposure to IPV among caregivers, it is imperative that there are a range of effective strategies to prevent and respond to it.

Prevention of IPV and children's exposure to it

The most direct way of preventing the negative consequences of IPV for children is to prevent or end the violence itself.[19] To date there is insufficient evidence about how to prevent IPV from happening (and in turn children's exposure to it), for example by targeting societal- and community-level risk factors such as gender inequality and poverty.[19] There is also little evidence about the effectiveness of public awareness campaigns.[20] There is some evidence to suggest that educational and skills-based programs to prevent adolescent victimization (commonly referred to as dating violence), may be effective, in particular, programs that are delivered in multiple settings (e.g., community and school), which are longer in duration and involve key adults in adolescents' lives (e.g., teachers, community leaders).[21] However the evidence is equivocal with other reviews concluding that these interventions have little effect on the occurrence of relationship violence, or on attitudes, knowledge or skills that may be associated with relationship violence.[22]

Interventions targeting families experiencing or at risk of child maltreatment (e.g., home visitation and parenting programs), which include, but may not explicitly target families experiencing IPV, are effective in improving child outcomes,[7,23] although the benefit of these broader interventions may be attenuated for families experiencing IPV.[24,25] Advocacy interventions aimed at adult victims (mostly women) to prevent the recurrence of IPV (and therefore children's continued exposure) can be effective,[26] but evidence is lacking about the impact of these

interventions on children in the family.[7,27,28]

Identifying children exposed to IPV

Children may need specific interventions to help them recover from their exposure to caregiver IPV but must first be identified as needing support. Existing evidence on how best to identify children is generally weak and there is a lack of evidence to show whether identification of children is linked with better outcomes such as access to care and improved wellbeing.[29] In the absence of good evidence, it is suggested that professionals use a case-finding approach (rather than screening), which means being alert to the signs and symptoms that a child may be exposed to IPV and providing a tailored initial response based on the child's presentation and safety considerations.[29]

We have some knowledge about the barriers that parents and professionals face when identifying children who have experienced IPV. Caregivers who have experienced IPV may not recognize the impact on their children or they may think that their child was unaware of the violence. They may also be reluctant to seek help for themselves or their children due to fear of involvement with child protections services, and the fear that their children will be removed from their care.[28] Professionals working directly with children and families are generally uncertain about how to respond when they suspect exposure to IPV and are particularly unclear when the violence involves emotional, but not physical harm.[30-33] Evidence suggests that training programs aimed at improving the response of professionals to children who have experienced IPV may improve participants' knowledge, attitudes and clinical competence up to a year after the intervention,[34] and it is recommended that they should be made widely available.[35]

Assessment and referral

If children's exposure to IPV is suspected or confirmed, a qualified professional's assessment is required, followed by a referral to evidence-based interventions and subsequent follow up.[29] Given significant variation in children's adjustment following exposure to IPV, comprehensive assessment is important to guide decisions about whether intervention is appropriate and if so, what type would best meet a child's needs. Although a number of instruments exist to measure children's exposure to IPV, their utility in clinical contexts is largely unknown and there is no single measure that is appropriate across all settings, presenting symptoms or age groups.[29] When children's exposure to IPV is suspected, there is some evidence to suggest that reports

from multiple informants (e.g., child and parent) regarding exposure should be obtained when possible.[29] There are many well validated measures to assess children's physical and mental health and wellbeing,[36-38] and these can be used to identify current levels of functioning and appropriate referral pathways.

Targeted intervention after IPV has occurred

Reviews indicate that a wide range of interventions have been developed to improve mental health outcomes among children exposed to IPV and these vary in terms of their therapeutic model, focus, format and mode of delivery.[39-42] Program developers and researchers have focused primarily on the needs of IPV-exposed children by offering services to children directly, to caregivers who are mothers, or to both mothers and children.[40]

There is limited rigorous evidence to show whether any of these interventions are effective and if they address what children and caregivers find helpful.[39,42] Overall, there are relatively few studies that evaluate the outcomes associated with accessing an intervention following experience of IPV; the available evidence is limited by some important methodological limitations.[39,40,42] The practical implication of this is that interventions are currently delivered without strong evidence showing that they make a difference to children and families or do more good than harm.

Since it will take some years for evidence to catch up with practice, what options should practitioners offer in the meantime? Looking across reviews of interventions, there is some preliminary evidence that psychotherapy for young children, trauma-focused cognitive behavioural therapy, group-based interventions for mothers and children, and parenting skills training along with practical support for parents may offer some benefits.[29,39,41] However it is important to note that reviews, often using the same data, draw different conclusions, and replication studies are needed before stronger conclusions can be drawn.

Research Gaps

- To date, most interventions that aim to enhance child outcomes, focus on working with individuals and families. There has been little emphasis on the impact of strategies which aim to improve those conditions at community and societal levels (e.g., poverty) that are associated with increased risk of IPV. This work is urgently needed.
- Most interventions that aim to improve outcomes for children are offered to the non-abusing

caregiver (often mothers) only, children only, or mother and children together. There is limited evidence about the effectiveness of interventions for caregivers who commit IPV in terms of their impact on child outcomes.

- Most interventions have been developed to respond to children who have experienced IPV between cis-gender parents, and where the violence has been perpetrated by a male caregiver against a female caregiver. There is an absence of interventions that explore how to effectively support children experiencing violence occurring between gender-diverse caregivers or where the male caregiver has been victimized.
- Evidence is lacking about to how to effectively support children living with ongoing IPV between caregivers. Often these children are excluded from interventions and ongoing violence is not measured during interventions delivered in research settings, leaving a gap in our understanding.
- As with adult victims, little is known about how the outcomes of evidence-based mental health treatments are affected when therapy is delivered in the context of exposure to current or past IPV.

Key Research Questions

- Which interventions are effective in preventing IPV and children's exposure to it?
- What are the most effective strategies for identifying children who have experienced IPV?
- Which evidence-based interventions are cost-effective and acceptable for preventing or reducing harm once a child has experienced IPV?
- What type of support is appropriate and effective for groups of children who are underserved by current approaches to intervention?

Conclusions

Children's exposure to IPV is a significant public health problem that requires a comprehensive evidence-based response. Current evidence about the effectiveness for each part of the IPV response in improving child outcomes is limited. There is an urgent need for evidence-based approaches to know what works, for whom and under what circumstances.

Implications for Parents, Services and Policy

Children who live with IPV are victims in their own right, who may experience the consequences of such exposure throughout their lifetime. However, it is important to remember that poor outcomes are not inevitable. The strengths of parents, families and wider communities can protect children from negative outcomes.

Preventing children's exposure to IPV before they experience negative outcomes should be a priority; when interventions focus on reducing the impairment associated with IPV this should be coupled with ongoing efforts to prevent recurrence of children's exposure to violence. Providers should work to increase support for parent survivors in their efforts to keep their children safe, while recognizing that many parents are fearful of information being reported to child protection agencies.

Frontline healthcare and social service professionals need training and support to help them identify children who may be exposed to IPV in their families or who have sequelae from past exposure (See: https://vegaproject.mcmaster.ca/). Programs for children affected by IPV should be a priority among mental health services; it is essential to ensure that services supporting children and families experiencing IPV are available, accessible and evaluated to determine their effectiveness.[43,44]

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