JOINING FORCES
Joining Families

FEATURED INTERVIEW

Children Exposed to Intimate Partner Violence: Concerns for their Physical and Emotional Safety

An interview with Melissa Kimber, PhD, RSW and Harriet MacMillan, CM, MD

Melissa Kimber, PhD, RSW *(top photo)*

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Harriet MacMillan, CM, MD
(bottom photo)

Harriet MacMillan, C.M., M.D. is a psychiatrist and pediatrician conducting family violence research. She is a Distinguished University Professor in the Departments of Psychiatry and Behavioural Neurosciences, and of Pediatrics at McMaster University. She holds the Chedoke Health Chair in Child Psychiatry and is a member of the Offord Centre for Child Studies. Dr. MacMillan's research focuses on the epidemiology of violence against children and women; she has led randomized controlled trials evaluating approaches to prevent child maltreatment and intimate partner violence. She was founding Director of the Child Advocacy and Assessment Program at McMaster Children's Hospital, a clinical program which addresses the needs of children who have experienced maltreatment. Dr. MacMillan was appointed as a member of the Order of Canada in 2016.

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Dr. McCarroll: Children's exposure to intimate partner violence (IPV) is increasingly recognized as a form of child maltreatment. Why should that be the case and how would you recognize it?

In This Issue

This issue of *Joining Forces Joining Families* (*JFJF*) features an interview with Melissa Kimber and Harriet MacMillan on children exposed to intimate partner violence (IPV). Separate articles address issues of the prevalence, evidence of harm, assessment, and interventions for children exposed. Additional articles describe the importance of the police response to IPV when children are exposed and the importance of emotional safety at home and at work. Our research methods article describes qualitative research, some of its procedures, and how it is often used. Websites of interest includes a wide variety of online resources that can be used to educate families about effects of IPV on children and resources for information and intervention.

Contents

The kinds of problems that you see in children who are exposed to IPV are similar to those seen in children who have experienced other types of maltreatment.

Dr. Kimber: The effects of children's exposure to IPV can really vary according to its intensity, its duration, and its frequency. The kinds of problems that you see in children who are exposed to IPV are similar to those seen in children who have experienced other types of maltreatment including physical abuse, sexual abuse, emotional abuse, and neglect. Some signs that might alert us to potential exposure to IPV are major shifts in the child's emotions and behavior. For example, some children display marked increases in aggression. Others could signal to us their exposure by becoming quite withdrawn from activities that they usually enjoy.

Dr. MacMillan: As well, children can manifest symptoms of posttraumatic stress disorder (PTSD). Sometimes people are expecting the full gamut of PTSD symptoms, and children may exhibit these, but often they have some symptoms of PTSD (which is separate from anxiety disorders), as well as symptoms of anxiety disorders, and/or depressive symptoms. In addition, there is the whole category of what we call the externalizing symptoms that you can see manifested among children exposed to IPV.

Dr. McCarroll: I have often seen in the literature that boys have externalizing symptoms and girls have internalizing symptoms. How consistent is that? Is that a good guideline for people or should they be on the lookout for both types of symptoms in both boys and girls?

Dr. Kimber: I think you are right. That is what the literature suggests. In Canada, as we have become more diverse, we have to think about gender differences, as well as cultural differences. Even though certain symptoms are more common among a certain gender – for example, externalizing symptoms among boys - girls also demonstrate externalizing symptoms. It depends on many factors, including the family context. Different types of symptoms may be exhibited by children depending on a range of factors, including genetic and environmental factors; an example of the latter would be parental response to certain behaviors.

Dr. MacMillan: It is important to think about the whole range of symptoms. If I am taking a history, I ask questions of the child and also of the parents that address both internalizing and externalizing symptoms regardless of the gender of the child.

Dr. McCarroll: How would you inquire about exposure to IPV when working with a child or family?

Dr. Kimber: We need to elicit information in a safe and respectful way. For any health professional interacting with children or adolescents and their families, I would suggest that they ask open-ended questions around the relationships within that home environment. I would ask, "Who is in your family?" "Tell me a little bit about how people get along in your family." For younger children, "If someone gets in trouble, what does that look like?" "What do your parents do for discipline? " "How might your parents let you know that you are in trouble?" "If your parents disagree about something, what happens?" "How do the other kids in your family [siblings] get along?"

Clinicians are more willing to ask about physical abuse. People can get behind that because it is often visible. We know that we are not supposed to hit one another. Where there is some tension, usually in the context of children's exposure to IPV, there is also a caregiver who is being exposed to violence and that is usually a mother. Mandatory reporting of children's exposure to IPV can be particularly difficult for mothers because they are also experiencing IPV at the same time that the child is being exposed to it in the family. The responses from the child welfare system, while variable,

Parents tend to underestimate the extent to which children are aware of and exposed to IPV. The behavioral and emotional effects of being exposed to IPV can be reduced by a warm and supportive relationship with a non-offending caregiver or another adult in the child or adolescent's life.

can potentially end up creating problems for the mother. That is an important factor that we have to keep in mind in this form of child maltreatment.

Dr. McCarroll: How do we keep track of children who have been exposed to IPV?

Dr. Kimber: It is not clear what child protection process is best for keeping track of children who have been exposed to child maltreatment or who are at risk for child maltreatment. What is most important is developing evidence-based effective intervention. We have an imperfect system. Mandatory reporting was rolled out and scaled up very quickly. There were good reasons for this such as the under-identification of maltreated children and the need to assess and ensure safety as quickly as possible. We are in different times now when there is much stronger recognition about the impact of reporting on child and family outcomes, and a willingness to question the extent to which it helps children who have experienced different forms of maltreatment. Entry into a registry can be stigmatizing. Mandatory reporting laws have increased the identification of child maltreatment, but we are unclear about the extent to which such identification actually improves child and family outcomes. It is really important that, once identified, these children are followed for safety reasons. We know that how agencies respond to different forms of child maltreatment can vary within and across jurisdictions. [*See text boxes on Army and Canadian policies for children exposed.*] This is particularly the case with children's exposure to IPV. We are just really starting to get a sense of its impact and how to address it, but we need some method of being able to check in with

kids. A key question is: how can we follow up to make sure children continue to be safe?

Dr. McCarroll: What are interventions for children exposed to IPV?

Dr. Kimber: The evidence comes across as weak. (See Howarth, Moore, Welton, et al., 2016). There are parenting interventions that improve family processes, but the extent to which they prevent or reduce IPV or children's exposure to IPV is unclear. If we have good and responsive parenting from the non-offending caregiver that will, hopefully, be protective in the context of IPV. But, we do not have any interventions yet where, for example, if a couple has risk factors for IPV and participate in an intervention, we can then expect that the likelihood of IPV in the home will be reduced.

Dr. MacMillan: We put a lot of emphasis on identification without the associated need for evidence-based intervention and the system support that is necessary.

Dr. Kimber: Children need caregivers who can respond to their needs in a safe environment. How we can mitigate these negative effects? The behavioral and emotional effects of being exposed to this form of violence can be reduced by a warm and supportive relationship with a non-offending caregiver or another adult in the child or adolescent's life. However, it is also important to remember that even when violence happens and the child or adolescent does not have a warm and supportive adult in their life, some kids really demonstrate remarkable resilience in the face of exposure to IPV and will not go on to develop negative health outcomes. We do not know the proportion, but from experience in my own clinical work and in research, I know there are children and adolescents who have had these experiences, yet do not go on to have the negative outcomes that we consistently see in the literature.

Dr. McCarroll: What would you do if you believe that children are resilient to their exposure to IPV?

Dr. Kimber: Let's say I find out a child was exposed to IPV and I was not seeing any kind of behavioral or emotional indicators that this has actually been an issue for them. They can be resilient in the period immediately following IPV, but I still think that safety trumps how the child currently is functioning. If someone made me aware that this child was being exposed to violence between their parents, even if the

Army Policies for Child Emotional Abuse or Neglect in the Context of Intimate Partner Violence

Army guidelines for establishing whether an incident of abuse or neglect meets its criteria are: (1) whether the act occurred and (2) the level of impact of the act on the victim. In incidents of intimate partner violence (IPV) that could involve children, two guidelines apply. First, child neglect may meet the criteria when the act of IPV is close enough in proximity to the child to create the risk of injury. In the second case, child emotional abuse may meet the criteria when the child is not exposed to the hazard (i.e., not close enough to the IPV to be harmed), but there is reasonable potential for psychological harm to the child. Regardless of whether the incident meets criteria for abuse or neglect, the Army offers treatment for children and families when there are clinical needs.

When there is IPV in the home, we can tell parents that they deserve a healthy and safe relationship, that you want to support them in a way that would be helpful and safe for them.

child was not demonstrating any emotional or behavioral problems, I would still have a duty to report this to child protection services. The importance of safety for their child is critical to me as a clinician.

Dr. MacMillan: When IPV is identified in the household, safety is really important. We need to look at how people are doing generally. A child who is living in a household where there is IPV deserves the opportunity to be assessed by someone who has experience in assessing mental health problems in children — for example, a family physician or a social worker — to understand what has happened, what they have experienced, and what problems they might be experiencing. The safety issues need to be paramount because we know that parents underestimate the extent to which their children are aware of and exposed to IPV.

Dr. McCarroll: What can you tell parents who have children about the risks to them from ongoing intimate partner violence?

Dr. Kimber: What we can do is offer validation that they deserve a healthy and safe relationship, that you want to support them in a way that would be helpful and safe for them. We can offer referrals for advocacy services, and assist them with safety planning. And if an individual is ready to leave an abusive relationship, we can support them to think about the safest way to do so, for themselves, and for their children.

Dr. McCarroll: What would you tell the offending parent about the potential involvement of child protection services?

Dr. Kimber: It would depend on the form of maltreatment exposure that has occurred. In the case of exposure to IPV, I would say something like the following: "Relationships can be

difficult and made even more challenging by stressors within and outside the home. In what you have told me, I have become concerned about the impact of the challenges at home on your child's well-being. When I have these concerns, I need to talk to child protection services about how best to support your child and your family. I would like for us to make the call to child protection together. Would you like to join me in making that call?" Asking the parent to join me for the call would depend on the information that I have been provided. For example, if I had met with the child and they said something to me that I felt child protection would need to know, but would also place the child at risk of harm, I would not ask the parent to join me. That would be the only reason that I would not ask a parent to join me for the phone call. As much as possible, I would answer any questions that the parent had, without making any absolute statements. In some cases, practitioners, to ease the tension that can arise with a child protection call, may tend to inadvertently say "I need to call child protection, but they probably won't do anything," or "Child protection will probably just talk with you," or "Don't worry, they won't take your kid away". Child protection responses to reports of child exposure to IPV can be variable and it is best not to predict what they will or will not do, but rather, to outline the different possibilities of response. We know that most of the time, a child is not removed from the home and child protection services do as much as they can to preserve the family system while ensuring the safety of the child/children. Finally, it is important to let the parents know about what you have been told from child protection, what will happen next (if they have been clear about this).

Dr. McCarroll: You have emphasized safety. Are you considering safety from a broader point than just physical safety? Children also observe relationships where there is emotional abuse between parents. Is that something that concerns you in addition to physical abuse between parents?

Dr. Kimber: Yes. We know that emotional abuse is just as harmful as physical abuse. For example, if I become aware of emotional violence between parents, I would take that as a safety concern and I would still contact child protection services. We know that emotional safety is important for healthy emotional and

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Canadian Policies for Accounting for Child Exposure to IPV

In Canada, legislation for child maltreatment is determined on a provincial/territorial (PT) basis. Most of the PTs include exposure to intimate partner violence (IPV) as a type of child maltreatment in their legislation, but even when it is not mentioned directly, it falls under the category of emotional harm (or risk of). The Canadian Incidence Study on Child Abuse and Neglect, which surveys child protection agencies about maltreatment approximately every five years, includes exposure to IPV as a type of child maltreatment. It is overseen by the Public Health Agency of Canada.

Exposure to Intimate Partner Violence: Effects on and Experiences of Children and Adults

By James E. McCarroll, PhD, Joshua C. Morganstein, MD, and Ronald J. Whalen, PhD

Exposure to IPV is a more appropriate term than witnessing as it includes children's presence, awareness of IPV between parents or caregivers and children's actual involvement in an incident.

Definitions of Exposures

Children's exposure to intimate partner violence (IPV) is increasingly recognized as a form of child maltreatment (McTavish, MacGregor, Wathen, & MacMillan, 2016; Wathen & MacMillan, 2013). There is no standard definition for clinical or research purposes of what constitutes children's exposure. Witnessing is a term that is commonly used to describe the concept of children's presence when IPV occurs. However, witnessing is too general a term as it implies or even specifies that the child must be present when IPV occurs. Exposure is the more appropriate term as it includes children's presence as well as a child's awareness of IPV between parents or caregivers and other circumstances such as children's actual involvement in an incident (MacMillan & Wathen, 2014). More specific definitions have been proposed including a taxonomy of 10 different types of exposure (e. g, child observes, participates, or overhears), nine characteristics of IPV as applied to children (e. g., types of IPV, nature of acts, and injuries), and six ways in which IPV victimizes children (e.g., terrorized, isolated, and emotionally neglected) (Holden, 2003).

The Canadian Incidence Study of Reported Child Abuse and Neglect in 2008 (CIS-2008) provided a profile of families with children 15 years and younger (n=2,184) who were receiving child welfare services in Canada where exposure to IPV was the sole reason for an investigation (Gonzalez, MacMillan, Tanaka, Jack, & Tonmyr, 2014). They found four mutually exclusive and exhaustive categories of child exposure: (1) indirect (overheard, but did not see IPV or saw its consequences), (2) emotional only (emotional violence between parents or caregivers), (3) direct only (child was present and witnessed physical IPV), and (4) co-occurring IPV (children were exposed to more than one type of IPV). The presence of mental or emotional harm was also counted as present or not present.

Non-violent coercive control is another type of exposure to IPV that is increasingly recognized as a form of child maltreatment. Research tends to emphasize controlling behaviors by fathers (or father figures) against the mother. These controlling behaviors include verbal abuse, restrictions of finances, isolation, and monitoring of her activities. Coercive control can also extend to the children. Examples are preventing them from spending time with their mother and grandparents, by monopolizing the mother's time, from visiting other children's houses, and from engaging in extracurricular activities (Katz, 2016). Threats of and harm to pets are other methods of coercive control (McDonald et al., 2015).

Epidemiology

Intimate partner violence is a worldwide tragedy. A review of 11 surveys estimated the prevalence of IPV for perpetration and victimization (Esquivel-Santoveña & Dixon, 2012). The 12-month rate of victimization of women was between 34.9% (Uganda) and 5.0% (China). The rate of victimization of men was between 12.3% (U.S.) and 5.0% (China). The authors also reported that during a 10-year period in the U.S., men's and women's perpetration and victimization remained relatively stable and symmetrical with approximately 12% of both engaging in physical violence including 4% severe violence. In addition, intimate partner homicide accounted for nearly one out of seven (13.5%; 39% females and 6% males) of all homicides in 66 countries between 1990-2011 (Stöckl et al., 2013). Global differences in IPV are important for greater understanding of its risk factors and other social indices of its origins.

Establishing the incidence and prevalence of children' exposure to IPV is difficult as IPV is underreported (McTavish et al., 2016). Worldwide, there are very limited data on children exposed to IPV. Studies have reported that underreporting is common by both parents and children. The UNICEF reported the estimated number of children exposed to IPV in the Americas, the UK, Europe, the Middle East, Africa, and the Asia-Pacific region (UNICEF, 2006). The number varied widely by country—from a few thousand (Iceland, 2,000 and New Zealand, 18,000) to several million (Pakistan, 6.1 million).

An estimate of children's exposure to all types of violence in the U.S. is the National

Children are not merely passive participants when there is IPV in the family. They often are actively involved physically and emotionally in attempting to understand the causes and consequences of IPV.

Survey of Children's Exposure to Violence (NatSCEV) (Finkelhor, Turner, Shattuck, & Hamby, 2015). The NatSCEV began in 2008 and has continued through 2014. It includes a representative sample of 4,000 children aged 0-17 years old. The NatSCEV, 2008-2011, found that a total of 17.3% of children had witnessed a parent assault another caregiver (e.g., witnessing a parent kick, choke or beat up another parent) in their lifetime and 6.1% in the past year (Finkelhor, Turner, Shattuck, & Hamby, 2013). Data from 2013-2014 found that 5.8% of children witnessed an assault between parents in the past year (Finkelhor et al., 2015). The percentage of children exposed was higher for females (7.4%) than for males (4.2%). The highest percentage by child age was for 2-5-year-olds (9.2) followed by 0-1 (7.1%) and 14-17 (5.9%).

Evidence of Harm

Some negative effects on children exposed to IPV include disturbances in attachment and emotion regulation (Carpenter & Stacks, 2009) conduct problems (Jouriles et al., 2018), internalizing problems such as depression, anxiety, suicidal thoughts, or self-harming behavior (Gonzalez et al., 2014), animal cruelty by children (Currie, 2006), and PTSD (Levendosky, Bogat, & Martinez-Torteya, 2013). The likelihood of traumatic symptoms in children changes across development and increases with child age and the number of symptoms increases with the frequency of IPV (Levendosky et al., 2013). The co-occurrence of multiple IPV subtypes was associated with increased odds for all child problems (Gonzalez et al., 2014).

Children are not merely passive participants when there is IPV in the family. They often are actively involved physically and emotionally in attempting to understand the causes and consequences of IPV. Children ages 7-12 whose mothers were receiving services at domestic violence agencies reported their thoughts and feelings on aggression in the home. Children often attempted to intervene in the violence and to withdraw. Both parents were seen as playing a role in the violence although they generally viewed the mother's partner as responsible. Lack of control of anger by the perpetrator was seen as the reason for the violence, but the children also reported that the victims provoked aggression. Sadness and anger were reported more frequently than anxiety (DeBoard-Lucas & Grych, 2011).

Effects on adults have included perpetration of IPV. However, evidence linking children's exposure to IPV and adult perpetration of IPV is limited in scope based on low methodological quality and is limited to studies of physical IPV (Kimber, Adham, Gill, McTavish, & MacMillan, 2018).

Whether exposed children will have a permanent negative outcome is not clearly established. In a review of resilience factors of exposed children, the secure attachment to a non-violent parent or other caregiver has been consistently found to be an important protective factor (Holt, Buckley, & Whelan, 2008). Other protective factors are positive peer and sibling relationships and self-esteem.

Interventions

Interventions for children exposed to IPV include procedures for (1) identifying and (2) preventing IPV (Wathen & MacMillan, 2013). However, evidence of effectiveness in preventing and decreasing IPV is limited. Interventions that have shown promise are addressing conduct problems in exposed children (Jouriles et al., 2009), and trauma-focused cognitive behavior therapy for children with PTSD related to exposure (Cohen, Mannarino, & Iyengar, 2011).

The question of what are good outcomes for exposed children (as well as other sources of trauma and distress) were evaluated in a larger review of clinical trials to measure the perceived benefits of interventions and the views of professionals, parents, and young people as to what constitutes a good outcome. Most trials evaluated symptoms whereas children, parents, and practitioners had broader concepts of success. Among these were functional outcomes such as school attainment, coping with challenge, self-expression, self-regulation, self-esteem, a sense of empowerment, and improvements in interpersonal contexts such as enhanced quality of the parent-child relationship (Howarth et al., 2015).

Assessment

There is no evidence to justify universal screening of children for exposure to IPV (Wathen & MacMillan, 2013) or for screening women for IPV in health care settings (Klevens et al., 2012; MacMillan & Wathen, 2014; MacMillan et al., 2009). Clinicians should, however, be alert to the signs and symptoms that children might exhibit as well as risk factors for IPV in their adult patients. Inquiry should be conducted as part of a history-taking diagnostic assessment

Addressing children's exposure to IPV is challenging for clinical and social service providers as well as policy-makers. Negative effects have been documented, but children also show resilience to negative outcomes.

using open-ended questions (e.g., "Do you feel safe at home?") and should be done individually to avoid putting the patient at risk for future violence or retribution. Disclosure of IPV requires inquiry into safety, but also support for the individual and consideration of referral to medical and community resources for evaluation and intervention. In addition, the clinician should be aware of local mandatory reporting policies and procedures.

Summary

Addressing children's exposure to IPV is challenging for clinical and social service providers as well as policy-makers. Negative effects have been documented, but children also show resilience to negative outcomes. Much is required of research to establish effects of different types of IPV at children's developmental stages as well as how to support the non-offending parent and the child. Increasing the awareness of parents and clinicians to the detrimental effects of children's exposure is also necessary through medical and social channels as well as public information campaigns.

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What is Qualitative Research and How is it Used?

By James E. McCarroll, PhD, Joshua C. Morganstein, MD, and Ronald J. Whalen, PhD

Qualitative research is an important technique for identifying areas for future empirical study. It can identify subtleties that broaden our understanding of the concepts under study.

Qualitative research is a major analytic technique employed in many types of research. There are many strategies for conducting qualitative research either as a unique approach to a question or in combination with or part of a larger study involving mixed research methods. In social research, it is used to understand such phenomena such as people's beliefs, experiences, attitudes, behavior, and interactions (Pathak, Jena, & Kaira, 2013). Qualitative research is an important technique for identifying areas for empirical study. It can identify subtleties that broaden our understanding of the concepts under study. Examples of qualitative procedures are found in studies involving interviews, focus groups, observations, and documentary material such as transcripts, case histories, and many other forms of written and spoken material. Applications of qualitative research can be found in diverse fields. For example, the chaplaincy can explore the meaning of experiences through conversations, written texts (journal, prayers, or letters), or visual forms (drawings and photographs) (Grossoehme, 2014).

Qualitative research procedures differ from those of quantitative research. Quantitative research is about measurement and its product is numeric; qualitative research generates non-numeric data such as themes that would be obtained from focus groups exploring a topic. For example, in the summary of police involvement with children exposed to intimate partner violence, Swerin (2018) suggested that interviews with police officers could explore why they may be less likely to arrest offenders when a child is present, why they are reluctant to speak with children, and what steps could be taken to reduce their concern (Swerin, Bostaph, King, & Gillespie, 2018).

Qualitative procedures can add dimensions that are not possible with numeric data in that participants can have a voice in the research that can enhance its quality. They can have an impact on data collection, analysis, and interpretation of results. Formal and informal interactions with the investigators can also have an effect on data collection, analysis, and interpretation of results as well as their experiences of benefits and harms (Pathak, Jena, & Kalra, 2013).

Comparison groups are often lacking in qualitative research due to the nature of the research. For example, in reviews of textual materials of homicides (e.g., law enforcement and medical examiner narratives), comparisons may be difficult to conceptualize (Holland, Brown, Hall, & Logan, 2015). However, in health research, comparisons are frequently possible and result in better research such as by understanding how experiences vary between groups on key variables. A review of 31 studies using qualitative research focusing on different health conditions found five different types of qualitative comparison groups (Lindsay, 2018). These were comparing (a) healthy controls, (b) no intervention or treatment, (c) two or more health conditions, (d) different aspects of a health condition, and (e) multiple perspectives of the same phenomenon. This review indicates that a variety of qualitative comparisons are possible and the possibility of comparisons should be considered when designing qualitative research.

Lindsay (2018) described some key steps involved in selecting and using a comparison group in qualitative research. These included (a) considering why and how having a comparison group would benefit the research, (b) consider matching by sociodemographic variables and other relevant characteristics, (c) in collecting data use the same design for both groups, (d) decide how to compare results within and between groups, and (e) in reporting the findings describe similarities and differences between the groups.

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Police Respond Differently to Intimate Partner Violence When Children Are Present

By James E. McCarroll, PhD, Joshua C. Morganstein, MD, and Ronald J. Whalen, PhD

Following an incident of IPV in which children may be involved, Army military police focus on building rapport with the children and ensuring that they are physically and mentally OK.

Police often encounter children when they respond to an incident of intimate partner violence (IPV). As reported in the accompanying interview in this edition of *JFJF*, children who are exposed to IPV are at risk for emotional and physical problems in childhood and in adult life. A study of police reports from 345 IPV incidents in a Northwestern U.S. city in 2013 found that children were present in 162 (47%) incidents. The average age of the children was 6.6 years and the average number of children present was 1.8. Most offenders were males (82%) and 56% were non-spouses. Thirty-nine percent of children present were under the age of four years. Police reported interacting directly with a child in 51% of cases where a child was four years old or older. That number increased with increasing child age.

Police-child interaction was recorded if the officer spoke directly to the child or to more of the children present. Child presence at an incident was a significant predictor of victim-directed intervention (e.g., referral, victim witness coordination) and victim-directed follow-up. However, victim follow-up decreased by 71% in cases of a female offender. Child presence decreased the likelihood of arrest by 50% due to officer discretion in not making the event more traumatic for the child.

The authors suggested that improvements to police responses to IPV incidents when children are present include increased training for officers in talking with children to help reestablish a sense of safety, to facilitate the healing process, and to improve children's attitude toward police. Strategies needed for police training could include increasing officers' willingness, comfort, and ability in talking with children after an IPV incident. Such approaches may help to reduce the trauma children suffer when they are exposed to IPV. Other suggestions as best practices were to identify and document the children in the home and their level of exposure to the incident, to speak with children at the child's eye level about what happened and what will happen next, and to assist with comforting the child.

Additional research needs are to determine the factors taken into consideration when responding to children exposed to IPV, and why officers are reluctant to speak with children. The authors suggested that collaboration is the key to an effective and comprehensive response to children exposed. In addition to the police response and to better police-community coordination, those who work with police might consider enhancing police education and training on responding to children exposed to IPV.

The Army trains military police personnel in methods to help children on the scene of an incident of IPV. Similar to the procedures suggested by Swerin (2018), the military police focus on building rapport with the children, asking what they were exposed to, and asking if they are physically and mentally ok. If they believe the children need a more thorough interview, they will refer the case for further investigation.

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An emotionally unsafe environment is one in which a child may feel unloved, unwanted, or serving only instrumental purposes for their caregivers.

behavioral adjustment in children and a healthy emotional environment is essential for their development. We know that if a home is not emotionally safe, it has negative consequences just as in homes that are not physically safe.

Health and social service providers may find it really challenging to identify and respond to emotional abuse and emotional neglect in children. If I were to extrapolate that to children's exposure to IPV, I think it is even harder to wrap one's head around the idea of children's exposure to emotional abuse between their parents or caregivers. How does one characterize that, and make a report to child protection services so that they would take seriously that there is a potential for harm?

Dr. McCarroll: Do you have a definition for emotional safety? I might think of it as freedom from threats, from coercion, from being exposed to yelling or harmful arguments.

Dr. Kimber: That is right. An environment where children are not emotionally safe is one where they may be feeling unloved, unwanted, or serving only instrumental purposes for their caregivers. A safe environment is one where a child is not living in the context of fearful, threatening, or controlling behavior that serves the purposes of the parent or the caregiver.

Dr. McCarroll: What would you say to parents when you fear for children's emotional safety?

Dr. Kimber: I would take a similar approach that I outlined above. I would not say, "I think you are emotionally abusing your child." Rather, I would say, "I have heard things from you and your child that make me concerned about

your child's emotional well-being." I would then provide some examples of what I have heard. For example, "I have heard that there is frequent name calling, yelling, or a lot of ignoring." We know that if a child experiences a pattern of inconsistent or harsh responses to their emotions, or overhears harsh communication between other family members, that this can lead to emotional and behavioral problems in children and adolescents. For this reason, I would then say something to the parent, like, "In meeting with you and your family, I have become concerned about the impact of these experiences on your child's well-being. When I have these concerns, I need to talk to child protection services about how best to support your child. I would like to make the call to child protection services together." Then I would continue with a similar process that I outlined previously.

Dr. McCarroll: This has been a pleasure. Thank you for your time and your work on this.

Dr. Kimber: You are welcome. Thank you for asking.

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Emotional Safety: An Important Human Need at Home and at Work

By James E. McCarroll, PhD, Joshua C. Morganstein, MD, and Ronald J. Whalen, PhD

Clinicians and other service providers are advised to consider emotional safety from their own perspective in terms of how they work with their family, clients, and staff within their organization.

In her interview in this issue or *Joining Forces Joining Families*, Dr. Kimber discussed emotional safety as part of a safe home environment for children. Emotional abuse of children may be considered an emotional injury leading to a lack of emotional safety. While physical abuse is easier to recognize and is more likely to receive the attention of child protective services, emotional abuse is more nuanced and difficult to detect. Lack of a standard definition of emotional abuse further complicates detection efforts. Emotional injuries can occur through coercion, threats, and belittling, as well as other forms of maltreatment. Results of emotional injury may include internalizing and externalizing symptoms, poor self-esteem, and guilt (Evans, Davies, & DiLillo, 2008; MacMillan, Wathen, & Varcoe, 2013).

Recognizing and providing emotional safety is also important in other human relationships. In addition to being an essential component of a child's home environment, emotional safety also can apply to other circumstances in which conflict may occur including nursing (de Castro, 2004), the workplace (Wang, Wu, & Huang, 2018), in intimate relationships such as in psychotherapy (Cathedral, 2012), and in research (Bowtell, Sawyer, Aroni, Green, & Duncan, 2013).

Physical safety is emphasized in organizations. However, emotional safety has been less recognized or fostered. Improved workplace safety has been related to emotional safety. Individuals can improve safety by taking responsibility for attention to safety issues and regulating their behavior accordingly and motivating others to do the same (Wang, Wu, and Huang, 2018). Proposed strategies for achieving an emotional safety culture were safety education and respecting and caring for organization members. Organizational and personal considerations of emotional safety are important to ensuring the staff that it is safe to practice and work.

Intimate relationships require emotional safety to be successful. In psychotherapy involving couples, emotional safety has been considered a key component of the therapeutic process. When couples feel emotionally safe, they can explore issues of conflict with the therapist. In this model, emotional safety is established through identifying emotional concerns underlying the couple's problems and then through maintaining esteem for each other and through secure attachment (Catherall, 2012).

In a more specialized psychotherapy, trauma-informed care, emotional safety has been included in addressing domestic violence services (Wilson, Fauci, & Goodman, 2015). Three components contributing to emotional safety in the provision of trauma-informed care are the physical environment, staff behaviors, and organizational policies. The physical space should help to establish emotional safety through having a home-like atmosphere, good security including good exterior lighting, and having quiet spaces to help establish calm. Staff should be accepting of survivor responses and be non-judgmental. Organizational policies should be clear and explicit about transparency and predictability about interactions with survivors. The climate of promoting emotional safety is a key element of establishing an overall sense of safety and the possibility of healing.

Qualitative health research can pose risks of harm to participants and to researchers through the emotional impact of in-depth interviews involving sensitive topics. Reflexivity and ethical mindfulness are strategies proposed for enhancing emotional safety (Bowtell, Sawyer, Aroni, Green, & Duncan, 2013). Reflexivity consists of identifying and considering the interactions between the researcher and the participant. Ethical mindfulness is having a non-judgmental attitude and open-mindedness to the present moment. There are also ethical challenges such as the blurring of boundaries when establishing rapport, confidentiality, and relationships with supervisors.
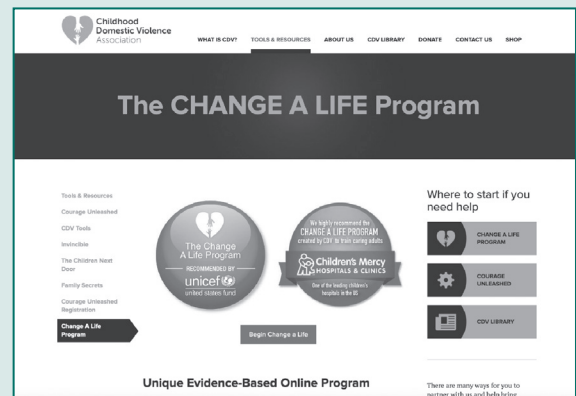
Children's exposure to intimate partner violence as well as other settings reviewed here illustrate that safety planning should include much more than physical safety (MacMillan, Wathen, & Varcoe, 2013). The similarities and differences in emotional safety and physical safety are important concepts for prevention and interventions involving risks as well as personal well-being. Clinicians and other service providers are advised to consider emotional safety from their own perspective in terms of how they work with their family, clients, and staff within their organization.

Websites of Interest

There are many websites that give information about how families can get help when intimate partner violence (IPV)/ domestic violence (DV) occurs. The Change a Life program teaches caring adults how to support a child. It is a free program consisting of four modules: learn, connect, support, and help. It features statements by noted researchers and extensive explanations of the concepts involved in children exposed to DV.
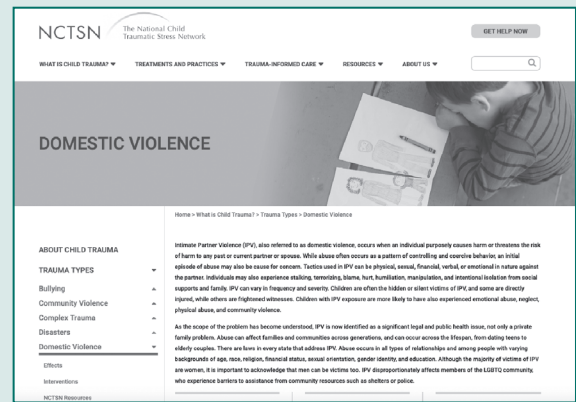**(See http://cdv.org/the-change-a-life-program)**

The National Child Traumatic Stress Network

provides a wide variety of resources including definitions and descriptions of the many types of child trauma and the effects of IPV/DV. There are resources for counseling and mental health interventions for families as well as information on how to help children in a family in which abuse is currently occurring or has occurred.
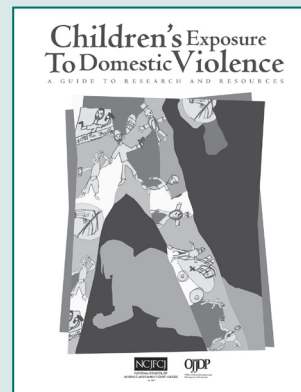**https://www.nctsn.org/what-is-child-trauma/trauma-types/domestic-violence**

The National Council of Juvenile and Family Court Judges and the Office of Juvenile Justice and Delinquency Prevention provide a manual for resources and research on children exposed to DV. This lengthy manual describes the impact of DV on children, legal issues and system responses (legal system, child protection, law enforcement) for children exposed, and additional information on national organizations, informational websites, and recommended reading on children exposed.
http://www.ncjfcj.org/sites/default/files/Childrens%20Exposure%20to%20Violence.pdf

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