Viewing Children’s Exposure to Intimate Partner Violence Through a Developmental, Social-Ecological, and Survivor Lens: The Current State of the Field, Challenges, and Future Directions

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Abstract
Although some children exposed to intimate partner violence (IPV) demonstrate resilience, the population-level health consequences of exposure across the lifespan and the related social and economic costs of such exposure are enormous. Using a developmental and social-ecological perspective, this article summarizes the literature examining the effects of IPV exposure on children, reviews key underlying mechanisms, and suggests the use of a public health prevention approach. It presents a discussion of next steps and identification of key challenges. One of the authors, a survivor of child exposure to IPV, presents a vignette that augments key sections and highlights children’s resilience.

Keywords
child exposure, intimate partner violence, prevention, lifespan, social ecology, resilience

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Speak Daughter Speak

Speak Daughter Speak,
I’ve been waiting to hear your voice.

Speak Daughter Speak,
The living waters are ready to burst forth.

Speak Daughter Speak,
The dam of pain, disappointment, and frustration has been broken.

Speak Daughter Speak,
Nations are listening,
Regions are listening,
Men are listening,
Angels are listening,
I AM Speaking!

I wrote this poem in 2011 and it continues to remind me that I am not called to be mute or a silent passenger of life and circumstances. I am called to activate what are mere words for someone else but keys to navigating life for me. Resilience has become a welcome friend. Speak Daughter Speak in itself is a form of resistance to a childhood trauma that held me silent, ashamed, angry, and yet, determined.—J. Catrice Brown

Each year an estimated 15.5 million children are exposed to intimate partner violence (IPV; i.e., watching or hearing the violence, involvement such as trying to intervene or stop the violence, or experiencing the aftermath of the violent event, such as seeing bruises; McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006), and one in four are exposed before the age of 18 (Finkelhor et al., 2009). Over half of these children are exposed to severe forms of IPV such as witnessing one caregiver physically assaulting the other or using a gun or knife against the other caregiver (McDonald et al., 2006). Furthermore, children’s exposure to IPV imposes a significant burden on localities, states, and society at large, made explicit over the child’s lifetime and over a wide range of behaviors and outcomes, including increased use of social services, health care utilization, educational outcomes, workforce productivity, and criminal behavior. It is estimated that an IPV-exposed child’s average costs to the national economy over their lifetime will reach nearly US$50,000, totaling over US$5 billion for all children exposed to IPV in the United States (Holmes, Richter, Votruba, Berg, & Bender, 2018).

Despite the evidence of the emotional and financial costs of child exposure to IPV, its subsummation under IPV generally has meant the lack of a nationally recognized comprehensive prevention plan, in contrast to other types of violence. To capture the most
recent evidence, this article reviews and summarizes the key child exposure to IPV literature in four substantive areas: (a) the negative effects of IPV exposure on children and youth; (b) the underlying mechanisms; (c) the protective factors promoting resilience; and (d) an overview of a public health approach to preventing child exposure to IPV. To illustrate each section, the personal story of the third author, a survivor of child exposure to IPV, is woven throughout the article. The inclusion of this personal story allows the unique experience of one individual to ground the reader in a review of 40 years of research. In addition, this story illuminates the resilience and experience of an African American woman, two elements that are central to her narrative. The story is noted in the text by indented paragraphs. This article concludes with a discussion of next steps for early intervention and prevention efforts and provides identification of key challenges in the field of child exposure to IPV for practitioners, researchers, and policymakers.

Negative Effects of Exposure to IPV: A Developmental Overview

Child exposure to IPV research began over 40 years ago with the first case study published detailing the negative effect of IPV exposure on children (Levine, 1975). Since then, hundreds of empirical studies have examined the relation between IPV exposure and a multitude of child outcomes, spanning from infancy through adolescence. In summarizing this literature, negative effects associated with IPV exposure have been identified in six broad domains, including behavioral, mental health, cognitive, social, physical health, and physiological outcomes. These domains are discussed below by discrete developmental time periods.

Infant and Toddler (Birth to 2 years)

Only a handful of studies have been conducted examining the effects of IPV exposure on infants and toddlers. IPV exposure significantly increases the odds of not meeting language, personal-social, and fine motor–adaptive milestones by age 3 compared with nonexposed children (Gilbert, Bauer, Carroll, & Downs, 2013). Research has linked IPV exposure to more externalizing behavior problems in toddlers (DeJonghe, von Eye, Bogat, & Levendosky, 2011) and trauma symptoms such as higher levels of distress, regardless of infant temperament (Dejonghe, Bogat, Levendosky, Von Eye, & Davidson, 2005), and more difficulty forming secure attachments to their mothers (Finger, Hans, Bernstein, & Cox, 2009). Prenatal exposure to IPV has also been shown to have an effect on infant trauma symptoms. Specifically, women who experienced IPV while pregnant have been observed to have more posttraumatic stress symptoms, influencing higher levels of later infant trauma symptoms (Lannert et al., 2014).

Preschool (3 to 5 years)

Most research suggests preschool-age children exposed to IPV experience higher levels of externalizing behavior problems (e.g., Fantuzzo et al., 1991; Holmes, Voith,
Gromoske, 2015; Sternberg, Baradaran, Abbott, Lamb, & Guterman, 2006) and internalizing symptoms (e.g., Fantuzzo et al., 1991; Oravecz, Osteen, Sharpe, & Randolph, 2011; Ybarra, Wilkens, & Lieberman, 2007). Exposure to IPV affects how children understand and interpret conflict. For example, one study found that preschool-age children exposed to IPV were less likely to understand violence in an organized manner (i.e., narrative coherence; understanding how violence plays out), which led to more behavioral problems compared with their nonexposed peers (Minze, McDonald, Rosentraub, & Jouriles, 2010). Children exposed to IPV are also more likely to have increased fearful reactions and greater involvement in conflict, which in turn, were related to higher anxiety and depression symptoms (Cummings, Pellegrini, Notarius, & Cummings, 1989; Davies, Cicchetti, & Martin, 2012). Some research has demonstrated that exposure to IPV is related to lower levels of executive functioning and poorer short-term and working memory skills during the preschool years (Gustafsson et al., 2013; Gustafsson, Coffman, & Cox, 2015).

One of the major developmental tasks for preschool children is prosocial skill development (i.e., being cooperative and responsible, having self-assertion and self-control, and showing empathy). Some research suggests that being exposed to IPV during preschool age was significantly related to less social competence compared with not being exposed (Fantuzzo et al., 1991; Wolfe, Jaffe, Wilson, & Zak, 1985), whereas other studies found no significant direct link between IPV exposure and prosocial skills or social competence (Farver, Xu, Eppe, Fernandez, & Schwartz, 2005).

School Age and Adolescence (6 to 17 Years)

The vast majority of research examining the effects of IPV exposure on child outcomes has been conducted with children who are school age or adolescents. Systematic reviews and meta-analyses have indicated that children in these age groups who are exposed to IPV are more likely to experience more externalizing behavior problems, internalizing symptoms, and posttraumatic stress symptoms, and reduced cognitive functioning, academic difficulties, and social competence, compared with their nonexposed peers (Evans, Davies, & DiLillo, 2008; Fong, Hawes, & Allen, 2017; Hungerford, Wait, Fritz, & Clements, 2012; Margolin & Vickerman, 2007; Vu, Jouriles, McDonald, & Rosenfield, 2016; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003).

Social relationships become important during this developmental period. Research has indicated that school-age children who are exposed to IPV are at an increased risk of bullying perpetration toward their peers (Baldry, 2003; Fredland, Campbell, & Han, 2008; Holt, Kaufman Kantor, & Finkelhor, 2009; Jenkins, 2000; Knous-Westfall, Ehrensaft, MacDonell, & Cohen, 2012) as well as an increased risk of being a victim of bullying (Knous-Westfall, Ehrensaft, MacDonell, & Cohen, 2012; Schwartz, Dodge, Pettit, & Bates, 1997). Exposure to IPV has been linked to both perpetration and victimization of teen dating violence. For perpetration, adolescents who have been exposed to IPV are more likely to engage in physical abuse and relational abuse toward their partners compared with adolescents who have not been exposed to IPV (Ferguson, Miguel, Garza, & Jerabeck, 2012; Garrido & Taussig, 2013; Jouriles, Mueller,
For victimization, adolescents who had been exposed to IPV were more likely to experience teen dating violence victimization compared with nonexposed adolescents (Choi & Temple, 2016; Karlsson, Temple, Weston, & Le, 2016). However, gender differences emerged from this research. One study (Choi & Temple, 2016) found that female adolescents who were exposed to IPV during childhood had the highest probability of experiencing physical and psychological teen dating violence compared with males who were exposed to IPV during childhood and males and females who were not exposed.

Who Am I?
I am the proud daughter of high schoolers who went their separate ways after graduation and my birth. I was raised by my mom and although I knew of my biological father, I did not meet him until I was 16 years old. My mom graduated from high school, gave birth and went to work to provide for me. Close to my third birthday, she got married and had two sons. By my eighth birthday, I was very familiar with my stepfather’s quick temper and constant attempts to get me to obey, respect, and yield to him. His tactics included yelling, spankings, and punishments. Yet my will and spirit refused to be broken, nor would I kowtow to him. Essentially, we tolerated each other.

No, I take that back. He tolerated me as his wife’s child. I hated him and his actions, and he knew it. I realize that hate is a strong word; yet, it is how I felt as a child. This man was physically, verbally, and emotionally abusive to my Mom and I hated him for that. I was also angry that he would try to inappropriately touch me when my mother was not around or at work. This meant I was constantly on guard against being left alone with him, nor could I sleep soundly when he was around. I associated his attempts to molest me as another way of trying to hurt me, but also to hurt my mom. I was angry, sad, and hurt at myself, my Mom, and even God, that I couldn’t protect her or my brothers from my stepfather. We were living witnesses and victims to his erratic mood swings, temper tantrums, drug and alcohol-induced fights, and poverty due to his frequent unemployment status and his abhorrent stewardship of our finances. I just wanted us to be safe, live in a nice home, have plenty of food and toys and, more than anything, to be far, far away from the monster, as I called him. I also wanted to be a child and not have to think about grown-up things. My exposure as a child to intimate partner violence kept me in protection and defense mode. It was very hard for me to let my guard down. Being a child during this time, my emotions were set off easily and my ability to trust outsiders or new people was very low. Thus, I trusted very few people outside of my neighbor, a young, African American man who was my age, and my mom’s side of the family.

Underlying Mechanisms

No one theory or underlying mechanism can fully explain the relationship between early exposure to IPV and possible adulthood IPV victimization and perpetration, and these pathways are not determined. Children who grow up in a relatively stress-free environment may thrive despite early adversity (Labella & Masten, 2018). For children who do not heal from early adversity, however, researchers, practitioners, and
policy makers should include facets from multiple ecological levels (individual, relational, community, and society) to intervene with children and prevent further harm in adulthood. Under the ecological level headings, the following underlying mechanisms are reviewed: developmental psychopathology, trauma, attachment, learned behavior, and environment.

**Individual Level**

*Trauma.* Individual responses to trauma—defined as an extreme event that overwhelms an individual’s coping skills and threatens their well-being (American Psychological Association, 2017)—can vary widely; however, if symptoms (e.g., intrusive memories, cognitive alterations, increased physiological arousal) do not diminish, those symptoms can have cascading effects on physiology; mental, cognitive, social, and physical health; and behavioral changes that affect later developmental stages (Shonkoff et al., 2012). Moreover, the timing, nature, and duration of these exposures have shown to have varying effects (Teicher & Samson, 2016), grounded in neurological and psychological etiologies.

Children exposed to IPV in their homes are vulnerable to neurological and psychological alterations that can prime them for later exposure to victimization and perpetration. If exposed to repetitive, prolonged, or cumulative traumatic events of an invasive interpersonal nature (e.g., exposure to IPV) during key developmental periods in childhood, outcomes are typically worse than those exposed to a single event (Courtois, 2008). Specifically, research indicates that the effects on the brain affect key psychological functioning that regulate interpersonal and emotion regulation, needed in social (e.g., school) and interpersonal (e.g., romantic relationships) settings (Maughan & Cicchetti, 2002; Puzzo, Smaragdi, Gonzalez, Martin-Key, & Fairchild, 2016). In addition, children growing up in violent homes are vulnerable to ineffective parenting (e.g., less attention provided to children, low emotional availability for children), which can lead to insecure attachments and poor self-regulation, setting children on developmental trajectories that heighten the risk of violence in adolescence (Dodge, Greenberg, & Malone, 2008). Emerging research has uncovered similar effects for children exposed to IPV in utero, finding increased stress reactivity, behavior problems, and negative emotional dispositions in infancy (e.g., Monk, Spicer, & Champagne, 2012) and middle childhood (see Dodge & Pettit, 2003).

**Relational Level**

*Attachment.* Bowlby’s (1982) research established the concept of attachment, the emotional bond that is established between a child and the child’s caregiver, who Bowlby commonly identified as the mother. It is theorized that one’s attachment type is established as a template or internal working model for all future relationships (Ainsworth, Blehar, Waters, & Wall, 1978). Children with healthy, or secure, attachments tend to have healthy romantic relationships as adults, whereas children with insecure attachments can have unhealthy, even violent or aggressive, interpersonal relationships as
adults (Rodriguez & Tucker, 2011). Theory proposes that children exposed to IPV may view their caregiver as threatening or as someone who is unavailable to attend to their needs, and thus are more likely to develop insecure attachments that are carried forward into later developmental domains with peers, friends, and romantic partners (Davies & Cummings, 1998). Empirical research supports this mechanism, particularly for IPV perpetration (Godbout et al., 2017).

**Learned behavior.** The Intergenerational Transmission of Violence (Widom & Wilson, 2015) is an application of social learning theory (Bandura, 1977) that asserts that violence is a learned behavior. When violence is modeled to children while they are still forming basic belief systems, they may witness violence as an appropriate way to address conflict, and thus become more likely to adopt these behaviors in their adult relationships (Dardis, Dixon, Edwards, & Turchik, 2015; Mbilinyi et al., 2012). There is much support for the transmission of exposure to IPV to women’s victimization (e.g., Renner & Slack, 2006) and to men’s perpetration (Dardis et al., 2015), and though a more recently studied phenomenon, there is some support for women’s perpetration (Dardis et al., 2015). Researchers have also examined more proximal, mediating factors contributing to IPV risk with individuals who have histories of exposure to IPV (see Background-Situational Model, Riggs & O’Leary, 1989), such as attitudes accepting of violence and anger expression/control (O’Keefe, 1998; Temple, Shorey, Tortolero, Wolfe, & Stuart, 2013).

**Developmental psychopathology.** Researchers have considered how individual capacities interact with one’s environment to shape the successes or failures of key developmental tasks and how those successes or failures then inform future outcomes (Cicchetti & Valentino, 2006). To wit, a violent home would likely interrupt or challenge a child’s capability of achieving developmental milestones (e.g., mastery of emotion regulation). Researchers theorize that younger children are more vulnerable because they have not yet had time to master key regulatory competencies, such as emotion regulation, that promote resilient behavior in later developmental periods (Masten, Burt, & Coatsworth, 2006). Because their behavior can be nonnormative among their peers, children exposed to IPV may have trouble establishing positive peer groups and may more often affiliate with deviant or aggressive peers (McCloskey & Stuewig, 2001) and later with romantic partners (Capaldi & Crosby, 1997).

**Community and Societal Level**

**Environment.** Social determinants of health are the environmental conditions in which people are born, grow, live, age, work, worship, and play (Centers for Disease Control and Prevention [CDC], 2017; World Health Organization [WHO], 2018). These conditions include economic stability, education, social and community context, health and health care, and neighborhood and the built environment. These resources are shaped by the distribution of money and resources at the global, national, and local levels (WHO, 2018). Correspondingly, those living in areas of relative disadvantage or
deprivation have significantly worse health outcomes, including IPV, and shorter life spans than those living in affluent areas (O’Campo et al., 1995; Wilkinson & Marmot, 2003); that is, adults living in disadvantaged areas report higher rates of IPV compared with those living in moderately or highly resourced areas (Voith & Brondino, 2017). Thus, children living in areas of concentrated disadvantage in urban (Beyer, Wallis, & Hamberger, 2015; Voith, 2017) and rural (Edwards, Mattingly, Dixon, & Banyard, 2014) settings are likely to have a higher risk of IPV exposure and, correspondingly, access to fewer resources that may provide ameliorating effects.

Answered prayers. My grandmother loved the Lord and she reminded me often that God answers our prayers. I wanted to believe her so bad that I prayed a lot for God to get us out of that situation. Little did I know, my prayers along with other people’s prayers were working. After a major physical fight with my stepfather, my mother moved us out of the house in the middle of the night. We lived with relatives before moving into our own home. My exposure as a child to IPV was coming to a close at the tender age of ten. I could finally sleep in peace.

Eight years later, I graduated from high school and headed off to college. I chose to go to counseling in college partly because I didn’t want to respond to an unconscious post-traumatic syndrome trigger of someone who reminded me of my stepfather by physically attacking them. I also didn’t want to project my experiences onto future situations that had nothing to do with my past exposure to IPV. After the initial meeting with a counselor, surprisingly, she didn’t recommend more sessions. Instead, she concluded that I was processing my experience just fine. The counselor was a white female, and while the racial difference between us didn’t bother me, I did wonder if culturally she was lacking in empathy or understanding of my needs. Unconvinced, I joined an African American sister support group led by two African American female graduate students. This was a much different experience and I was able to relate culturally and through my gender to both the participants and the leaders. I felt heard, challenged to grow, and supported. I experienced a great desire to be proud of being an African American woman when I went to college. This desire was definitely fueled by a radical push for equality and equity on our campus, which had a very small African American student population. I believe some of that played into my interest in anchoring that support.

Resilience and Protective Factors

Although children exposed to IPV are at heightened risk of developing emotional, behavioral, cognitive, health, and mental health problems, not all exposed children display such problems (Vu et al., 2016; Wolfe et al., 2003). In fact, some children are resilient—meaning, they continue to thrive and achieve adaptive development despite their early adverse life events (Rutter, 1985). Research documents a range of resilience in children who have been exposed to IPV (Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Kitzmann, Gaylord, Holt, & Kenny, 2003). For example, Kitzman et al.’s (2003) meta-analytic review found that 37% of children exposed to IPV fare just as well, or better, in psychological adjustment than children not exposed. Three
types of protective factors (i.e., theoretically sensitive to interventions) that promote resilience and optimal development in children exposed to IPV are described below.

Child Protective Factors

Child characteristics, including coping ability, self-esteem, temperament, prosocial skills, and physiological reactivity have been identified as potential protective factors that seem to shield youths from the negative outcomes associated with exposure to IPV. Specifically, children who are able to calm themselves with self-talk (i.e., cognitively self-soothe) during their parents’ conflict have a lower risk of experiencing high levels of stress and, ultimately, behavioral problems (Rossman & Rosenberg, 1992). Children with easy temperaments marked by approachability, positivity, and low reactivity also showed more positive behavioral adaptation after exposure to IPV (Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009). Adolescents exposed to IPV with stronger coping abilities reported fewer physical health (e.g., colds, flu, stomachaches, aches, and pains) and mental health problems (e.g., internalizing, externalizing; Fredland et al., 2008). Other research has documented that youths with higher self-esteem and better prosocial skills are more resilient to poor behavioral outcomes despite exposure to IPV (Garrido & Taussig, 2013; Oravecz et al., 2011; Salami, 2010). These results suggest that a lower physiological reactivity baseline may protect IPV-exposed children from the negative effects of acute or chronic stress exposure.

Peer Protective Factors

Supportive peer relationships have been identified as a protective factor for adolescents exposed to IPV. Compared with nonexposed peers, adolescents exposed to IPV were more likely to seek out peer support (Camacho, Ehrensaft, & Cohen, 2012). Those who felt that they could talk with friends about difficult situations (i.e., peer communication) had lower risk of running away, dropping out of high school, experiencing depression, and perpetrating teen dating violence (Levendosky, Huth-Bocks, Semel, & Shapiro, 2002; Margolin, 1998; Tajima, Herrenkohl, Moylan, & Derr, 2011).

Parenting Protective Factors

Similar to the idea that children’s outcomes differ despite being exposed to IPV, parenting qualities also vary among women experiencing IPV. Some women survivors are able to maintain positive and supportive parenting with their children, which has been linked to better child behavioral and mental health outcomes. For example, victimized mothers’ higher levels of expressed sensitivity and positive regard toward their children predicted higher levels of executive functioning in children, such as working memory and attention shifting (Gustafsson et al., 2015). Positive parenting practices, such as parents’ use of nurturance (i.e., provision of emotional and physical care), consistency, responsiveness, and control has been linked to fewer behavioral problems in children exposed to IPV (Oravecz, Koblinsky, & Randolph, 2008). For
adolescents exposed to IPV, mother’s warmth, involvement, and use of appropriate discipline with their adolescents has been linked to lower levels of teen dating violence victimization (Garrido & Taussig, 2013), and parental acceptance and responsiveness have been linked to reduced risk of teen pregnancy and running away from home (Tajima et al., 2011). Another group of studies specifically examining the protective relationship between the nonoffending caregiver’s mental health and children’s adjustment following exposure to IPV found that children who have been exposed to IPV exhibited fewer behavioral and mental health problems when they have a mother who is less depressed (Graham-Bermann, Gruber, Howell, & Girz, 2009; Holmes, 2013; Hughes & Luke, 1998; Martinez-Torteya et al., 2009).

Full circle. While being in the sister support group, I realized that the counselor was right. Whatever I was dealing with in my late teens were my own young adult issues and were not primarily due to my childhood trauma. Upon reflection, I believe that being a year-round athlete in high school, being very active in other activities like student council, along with a fierce desire to do “big things” really helped me to process my childhood and teenage experiences. Hallelujah! Now what? How do I continue to grow from this? For me, my spiritual relationship has been my rock and foundation for continuing to build my resilience and growth. My spirituality also helped me to release the hate in my heart that I held towards my stepfather. The hatred only hurt me, not the person it was directed towards. Releasing the anger gave me freedom and a lift. It also helped me to be able to share my experience with others. The powerlessness I felt as a child, I didn’t feel that anymore. Another way that I processed my experience was through writing and reflection. I’ve been very reflective from a young age. I’m the “deep thinker” of the family. I used to write as a method of processing what was happening to me or what I saw happening to others. Even writing this vignette has been cathartic for me.

Thirty-three years later, I’ve come full circle. I’ve also been able to reconcile and recently restore my relationship with my biological dad. I’ve graduated college with my bachelor’s (even though it took 19 years), earned a master’s degree and post-graduate certificate. Being in my doctoral program now is a dream come true. I’ve also joined the board of the Domestic Violence and Child Advocacy Center (DVCAC) and that has been a transforming experience for me. I went through a board-matching program and, based on my interests, DVCAC was recommended as a top match. It was an unexpected recommendation as I was only vaguely aware of the organization and didn’t think my past experience would be a reason to serve on the board of an organization that specifically dealt with my childhood exposure to IPV. It is with DVCAC that I’ve had the opportunity to share my story publicly outside of church or personal conversation. I shared my story to remind all of us that there’s always something one can do to help victims of DV/IPV. Whether it is an encouraging word, prayer, sharing resources, or being present, my family and I benefited tremendously from them all and we’re extremely grateful.

**An Overview of Prevention Efforts to Reduce Child Exposure to IPV**

Prevention efforts to reduce child exposure to IPV are often conceptualized and implemented in parallel to reducing IPV and/or child maltreatment efforts. In addition,
Although research on child exposure to IPV fully examines the problem, there is not correspondingly robust evidence on prevention strategies to stop violence before it begins. We describe an overview to the public health approach to IPV prevention, with a discussion of its alignment to the problem of child exposure to IPV.

A Public Health Approach to IPV Prevention

A public health approach to IPV prevention has existed for at least three decades. Early on, Wolfe and Jaffe (1999) proposed such an approach. The authors outlined two key public health approaches, that of determining causality to address a problem at its root, and a three-level typology (i.e., primary, secondary, tertiary) based on assessment of risk and harm. Further development of a public health approach to gender-based violence prevention to specifically target child exposure to IPV is a natural fit and stands to have a substantial impact on the lives of children. Three tenets ground a public health approach: operate within the social-ecological framework, be evidence driven, and be population based.

A social-ecological framework to prevent violence at the population level has been instrumental to the public health approach promoted by the U.S. Centers for Disease Control and Prevention (Niolon et al., 2017). The CDC uses a four-level social-ecological framework, which entails individual, relational, community, and societal levels (CDC, 2015). A clear emphasis on a comprehensive, multilevel approach to prevention means that efforts are “more than education” and go “beyond the individual” (Cohen & Swift, 1999, p. 203).

A public health approach to prevention promotes evidence-based prevention efforts. Evidence is understood on a continuum of rigor, with a prioritization and elevation of outcome-based, randomized controlled trials to test an intervention’s effectiveness. For example, many CDC reports aimed at shaping the field of injury prevention provide summaries of outcome-based findings (see DeGue, 2014, on prevention efforts for campus sexual assault). However, this argument for evidence-driven prevention often does not shape local practice-level efforts.

Although the social-ecological framework describes all levels equally and does not privilege one of its levels above others, the public health approach argues for more emphasis on population-level change, with prevention approaches concentrated at the community and policy/social level (e.g., see Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016; Niolon et al., 2017; Wilkins, Tsao, Hertz, Davis, & Klevens, 2014). The phrase “moving upstream” is used to describe this population-level focus; the phrase refers to the take-away line from a story, referred to by the CDC as the “Fisherman’s Tale” (see Veto Violence, n.d.). Although a moving upstream approach is sensible, the dominant approach to IPV prevention has been at the critical, but sometimes too late, stage of trying to keep people from drowning in the stream.

Prevention of Child IPV Exposure From a Public Health Approach

Although a distinct public health approach to preventing IPV exists (see Niolon et al., 2017), the same cannot be said about preventing child exposure to IPV. In part, as
described above, preventing child exposure to IPV often is subsumed under prevent-
ing IPV, supporting the argument that child exposure to IPV is prevented best by pre-
venting IPV (Kyegombe et al., 2015; McTavish, MacGregor, Wathen, & MacMillan,
2016). For example, the CDC Division of Injury Prevention and Control (IPC) publi-
cation list does not identify child exposure to IPV as a separate area of violence
research. Likewise, the specific term is not used in the recent wave of CDC-IPC’s
“technical packages” including IPV (Niolon et al., 2017) and child maltreatment
(Fortson et al., 2016), or the report on the links between different types of violence
(Wilkins et al., 2014). The prevention of child exposure to IPV may also be absorbed
as one of many adverse childhood experiences.

**A multiple-forms or intersections-of-violence frame.** Recently, the framing of multiple
forms of violence as interconnected, including shared risks and protective factors, has
emerged both in the United States (e.g., Wilkins et al., 2014) and globally (Guedes,
Bott, Garcia-Moreno, & Colombini, 2016; Guedes & Mikton, 2013). The prime U.S.
example of this framing is the CDC-IPC’s report Connecting the Dots: An Overview
of the Links Among Different Types of Violence (Wilkins et al., 2014). Based on evi-
dence of shared risk and protective factors between multiple types of violence, the
report argues that prevention of one type of violence can, in turn, prevent other types.
Including shared risk and protective factors of child IPV exposure is a natural fit and
will ensure a greater impact of this strategy.

**Community context.** Another key organizing connecting-the-dots principle is the focus
on the community context of multiple types of violence cooccurrence. The report doc-
uments evidence that “families and children living in communities where there are
many risk factors (e.g., high poverty, unemployment, and crime) are more likely than
families and children living in other communities to experience multiple forms of
violence” (Wilkins et al., 2014, p. 3). This community-level understanding of the
cooccurrence of multiple forms of violence shifts attention from individual-level to
community- and policy-level prevention efforts. Overall, the public health approach
suggests that preventionists reimagine a wider range of community-level stakeholders
or sectors with a shared purpose to strategize evidence-based violence prevention
(Fortson et al., 2016; Wilkins et al., 2014).

**Changing social norms and reframing the narrative.** Changing socially accepted rules that
support harmful norms about masculinity and femininity (Wilkins et al., 2014) and
aggression toward others (Wilkins et al., 2014) is a necessary step to decrease the risk
factors associated with perpetration of IPV and child maltreatment, among other kinds
of violence. The adoption of positive social norms can also occur at the community
and society levels, such as city-level social marketing campaigns and local, state, and
federal policy. The CDC also suggests that reframing the narrative of who is respon-
sible for preventing violence from occurring and what the causes of violence are must
take place to bring about societal-level change.
Next Steps for Early Intervention and Prevention Efforts

Using the malleable protective factors (i.e., theoretically sensitive to interventions) that promote resilience and optimal development in children exposed to IPV as described in the above literature review, focused efforts can be directed toward effective or promising programs promoting these protective factors within children and their environments (Howell & Graham-Bermann, 2011; Masten, 2001). Simultaneously, support for all parents is needed. Considering the parenting protective factors for child exposure to IPV, focusing intervention and prevention efforts on the nonabusive caregiver is also critical. Although some experimental designs are testing interventions for mothers and children after IPV has taken place (e.g., Graham-Bermann, Miller-Graff, Howell, & Grogan-Kaylor, 2015), more attention and testing of primary prevention approaches from the research, practice, and policy sectors are needed.

An emerging area of early intervention and prevention efforts involves engaging fathers, particularly expectant and new fathers. A recent philosophical change relevant to preventing child exposure to IPV has taken place in the IPV field, shifting the social construction of men who parent from perpetrators alone to fathers (Stover, 2013). However, engaging fathers as possible prevention agents has yet to be adopted within all IPV and other family sectors, including child welfare and children’s mental health (Scott & Lishak, 2012). The current scope of engaging fathers to prevent IPV and child exposure to IPV in the United States has focused on secondary and tertiary prevention at the individual and relationship levels of the social-ecological framework. While many fatherhood programs addressing IPV exist as community-based efforts, several programs in the United States and Canada have been tested using rigorous research methods and have shown significant attitudinal and behavioral changes (e.g., Caring Dads) (Crooks, Scott, Francis, Kelly, & Reid, 2006; Pennell, 2015). These promising practices share several commonalities: They address multiple forms of violence—IPV and child maltreatment; they are group-based; they use a psycho-educational, cognitive behavioral approach; and they include child development and family violence topics in the curriculum.

To address the lack of prevention programs that target IPV perpetration risk factors for expectant and new fathers universally or men with histories of IPV (Sinnott & Artz, 2016), a new focus is urgently needed (Carlson & Casey, 2018). A transition-to-fatherhood program that includes an IPV prevention approach must include a gender-equitable frame that promotes positive gender and sexual social norms in addition to healthy nonviolent child care practices. This approach is also imperative to reshape the narrative and reduce the common practice of holding mothers responsible for family violence (Sinnott & Artz, 2016).

However, although individual- and relationship-level interventions that aim to reduce IPV and child maltreatment are valuable and necessary strategies, a multilevel approach across the social ecology is necessary to reach the most people for the most good. In the United States, the development and ownership of a comprehensive prevention approach to reduce child exposure to IPV is needed. The next section describes
the need for a comprehensive approach that includes all levels of prevention from the individual to policy change, and addresses the root causes of IPV.

**Key Challenges**

While the past 40 years of research on the effect of IPV on children and their adult-hoods provides strong evidence for the need for early intervention, the key challenges that remain warrant increased attention to the prevention of child exposure to IPV. The first challenge is the need for more developed articulation of a child exposure to IPV comprehensive prevention approach; such an approach could prove instrumental in garnering concentrated effort and attention to this serious public health issue. As aforementioned, the social-ecological prevention framework has been applied consistently in the prevention of IPV (e.g., Wolfe & Jaffe, 1999), sexual assault (e.g., Casey & Lindhorst, 2009) and, more generally, gender-based violence (e.g., Heise, 1998); however, it has been applied less specifically to the prevention of child exposure to IPV (for a noted exception, see Osofsky, 2003). The second challenge is the need for multisector engagement in community- and societal-level prevention, as the CDC technical packages to prevent family violence suggest (Fortson et al., 2016; Niolon et al., 2017; Wilkins et al., 2014). Multisector engagement includes increasing protective factors at the society and policy levels, such as providing economic opportunities for low-income people and strengthening community-led efforts to increase community connectedness and reduce risk factors, such as women’s wage inequity with attention to the disproportionate inequity for women of color. The challenges outlined here serve as barriers to a comprehensive, public health approach to ending children’s exposure to IPV. Pulling together the extraordinary work of the past 40 years and using it as a platform to launch the next wave of coordinated, collaborative research to “connect the dots” is essential to the field’s advancement.

**Reflections on prevention.** I was asked to close by reflecting on what I think could have prevented my exposure to DV/IPV. I think back to the times of my exposure and it was the late 1970s and early 1980s. It was such a different time than today in so many ways. Personally, I believe things would have been different had my stepfather owned up to his actions and actually applied the help and counsel he received to deal with his issues. He was a great percussionist and loved music, yet couldn’t find it within himself at that time to channel his angst, anger, frustrations to more productive and nonviolent activities consistently. His acknowledgement of change only came when he thought he was losing my mother or his sons, and even then, it was fleeting and superficial.

During that time, Cleveland, Ohio, was just beginning to have consistent services for DV/IPV victims. I don’t recall any information being shared in my elementary school or any areas I frequented. Increasing public awareness about the support and services available to DV/IPV victims/survivors could have been a prevention method. In addition, if these services had been tailored to the African American community, I believe that would be a great preventative measure against DV/IPV. I also often wonder if my mom would have married my stepfather if she had been in a better financial position as a single mother.
While it was her intention to go to college, my arrival delayed that dream. I believe had she gone directly to college, a lot of things may have been different. My biological dad recently shared with me how he tried to financially provide for me when he went into the army after high school. His efforts were unknown to my mom and essentially rebuffed due to family interference. Knowing how poor we were and how much we could have used the money, the knowledge of this is still hard to comprehend.

Writing this vignette was harder than I thought. I’ve cried, walked away from it, been proud and in awe of my journey. I also realized that I unfairly judged my mom for her decisions. I’ve seen her sacrifices through mature eyes and I have great respect and love for her, both as a woman and as my mom. She’s a model of tenacity and love in action to me. This is my story within my family’s story and I own that my telling of it is only one lens of our experience. The detailed triumphs of my mom and brothers have far exceeded the odds. My mom remarried, graduated college (before me), and is enjoying a successful career. My brothers have beautiful families and careers they enjoy. By no stretch of the imagination was it easy to get to this point, and we don’t consider ourselves to have arrived. We’re all works in progress. Personally, I use the experience of the past trauma as a footstool and marker to denote how vastly different our lives are now. And I’m reminded that even the most violent storms leave beautiful rainbows.

Conclusion

Further raising the issue and prevention of child exposure to IPV to the forefront of public awareness requires a definitive, comprehensive, nationally adopted plan grounded in the knowledge base of the developmental impact on children into their adulthoods that engages multiple sectors across the social ecology. The evidence on protective factors and resilience and the vignette presented here suggest that children can flourish when faced with seemingly insurmountable challenges. However, the consequences of deeply rooted social contexts and oppression, such as harmful gender norms and racial inequities and related social determinants of health, may delay or derail the opportunities to heal, recover, and stop the transmission of intergenerational violence. To fully address these complexities, a comprehensive child exposure to IPV prevention plan requires the inclusion of an antioppression lens, centered on the lived experiences of survivors and their families and the promotion of their well-being.

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