

Screening & Intervention for Children Exposed to Family Violence

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Childhood exposure to family violence is epidemic in the US. In a recent national survey of childhood exposures to violence from the University of New Hampshire (NatSCEV), 8.4% of children were reported to have witnessed a family assault in the past year, with lifetime exposure for those aged 14-17 reported at 32%.¹ In special populations such as child welfare and juvenile justice, the rates of childhood exposure to violence between caregivers are much higher.^{2,3}

There are a variety of ways children can be exposed to family violence, with some children directly involved in violence and others seeing, hearing, and/or experiencing the aftermath of violence and its effect on parenting from caregivers. All types of exposure have the potential to profoundly impact children at every developmental stage. However, specific effects of violence exposure on children can vary across development, from fetal development to adolescence, with potential to interrupt children's attainment of developmental competencies and to negatively influence mental health.⁴ Studies of children exposed to family violence demonstrate a range of presentations, with some having psychological symptoms in the clinical range, some in the borderline range, and some apparently resilient.^{5,6}

Adverse childhood experiences (ACEs) including witnessing intimate partner violence (IPV) have been shown to increase risk for physical and mental health disorders in adulthood.⁷ Exposed children and adolescents are also at higher risk for mental health and behavioral difficulties in childhood, and show both externalizing problems (such as aggression and conduct disorders), and internalizing problems (such as anxiety and depression).^{6,8} For adolescents, risk for alcohol and drug abuse and depressed affect rises in a graded fashion as frequency of witnessing IPV increases.⁹ Mothers asked to describe the impact of family violence exposure on their children highlight aggression as well as other psychological, social, and school problems.¹⁰

There is an estimated
40%
CO-OCCURENCE RATE
of IPV & child maltreatment

There is significant overlap between exposure to intimate partner violence and other forms of child maltreatment, with co-occurrence rates estimated at 40%.^{8,11} A growing body of literature focuses on the devastating impact of polyvictimization, in which an individual child suffers multiple kinds of adversity. For children exposed to intimate partner violence in the original ACEs study the risk of other adverse experiences was 2-6 times higher, and as frequency of witnessing IPV

increased, so did risk for every category of adverse experience, including other forms of child maltreatment.¹² In one national survey, more than one third of youth who witnessed partner violence had suffered another form of maltreatment in the past year, and more than half had been otherwise maltreated in their lifetime.¹³ Polyvictimization is associated with reduced well-being, poor mastery and self esteem, and increased distress.¹⁴ Polyvictimization is more strongly associated with negative behavioral and mental health outcomes than any single type of victimization.^{3,15,16}

Protective factors can buffer the adverse effects of violence exposure. Paramount is a strong attachment to a caring adult.^{8,17} Protective factors include both social resources (peer, friend, and family support) and internal resources such as temperament, intelligence, spirituality, self-esteem and mastery.¹⁸⁻²¹ Child functioning after exposure to violence is strongly influenced by parent functioning; maternal mental health and parenting skills are associated with resilience in both preschool and school aged children.^{5,22,23} This highlights the importance of domestic violence advocacy services for caregivers, who can benefit from the support and connections these services provide.



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SCREENING FOR FAMILY VIOLENCE

The US Preventive Services Task Force recommends universal screening of women of reproductive age in healthcare settings.²⁴ Despite this recommendation and longstanding endorsement of routine screening by multiple medical professional organizations, there remain many barriers to routine screening in healthcare settings, with unique additional barriers in pediatric settings. Successful screening has been demonstrated in pediatric primary care²⁵⁻²⁸ and emergency department settings,^{29,30} and rates of positive screens in these settings range from 10-23%. Studies in healthcare settings collectively demonstrate the potential for identification and beneficial intervention for a vast number of families who may be unconnected to appropriate resources.³¹ There are of course important opportunities for screening in other child-serving sectors such as child welfare, education, law enforcement, the judiciary, and home visiting and early intervention programs. A public health approach with cross sector collaboration could lead to higher rates of identification and coordinated services for these most vulnerable families.

INTERVENTION

The evidence regarding interventions for children exposed to family violence is still developing. Both psychotherapeutic and group psychoeducational interventions for children have been shown to improve mental health and behavioral outcomes.³² Psychotherapeutic treatments for children and adolescents who have experienced trauma (including family violence) have been shown to reduce PTSD and associated negative mental health outcomes.^{33,34} Child-parent psychotherapy has been shown to reduce trauma and behavior symptoms for preschooler/mother pairs.³⁵ Group psychoeducational interventions for children with parallel interventions for mothers have been shown to reduce internalizing problems in preschool children³⁶ and both internalizing and externalizing problems in school age children.³⁷ Parenting and emotional support for mothers has been shown to reduce child conduct problems.³⁸ The offending parent should be held responsible for the violence and the relationship between the child and the non-offending parent must be supported as a priority.

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There is less evidence about which interventions increase resilience in children exposed to family violence, and an urgent need for more high quality research in this area.³⁹ Resilience has been defined as a dynamic process in which psychological, social, environmental and biological factors interact to enable an individual at any stage of life to develop, maintain, or regain their mental health despite exposure to adversity.³⁹ There is widespread recognition that supporting a safe, stable, nurturing relationship with a caregiver is the most important way to support resilience in children,¹⁷ underlining the importance of two-generation solutions focused on both

child and caregiver. The importance of mastery and self-esteem has also been emphasized with the observation that these measures of self regard are strongly influenced by family, peer, and community support.¹⁴ Work with high-risk adolescents shows that adoption of positive youth development practices such as engaging youth in decision-making and a focus on building on recognized strengths is associated with increased youth resilience.⁴⁰

Given that protective factors can buffer the adverse effects of violence exposure, it is critical that intervention strategies for children exposed to family violence include a focus on building protective factors for children at the individual, family, and community level. As polyvictimization is associated with reduced psychosocial resources,¹⁴ children who have suffered multiple adversities need increased attention to the development of protective factors. All children identified to have suffered adversity should have informed assessment to capture each child's situation and needs. An individual plan for the child should address treatment for any psychological symptoms, build on strengths, and increase protective factors with a goal of improving resilience. Finally, any plan to increase child well-being should include support for caregiver mental health and parenting including referral of caregiver to domestic violence advocacy services.

AVAILABLE SCREENING TOOLS

The US Preventive Services Task Force points to the following screening instruments as having demonstrated the highest levels of sensitivity and specificity for identifying IPV:

Hurt, Insult, Threaten, Scream (HITS)
(available in English & Spanish)

Ongoing Abuse Screen/Ongoing
Violence Assessment Tool
(OAS/OVAT)

Slapped, Threatened, and Throw
(STaT)

Humiliation, Afraid, Rape, Kick (HARK)

Modified Childhood Trauma
Questionnaire-Short Form (CTQ-SF)

Woman Abuse Screen Tool (WAST)

WAYS TO PROMOTE RESILIENCY

According to [Futures Without Violence](#)⁴¹, there are simple ways that parents can connect with a child and help them feel loved.

Play with the child - Find activities you can do together like reading a book, coloring, or playing a board game.

Listen to the child - Help the child feel heard, seen and valued.

Be a cheerleaders for the child - Tell the child that s/he is loved and encourage exploration of new activities that interest her/him.

Comfort the child - Provide support when the child is feeling scared or overwhelmed, including techniques such as taking deep breaths and counting to ten. Help the child identify other people and places that help them feel safe and supported.

Talk to the child about her/his feelings - Help the child label emotions and model healthy ways to express feelings.

Create calm and predictable environments - Help the child know what to expect whenever possible by creating habits and routines.

Set clear rules & expectations - Ensure clear expectations about acceptable behavior and use positive reinforcements whenever possible.

Create a network of support - It's ok to ask for support and give support back to other families when ready.



LISTEN



TALK



COMFORT

LEARN MORE AT www.ctccfv.org

NEED HELP?

Parents looking for help can call the statewide domestic violence hotline. Counselors are available 24 hours per day, 7 days per week. All services are confidential, safe and free.

888.774.2900
ENGLISH

844.831.9200
ESPAÑOL

The Children's Center on Family Violence is a partnership between Connecticut Children's Medical Center and Connecticut Coalition Against Domestic Violence. It was established in 2016 to respond to and reduce the number of children impacted by family violence through a trauma-informed, multidisciplinary, multiagency approach. Learn more about The Center and our work at www.ctccfv.org.

Endnotes

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