



**RESEARCH BRIEF:**  
**Identifying and Responding to Children's Exposure to  
Intimate Partner Violence**  
**Fall 2016**

**What We Know**

- Children's exposure to intimate partner violence (CE-IPV) occurs when children are implicitly and/or explicitly aware of IPV between parents/caregivers; they may or may not directly "witness" it.
- CE-IPV results in a wide range of serious consequences including emotional, behavioural, physical, social, and academic problems, and is increasingly recognized as having outcomes similar to child physical, sexual, and emotional abuse, and neglect (Bair-Merritt et al., 2006; Lourenço et al., 2013). In Canada:
  - the 2012 Canadian Community Health Survey found 7.9% of adults across Canada retrospectively reported being exposed to IPV; exposure was narrowly defined as seeing or hearing a caregiver hit another at least three times, which likely explains the relatively low rate (Afifi et al., 2014);
  - the 2008 Canadian Incidence Study (Public Health Agency of Canada, 2010), which tracked over 15,000 child maltreatment investigations using a representative sample of 112 Canadian Child Welfare Service organizations, found that CE-IPV accounted for 34% of substantiated child maltreatment cases.
- Children exposed to IPV are at increased risk for other forms of child maltreatment, which may compound their risk of impairment (Park et al., 2012; Sternberg et al., 2006).
- Evidence from multiple systematic reviews suggests that children exposed to IPV are more likely to be perpetrators and victims of IPV in adulthood, although some evidence is conflicting (Capaldi et al., 2012; Gil-Gonzalez et al., 2008; Stith et al., 2000; Wood & Sommers, 2011).

*Identification of CE-IPV*

- Randomized controlled trials (RCTs) and systematic reviews have concluded that universal screening for IPV in healthcare settings is not warranted (e.g., O'Doherty et al., 2015). This conclusion is consistent with the World Health Organization's recommendation (WHO, 2013) that providers be prepared to ask about IPV when women present with clinical signs and symptoms, and offer first-line support.
- There is no evidence for screening children for IPV exposure. Providers should be alert to signs and symptoms in children (e.g., fearfulness, distress, aggressive or oppositional behaviour), and adults, which can fall into three sometimes overlapping categories (see [PreVAiL IPV brief](#)):
  - signs and symptoms directly related to IPV exposure (injuries, mental health issues such as depressive or post-traumatic stress symptoms, chronic pain);
  - behavioural indicators or cues on the part of victim (e.g., repeatedly cancels visits, increased use of health services, defers to partner in visit) and/or indicators that suggest an abusive partner (always present, answers for partner, other controlling behaviour, etc.);
  - specific evidence-based risk indicators (e.g., alcohol/drug misuse, financial strain, expressing traditional gender norms, etc.).
- Assessment of emotional and behavioural problems in children must include evaluation for exposure to all forms of child maltreatment, including CE-IPV.

- When discussing CE-IPV with caregivers and children, safety of the child and the abused caregiver is paramount (MacMillan et al., 2010; MacMillan et al., 2013). Providers must:
  - interview each child and caregiver separately;
  - ensure that the abusive caregiver cannot overhear the discussion;
  - assess safety, including at a minimum, asking if it is safe for the caregiver and child to return home.
- Disclosures of IPV, either by a caregiver or a child, can be complicated by mandatory reporting (MR) legislation (Douglas & Walsh, 2015; Humphreys, 2008). In Canada, only some provinces/territories include CE-IPV as a circumstance where a child is in need of protection, although it may be reportable under emotional abuse or neglect (Cross et al., 2012; Mathews & Kenny, 2008) (see [VEGA MR Brief](#)). Qualitative evidence suggests mandated reporters (including health and social service providers) are less comfortable identifying and responding to less overt forms of child maltreatment and that some are unsure about how to respond to CE-IPV (McTavish et al., under review). Providers should:
  - understand the mandatory reporting legislation relevant to their jurisdiction;
  - explain the limits of confidentiality to caregivers and children before they are asked about IPV (Feder et al., 2006; Feder & MacMillan, 2015);
  - inform non-abusing caregivers that a report is being made, or have caregivers 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).

#### *Interventions for CE-IPV (health care and community-based services)*

- Evidence supporting specific interventions for CE-IPV is generally lacking (McTavish et al., 2016; Rizo et al., 2011). Although some RCTs of psychotherapeutic interventions show benefits, results should be interpreted with caution due to the potential for risk of bias in some studies and the small number of studies evaluating each intervention:
  - child-parent psychotherapy (Lieberman et al., 2005) for children aged 3 - 5 and their mothers shows short-term benefit in post-traumatic stress disorder (PTSD) symptoms and a follow-up study suggests improvements for children remain at 6 months follow-up (Lieberman et al., 2006);
  - a study of trauma-focused cognitive behavioural therapy (TF-CBT) for children aged 7 - 14 found short-term improvements in anxiety and PTSD symptoms, but not depression (Cohen et al., 2011);
  - community-based group therapies for mothers and children have shown improvement in child mood and self-esteem (McWhirter, 2011);
  - a parenting skills and training intervention for children aged 4 - 9 and their mothers shows improvements for externalizing problems (Jouriles et al., 2001, 2009);
  - advocacy offered to mothers plus psychoeducation for children may improve children's self-worth (Sullivan et al., 2002);
  - some intervention approaches for CE-IPV (e.g., play therapy) have not been well-evaluated.
- The effectiveness of shelter services in reducing IPV and improving other outcomes for women and children remains understudied. The literature is characterized by methodological weaknesses (Wathen et al., 2014). Nevertheless, for women and children in crisis, shelters remain a crucial service.
- Children with diagnosed mental health problems (e.g., mood and/or behavioural disorders) should receive treatment in accordance with the WHO mhGAP intervention guidelines (WHO, n.d.), and/or national or profession-specific practice guidelines.



## **Practice & Policy Implications of Current Best Evidence**

- Based on currently available evidence, health care providers and settings should:
  - develop and implement protocols for referral of caregivers and children exposed to IPV, according to their needs, to local services;
  - be alert to the signs and symptoms associated with IPV and CE-IPV (as above) and ask questions about abuse when these indicators are present (case finding);
  - ensure that caregivers and children are asked about IPV in sensitive, safe, and appropriate ways and that their needs and safety are prioritized.
- Education of health care providers and settings is urgently required in both key health and social service university and college-level programs as well as in continuing professional education modules for health care providers already in practice (WHO, 2013; Wathen et al., 2009).

## **What We Don't Know – Research Gaps**

- Research evaluating the effectiveness of specific services and interventions for adults and children exposed to IPV remains a key priority (Wathen et al., 2012). Development of, and research on, new and promising interventions, as well as evaluation of existing services on child outcomes (including shelter and advocacy services), is urgently required.
- Further research on the effects of CE-IPV on children is needed, with particular attention to the potentially varying impacts of different types of exposure (e.g., exposure to physical IPV vs. psychological IPV, directly witnessing IPV vs. being aware of it, etc.).
- Safety planning strategies for children exposed to IPV (e.g., storage of contact information and resources, strategies for informing others) should be evaluated (MacMillan et al., 2013).

## **How to cite this document**

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## **For more information**

For more information: [www.PreVAiLResearch.ca](http://www.PreVAiLResearch.ca)  [www.projectVEGA.ca](http://www.projectVEGA.ca) 

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