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Developing assessments for child exposure to intimate partner violence in Switzerland - A study of medico-legal reports in clinical settings

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Title: Developing assessments for child exposure to intimate partner violence in Switzerland – A study of medico-legal reports in clinical settings

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Abstract:

Purpose: Evidence to inform assessment of needs of children exposed to intimate partner violence (IPV) in health settings is limited. A Swiss hospital-based medico-legal consultation for adult victims of violence also detects children's exposure to IPV and refers cases to the Pediatrics Child Abuse and Neglect Team. Based on a conceptual ecological framework, this study examined the nature and circumstances of children's exposure to IPV described in accounts collected by nurses in consultations with adult IPV victims. **Methods:** From 2011-2014, 438 parents (88% female) of 668 children aged 0 to 18 sought medico-legal care from the Violence Medical Unit in Lausanne Switzerland following assaults by intimate partners (85% male). As part of the consultation, nurses completed a semi-structured questionnaire with victimized parents, recording their answers in the patient file. Victims' statements about the abuse, their personal, family and social contexts, and their children's exposure to IPV were analyzed. Descriptive statistics and qualitative thematic content analyses were conducted to identify, from the victimized parents' accounts, elements useful to understand the nature

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and circumstances of children's exposure and involvement during violent events. **Results:** Parent statements on specific violent events described children being present in 75% of the cases. Children were said to be exposed to, and responded to, severe physical violence, serious threats and insults, in the context of repeated assaults and coercive control. Families, especially mothers, were often coping with additional socio-economic vulnerabilities.

Conclusions: Implications for further developing assessments of children living with IPV, especially in health settings were identified.

Keywords: Intimate partner violence; domestic violence; child maltreatment; children's exposure; child needs assessment; clinical legal medicine

Introduction

Children's exposure to intimate partner violence (IPV) is now recognized at the international level as a form of child maltreatment (Dubowitz, Hein, & Tummala, 2018), and as an Adverse Childhood Experience (ACE). Research on ACEs has shown that experiences of abuse during childhood, as well as family stressors such as parental substance abuse or domestic violence have negative effects on lifelong health. Besides, the combined effects of several ACEs are multiplied (Bellis et al., 2014). Due to the harmful effects on development and lifelong health, it is a considerable global public health concern (WHO, 2002; Holt, Buckley, & Whelan, 2008).

Health services are often a primary point of contact with adult and child victims of IPV and WHO guidelines recommend a 'case finding approach' for adult victims (WHO, 2013) although methods of identification of children's needs in cases of IPV in healthcare remain underdeveloped (Lewis et al., 2017). Clinical legal medicine has a unique role to play in this respect, by taking both legal and healthcare aspects of child protection into account. However, there is a lack of research on medico-legal responses and more broadly on health responses to children's exposure to IPV (Howarth et al., 2016).

IPV Exposure is Multifaceted

While the issue of children exposed to IPV is gaining increasing interest in Switzerland, the evidence on this subject has mostly developed in other countries and is not widely known. For instance, there is still insufficient awareness that children's exposure to IPV extends far beyond "witnessing" or "observing" acts of physical violence. Holden (2003) proposed a "taxonomy" of child exposure to IPV that reflects its many facets: exposure prenatally where there is violence to the mother in pregnancy; where there is direct violence to the mother and also violence to the child from either parent; seeing or hearing the violence; the child intervening to stop the violence; being manipulated or forced into participating;

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observing the initial effects of the violence; hearing about the violence indirectly; experiences that result from the aftermath; or being seemingly unaware. Other researchers have noted the harmful emotional and developmental impacts of child exposure IPV where there is coercive, controlling behavior that involves the children, often continuing after the parents have separated (Radford and Hester, 2015; Stark, 2007). This work considers how children and young people may experience the direct and indirect consequences of living in a violent home, coping with a climate of fear, 'walking on eggshells' and living with the aftermath of the poverty, social isolation and transience that often results. Taking on responsibility to manage the abusive parent's behavior to protect himself or herself or the mother from post separation violence, harassment or stalking behavior may also cause considerable distress to children and young people (Fortin et al., 2012; Radford & Hester, 2006; Trinder, Firth, & Jenks, 2010).

Different children and young people, even those living in the same family, may be affected in different ways and, as with all forms of child maltreatment, the impact varies for children at different developmental stages (Radford et al., 2019). Children and young people however are not passive victims and, at even very young ages, may take steps to act against the violence (Stanley, 2011). Katz's qualitative research with children and young people exposed to IPV towards their mothers found that both parent and child played an active role in supporting one another's safety and recovery (Katz, 2015). While all children need to be safe, their responses, coping strategies and needs for support and for help will not necessarily be the same (Jaffe et al., 2012). All children exposed to IPV are not "doomed to a life fraught with difficulties" (Øverlien, 2010, p. 91).

The Swiss Context

In Switzerland two studies have investigated intimate partner violence against women on population samples (De Puy, Gillioz, & Ducret, 2003; Killias, Simonin, & De Puy, 2005). These showed that violence and abuse against female victims was characterized by coercive control and dominance from their male partners. They also revealed that female IPV victims talked more readily about the abuse to healthcare and mental health professionals, than to victim services, to the police or justice. A similar trend was found in a survey in the canton of Geneva with both female and male IPV victims (OCSTAT, 2013). A study at the Lausanne University Hospital showed that approximately one out of four patients came to the emergency service following a physical assault (Hofner et al., 2005). This finding was one of the incentives for the creation in 2006 of the Violence Medical Unit (VMU), a medico-legal consultation for victims of interpersonal violence. Since then, the hospital's emergency

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service has systematically been asking whether injuries resulted from violence and has encouraged victims to make an appointment at the VMU. From the beginning, the VMU has shared information regarding children exposed to IPV, reported by their victimized parent, with the CHUV's Child Abuse and Neglect Team (CAN Team), a multidisciplinary group including pediatricians, nurses, social workers and psychologists. Through this collaboration, the VMU has been at the forefront of detecting and the CAN Team responding to children's exposure to IPV. Until then the CAN Team had not dealt with this form of child maltreatment (Cheseaux, Duc Marwood, & Romain-Glassey, 2013).

Generally, IPV and child abuse have largely been constructed in Switzerland as two different social problems, with distinct responses in different services and institutions. In this context, the growing visibility of the issue of children's exposure to IPV challenges these traditional divisions. Over the past two decades there has been considerable progress in Switzerland in terms of IPV prevention and intervention, following the first national campaign in 1997 and the (still to this day) largely disseminated finding that one out of five women are victims of physical or sexual violence by an intimate partner during their lifetime (Gillioz, De Puy, & Ducret, 1997). Protection of victims and their children has been a priority of IPV prevention and intervention. However, until recently children were pictured as witnesses, indirect or collateral victims of IPV. As such, they were not considered as in need of specific assessments. As a result, responses to children's exposure to IPV are still underdeveloped. Among many professionals, and especially in healthcare settings, child maltreatment is envisioned mostly as physical and sexual forms of child abuse (Krüger, Lätsch, & Voll, 2016, p. XII). Only recently have official statistics been published on children's exposure to IPV in Switzerland. In 2015, the police intervened in more than 14,000 IPV events. In 50-60% of interventions, children were present, and 40% of them were under seven years of age (Huber Bohnet, 2016).

Switzerland is a federal state with large autonomy of each of the 26 cantons, e.g. in healthcare, education, policing. The Federal, cantonal and communal governments share legislative powers. At the Swiss federal level, an amendment to the Civil Code regarding protection of children against abuse and maltreatment came into effect in 2019. Until then, professional secrecy binding medical doctors, psychologists or lawyers could only be suspended if a criminal offence had been committed. Henceforth, they may turn towards child protection authorities if the interest of the child demands it. So far, only a limited number of other professionals (e.g. teachers, social workers) had a statutory responsibility to report a child's situation to Child Protection Services (CPS) if they suspected a risk for the child's

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welfare. Under the new law all professionals in regular contact with children – including daycare, sports or leisure activities facilitators – have a duty to report to CPS when they have concrete knowledge that a child's physical, psychological or sexual integrity is endangered (Office federal de la justice, 2018). Yet professionals in contact with children and their parents, including pediatricians, lack guidance on how to identify this type of victimization, and when they do they are often at a loss as to what to do about it. In this context, it appears particularly timely to develop evidence-based awareness and knowledge about, and to develop assessments for child exposure to intimate partner violence.

The present study was carried out in one of the settings at the cantonal level that has been at the forefront of the protection of victims of domestic violence and child maltreatment (BFEG, 2018). Healthcare professionals in Vaud have since 2004 an obligation to report child maltreatment to the District Court and to Child Protection Services (CPS). The policy of the Cantonal Lausanne University Hospital (CHUV) is that all suspected or actual case of child maltreatment must be referred to the CAN Team, who decide whether to report the case to CPS. However, reports to CPS are not automatic and are reserved to situations where children are considered to be in serious danger and the parents deemed to be unable to protect them. In all cases of children exposed to IPV brought to the CAN team's attention by the VMU, a member of the CAN Team calls or meets with the IPV victim and makes suggestions for the children's wellbeing (e.g. family or child therapy) and if the victim agrees calls the pediatrician. Rarely are IPV perpetrators seen and the CAN Team does not meet with the children. As awareness about the consequences of child exposure to IPV has grown in the hospital, assessment criteria have evolved at the VMU and an increasing number of cases have been referred to the CAN-Team. There is, however, no formal child-focused assessment framework to help evaluate the risk of harm, as is for instance the case in the UK.

The present study was motivated by the awareness that in the VMU medico-legal consultation, mothers and fathers who were victims of IPV provided important insight into their children's exposure to IPV and these insights could be a starting point for further developing child-focused assessments in this clinical setting, and build awareness of professionals in other settings. One of the VMU's missions is to offer consultancy and training to a wide range of professionals in contact with IPV victims in healthcare, social work, police or justice. Frequently, when children's exposure to IPV had been detected at the VMU, it was unbeknown to professionals in contact with these children (especially to the children's pediatricians, school or day care staff). Given the large number of children exposed to IPV identified through the VMU, it appeared important to undertake a systematic analysis

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of these cases and suggest appropriate actions centered on the children's needs. It was also deemed important to take into account the challenges and needs of the IPV victims in their parental role. Such knowledge and recommendations would be useful to a wide range of professionals and institutions involved in IPV prevention and childcare.

Conceptual Framework

In French-speaking Switzerland a systemic psychotherapeutic approach of partner violence is quite popular as a conceptual framework to understand IPV (Perrone & Nannini, 1995; Vannotti & Morier-Genoud, 2003). This perspective can be in tension with the notion that IPV is a public health problem and a form of violence largely perpetrated against women, as defined in the Istanbul Convention that came into effect in 2018 in Switzerland, or in cantonal policies of expulsion from home of violent intimate partners. By considering both partners as mutually responsible for IPV, whether it is considered "symmetrical", when both partners are supposedly equally violent, or "complementary" when there is coercive control, this model can result in victim blaming and has the limitations of "single factor theories of violence" (Heise, 2011, page 5). It individualizes the problem and largely ignores the important role of gender, power and coercive control in domestic violence (Stark, 2007), where undermining the relationship between the mother and child is a common strategy for isolating the victim and limiting her options to escape (Radford & Hester, 2006). For instance in the canton of Geneva, an over-psychologization in the political and judicial approach to IPV has been criticized, as well as the lack of a gender perspective in the training of social workers or healthcare professionals dealing with families (Roca i Escoda & Lieber, 2015). Regarding children exposed to IPV, the current practice tends to maintain the bond of a child with both parents, especially fathers. In cases involving IPV there is a tendency to view the violence as a problem between the parents, unrelated to the parental bond and to disregard it is relevant to fathering. This is harmful for victims and for children living with the violence.

Explanations of violence cannot be limited to the individual and family level but should take into account social dimensions, such as age, gender differences and inequalities, norms and structures that contribute to the tolerance of violence. Ecological models are useful to understand the range of interactions between individual, family and environmental/community vulnerabilities associated with complex phenomena such as child maltreatment (Garbarino, 1978; Belsky, 1980 & 1993), child development (Bronfenbrenner, 1994), or intimate partner violence (Heise, 2011). Levondosky and Graham-Bermann (2001) in particular draw on the ecological theories of child development by Bronfenbrenner (1978), and of child maltreatment (Belsky, 1980; 1993) to conceptualize the inter-related traumatic

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impact of IPV on women and children. These authors take into account the interactions between risks and protective factors for individuals (the 'ontological' level) within the family context (the 'microsystem'), within the wider community and family network (the 'mesosystem'), and the broader social, political and cultural context (the 'macrosystem'). The advantage of this conceptual approach is that the focus of understanding and developing responses does not rest at the level of an individual's or family's pathology or general failings. The model allows researchers and practitioners to consider that IPV may have a continuum of different impacts that are influenced by different strengths and vulnerabilities of individuals, families, their communities and the wider context, including the intersectional inequalities of age, gender, power and discrimination (Crenshaw, 1992; Yuval-Davis, 2015).

Relevance and scope of the study

The design of the present study was primarily exploratory and descriptive. This approach was justified by limited research and evidence on children's exposure to IPV in Switzerland and by the need to investigate how this phenomenon manifested itself and can be addressed in the Swiss context. Gathering such evidence was envisioned as a first step towards informing evidence-based practices, particularly on assessment within the clinical setting.

Bronfenbrenner's (1994) and Heise's (2011) writings on the ecological framework constituted the theoretical backbone of our study. According to these conceptual frameworks, children's exposure to IPV is understood and prevented at the levels of individual risk factors (the ontological level), of interactions in the family (the microsystem level), environmental and neighborhood factors (the mesosocial level) and the broader structural/societal context (the macrosocial context of policies, structural inequalities, poverty etc.). Moreover, although the study is based on the analysis of specific IPV events, our understanding of IPV relies on the clear evidence, including in the Swiss context, which is not limited to outbursts of physical, sexual or verbal violence, but includes a pattern of coercive, controlling behavior that can target and draw in children.

The purpose of the present study was to identify and examine retrospectively the information available on children exposed to IPV from the statements collected by nurses from parents who were IPV victims. The research questions were:

1. To what extent does information collected by nurses during medico-legal consultations with parents who are IPV victims help understand the circumstances surrounding children's exposure to IPV?

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2. In particular, what insight does such information give into the nature and circumstances of children's involvement during IPV events?
3. What further steps should be taken to further develop assessment of children's exposure to IPV?

Method

The Specificity of Medico-Legal Data

The VMU has collected extensive medico-legal data from adult IPV victims with children, documenting via victimized parents' reports, also information relevant to their children's exposure to violence. Most victims who come to the VMU have first visited the hospital Emergency Service where the medical staff are obligated to inform all victims of violence about VMU. Nevertheless, victims are sometimes referred directly by other professionals such as medical doctors, social workers, police officers or lawyers. Consultations at the VMU are always voluntary, by appointment and free. They are available whether or not the victim intends to file a legal complaint. At the start of a consultation, the attending nurse informs the patient that the consultation is confidential, except when children were exposed to the violence, because of the hospital regulation to inform the Pediatrics CAN Team when children might be in danger. It is extremely rare for parents to refuse to pursue the consultation because of this restriction.

The information collected by the VMU was not limited to formal victim statements intended for use in the courts. Many details contained in the medico-legal reports, collected primarily for clinical assessment purposes, were also of interest for research. The semi-structured questionnaire that was part of the patient file provided information about the victim's partner, the victim's marital history and current situation; the number and ages of the victim's children (see Appendix 1). In particular, nurses produced accounts, based on the victim's statements, of violent events and children's involvement in much detail, as the victims were asked to recollect the facts shortly after they occurred.

Population

The sample of case files (patient files) included in the study was selected from the VMU Access database in two stages. Firstly, data concerning the whole population of adult victims of IPV who attended VMU between January 1, 2011 and December 31, 2014 was selected, and secondly, only situations in which children were involved were included. Case files for a total sample of 438 adult IPV victims (88% female) who were parents of 668 children were retrieved. These mothers or fathers had consulted VMU following an assault by a current or former intimate partner (85% male). Within the four years (2011-2014), most

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victims consulted the VMU for one violent event, 25 consulted twice (22 women and 3 men) for two distinct IPV assaults by the same perpetrator (n=463 consultations). In accordance with the study protocol (2017 – 01736), approved by the Swiss Ethics Committee (CER-VD), use of retrospective data concerning the VMU patients from 2011-2014 was authorized without explicit patient consent under the condition that all personal data be depersonalized and coded. The citations extracted from the patient files were translated from French into English for this paper. They comply with the code using a random number in lieu of the name and patient identification number.

Measures

As part of the usual assessment process with the patients during the medico-legal consultation, attending nurses filled semi-structured forms that constituted the case files (the patient files, 18 pages) noting verbal responses of patients. Nurses systematically entered responses to structured questions into the Access database after each consultation. Quantitative data were extracted from this Access database. This included sociodemographic data provided by the 438 victims about themselves, their perpetrators and their children; characteristics of 463 violent events (time, day, location of the assault; injuries sustained; alcohol consumption of perpetrator and victim, verbal threats).

During the exploratory analytical process guided by the first research question – i.e. identifying what information contained in the patient files (case reports) was most useful to understand children's exposure to IPV - it was found that the quantitative data were complemented by the qualitative data from the descriptions of the violent events in which children were present. These gave some insight into the ways children were involved in the violent events and the continuum of violence and abuse. The qualitative data consisted of detailed accounts from the victimized parents of 243 violent events in which at least one child was present. These accounts were recorded by the nurses to document as precisely and factually as possible events in which physical violence was inflicted on the victim. However, they also described other circumstances surrounding the physical assault, including insults, threats, reactions and responses of the children. Nurses were trained to collect specific factual data during medico-legal interviewing of victim, and this process is similar to a semi-structured interview technique. As the victims recounted what happened before, during and after the violent event, nurses asked them to clarify in as much detail as possible who did what, where, how, when, including the victim, perpetrator, children and other persons present.

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Analyses

The five members of the VMU multidisciplinary research team analyzed the data. The team comprised one nurse, two forensic pathologists in training, the head doctor of the VMU and the sociologist in charge of research projects at VMU. Quantitative analyses were guided by the first and more general research question. Two types of information were found to contribute to the understanding the context in which children lived and were exposed to IPV. Firstly, sociodemographic data provided some insight into the children's family and social environment. Secondly, by looking at the timing and location of violent events, as well as injuries sustained by the victimized parent, their likely implications for the children were envisaged.

After transferring the selected quantitative data from the Access database into a statistical software (IBM SPSS Statistics 23), simple descriptive statistics (percentages, crosstabs by gender, Pearson's Chi-square) were computed from a SPSS database for 438 cases covering the socio-demographic characteristics of 438 victims, of their 668 children, and of the 438 perpetrators. Another database was set up to analyze the 463 violent events.

Qualitative thematic analyses were performed in order to look into the second research question, namely the nature and circumstances of children's direct involvement, where they were present during IPV events. Thematic content analyses (Bardin, 2013) focused on the victims' statement of 243 events in which at least one child was reported to be present. Initially, three members of the research team separately identified significant themes by reading and annotating 100 descriptions of events. The content analysis was partly deductive (looking for indicators of the multifaceted children's involvement identified in previous research, especially Holden's (2003) taxonomy. However, the approach was also partly inductive by allowing unforeseen themes to come up. The team discussed jointly their independent findings and agreed on a list of codes that reflected the different ways in which the children were said to be implicated during the violent events. Each researcher subsequently analyzed separately the 143 remaining reports. This process confirmed qualitative thematic saturation and the relevance of the categories covering how children who were present during IPV events were involved (Spencer et al., 2014).

The third research question is addressed in the Discussion section.

Results

Based on analyses of the data collected by nurses from a majority of mothers and a minority of fathers who were victims of IPV, the findings provide some elements at various levels of the ecological framework that help understand the nature and circumstances of children's exposure to IPV, as reported by their victimized parent. The first section presents socio-demographic findings about the children and their families, situating the children within the microsocial (family) and mesosocial environment (socio-economic status of parents). The second section lays out characteristics of the violent events that were most likely to be noticeable by the children and were examples of the continuing context of violence and abuse in which the children lived, as the victims generally reported a history of IPV over several years, often before or since the birth of their children.

The third section is the core of our study. It considers children's presence and standpoint during the violent events (how the children participated in the IPV, and responded to it, and were active in the microsocial environment).

The Children, their Family and Social Environment

The systematic analyses of the data contained in the case files on the child, family and social environment shows a high degree of vulnerability among children and their families. It is noteworthy that a large number of the victims' children were quite young. Among the 668 children, those aged 0-6 represented the largest group (46.3%). Children aged 7-12 were the second largest group (32.3%) and teenagers (aged 13-18) were the smallest age category (21.4%). Approximately one-third (34%) were single children while two thirds of the children had one or several siblings. Eighteen women (4.7% of female victims) were pregnant at the time of the assault, seven of whom with their first child.

Significant proportions of IPV victims were living with social or economic insecurities or were financially dependent on their partners (Table 1, column 2 and 3), especially mothers. Besides, 49.0% of female and 28.8% male IPV victims were without a paid occupation ($p < .01$). Among the victims with foreign nationalities, 40.7% of men and 64.7% of women had short-term residence permits ($p < .05$). The victimized parents (see Table 1, columns 4 and 5) provided information on the parents or stepparents who perpetrated the violence. The socioeconomic situations of perpetrators (largely fathers or father figures) although generally more favorable than those of the victims (largely mothers), nevertheless revealed similar situations of socio-economic vulnerability.

TABLE 1 ABOUT HERE

IPV Characteristics and Implications for the Children

Descriptive statistics concerning 463 violent events were produced, focusing on aspects that were likely to be experienced by the children, whether they were present or not during violent events.

Where, when and how? Data on the timing and location of events showed that these occurred typically in the home at times when the children were likely to be present. Children were recorded as being present in 75% of the events. Events described in the victim statements included accounts of insults, screaming, and serious threats as well as physical assaults. An important finding was that the “violent events” described in statements were practically never limited to one single physical attack. Typically, violent events comprised several phases over several hours or days, involving a series of violent and abusive attacks, in which the perpetrator pursued the victim in different parts of the premises. When there were attempts by the victims to flee to another room, or exit the building with the children, the violence often escalated in severity. The following excerpt gives one example of the ways children were caught in the middle of an assault and endangered both emotionally and physically. In the mother's words, the perpetrator treated the children as inanimate “objects” he could claim as his possession.

While her husband seized her by the neck, the victim had trouble breathing but managed to tell her son (age 11) to get dressed because they were going to leave the house. Her husband let go of her. She tried to put clothes on their daughter (age 3) but her husband tore them away (...). Her husband grabbed their daughter from her arms, she took the child back and said ‘she is not an object’. She had barely time to put the child down as her husband shoved her several times, pushing her from the living room to the bathroom (...) She fell into the bathtub and hit her back and forehead. The boy tried to call the police but the phone was unplugged (...) The victim picked up their daughter and opened the door in spite of her husband trying to prevent her (...) She managed to leave with the two children.

Visible injuries and emotional distress. Records from the medical examinations showed that the victims had injuries that were noticeable by the children several days after they were sustained. The most frequent were bruises and hematomas (76.7%) or abrasions (60.5%), most of them located on the upper limbs (70.6%), on the head (49.5%), or on the neck (16.6%). Fractures were relatively infrequent but most of the events that resulted in fractures affected women (18 out of 19). Nurses systematically recorded emotional complaints of the victims. The victimized parents often remarked that children who had been

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present during a violent event subsequently expressed dismay in various ways (e.g. sleep or digestive disorders reported for very young children, verbal concern for the victim or questions about what happened). Even very young children, according to the victims' statement, indicated they were aware of the violence, for instance:

Mrs. Z said she was rubbing her head and told her daughter it hurt because she fell.

Her daughter (3 years old) replied, "No, it's daddy who did boom to you and you fell.

Then you left (she sought refuge with neighbors) and you came back".

Recorded incidents where alcohol was mentioned. Standardized questions were systematically asked about alcohol consumption. Perpetrators were said to be under the influence of alcohol in about one third of violent events (35.2%) and at almost the same rate, victims (31.3%) stated that the perpetrator had a drinking problem. It was more unusual for the victim to declare being inebriated at the time of the assault (14.9%); and when this was the case, both victim and perpetrator were recorded as being under the influence of alcohol (11.2%). Qualitative analyses indicated that verbal and physical attacks tended to be brutal and persistent whether or not the perpetrator was inebriated. A notable difference however in the victims' account was that when a perpetrator came home drunk, he insulted and attacked the victim forcefully and immediately. The suddenness of the outburst is likely to be particularly alarming for a child, who as in the following example is the target of her father's rage, and her mother assaulted after trying to protect her daughter:

Her husband was 'very drunk'. He yelled at their daughter (11 years old) because she had closed the door of the house. Mrs. X (the victim, his wife) protested, her husband lifted the table on which Mrs. X was working and shoved it on her chest. Mrs X got up to leave through the kitchen door. She looked back (...) and saw that her husband was threatening her with a knife".

Serious threats. Victims were asked about threats and the nurses noted their precise formulation. The content analysis of threats indicated that they were common and of a serious nature. When children were present, and not necessarily in the same room, hearing these threats could be frightening. Perpetrators made verbal threats in half of the violent events (50.8%). In 63 events (13.6%) there were multiple threats. Almost one in three victim reports included a record of death threats to the victim (32.2%). One in every eight of the records mentioned threats concerning the children (12.1% of events). The most common threat was to take the children away from the victim (5.8%) followed by threats to hurt or kill the children (3.7%). The formulation of threats made in the presence of children, as conveyed by victimized parents, appeared particularly harsh, for instance:

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“I will send you back to your country and put our child in a foster home” (female victim, mother of a 2-year old).

“I will cut myself, injure our daughter and tell the police you did it” (male victim, father of a 1-year old).

He threatened to kill her and their children (2 and 4 years old) by pouring gasoline on them and setting them on fire.

A number of times, when children were present, perpetrators threatened victims with knives even though they were rarely used to stab the victim. Occasionally, a perpetrator was said to have threatened a child directly:

“Their son said (age 4), hiding his eyes with his hands, ‘Daddy, please!’ His father (mother’s perpetrator) told him ‘shut up or I’ll beat you up’”.

Previous violent events. In the majority of cases (85.6%) victims said that there had been previous violence from the same perpetrator before the specific violent event that motivated the medico-legal consultation. There were many indications that the violence and abuse was not limited to discrete incidents of violence but formed a pattern of behavior and permeated the families’ everyday life. In the following examples it appears that the children are used in two different ways as a means for the perpetrator to reinforce his power over his wife. In the first case, because the mother is trying to protect herself and her children by not questioning him, and in the second case because the husband invokes the mother’s parental duty as a means to isolate and control her.

(8 years previously) Her husband wanted to have sex. When she refused, he slapped her (...) (4 years previously) he punched her in the face in the presence of their 4-year old child. (...) Her husband becomes easily irritated, she makes efforts to calm him down and defuse the violence by all means. She is afraid of him (mother of two children aged 3 and 8).

Mrs. Y. mentions her husband insults her frequently. She adds that she has no access to the bank account and that her husband gives her a monthly budget, and she can’t spend any of the money without his prior consent and then he controls all receipts.

Three years ago he pressured her to quit her job and disapproved of the fact that their daughter was in daycare (mother of a child aged 5).

Children’s Involvement in Violent Events

Victim statements about 243 violent events that documented the presence of children were examined. Even if there were indications of protective actions by and towards the children, they were not included in the analyses presented here. The focus of the analyses was

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to look at the (potentially) most detrimental aspects of the children's involvement. The relentlessness of the attacks, aggravated by verbal violence and threats as described in the qualitative results, helped understand – better than only the statistical results - how upsetting these events had been for the victims and their children.

The findings from the qualitative content analyses of the records indicate that even for very young children, the children were not passive observers but frequently took active steps in response to the violence. Children's involvement was found to be of three major types: a) parents involved children during the violent event; b) children responded to assaults; and c) children commented or asked questions after the assault. These different types of involvement were not mutually exclusive.

When Parents Involved the Children. The violence was often initiated in the course of a verbal dispute about the children mostly around custody and separation or criticism of the partner's parenting skills. Sometimes disparaging remarks about the victim were made to the children and as a means to excuse the violence, for instance:

“According to the victimized mother her husband told their children, ‘Mommy is mean, she doesn't love daddy, that's why I spanked her’” (mother of three children aged 3, 6 and 7).

When children were present, hearing that they were at the center of arguments that resulted in physical violence could cause distress. Another way children were drawn into the event was by being asked to call the police, while facing often life-threatening situations. In the following example, the stress that this type of emergency could represent for the child was apparent:

“The victimized mother told their son (age 7) ‘I cannot breathe... go call the cops’”.

The children's responses. Victim statements gave accounts of two types of responses initiated by children to the parental violence: emotional manifestations (cries and screams) and interventions (verbal or physical). Children were often alerted by the noise, especially when sleeping or staying in another room. Often they responded to the violence by protesting verbally:

“He (aged 11) yelled at his mother ‘mom, mom, can't you see he's about to kill you!’ He added that she had to do something otherwise they were all going to die (his mother, his sister aged 3 and himself”.

“The mother (victim) wanted to leave with her daughter (age 4). She saw her husband locked them in. She asked her husband for the key but he refused. Their daughter kept repeating ‘Daddy, stop!’”.

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This citation shows the different manifestations of three siblings:

Their son (age 7) stormed out of his room and jumped on his father, grabbed his hair and hit him (their father was strangling their mother) (...). Their two other children were standing up in their bedroom. Their daughter (age 6) was crying and their younger son (age 3) was agitated and repeated, "There's whacking going on!"

Children commenting on or asking questions about the violence. In the immediate aftermath of the violence, children asked questions about what had happened:

Her daughter (age 3) asked their mother why she was crying, if she was hurt. She also said, "from now on I will protect you". Her other daughter (age 2) asked their mother "you OK?"

Discussion

The study's purpose was to retrieve and identify information most relevant to the situation of children exposed to IPV by looking at medico-legal documentation collected from their mothers (less often fathers) who reported an assault by an intimate partner

The first research question sought to identify information that was relevant to understand the context in which children exposed to IPV lived. An important finding was that the parents of the children exposed to IPV, whether victims or perpetrators, often experienced multiple vulnerabilities at the mesosocial level of the ecological conceptual model. Mothers of small children especially were more likely to be without paid work and prone to be financially dependent on their violent partners, limiting their options for moving out with their children. One aspect of coercive control is the social isolation of victims. Those without a professional occupation were likely to be even more deprived of social support. Short-term residency permits and "third-country" nationalities could also limit job opportunities, financial independence and social support of victims. Recent immigrants from Africa, Latin America or Asia may have had poor knowledge of and limited access to health, social and legal services for themselves and their children. Research into intersectionality has shown that combined discriminations and inequalities such as gender, migration, and poverty increase vulnerability of individuals and families (Yuval-Davis, 2015). Women were the majority of victims of IPV in this study and men the majority of perpetrators and children were exposed to this gendered pattern of violence and coercive control. Assessments of children's needs in Switzerland are often influenced by a psychological systemic analysis of family dynamics (i.e. restricted to the ontological and microsocial levels). This tends to limit responses to family or individual therapies without addressing the practical and structural barriers and inequalities such as

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poverty or lack of citizen status found among families in this study, restricting options to be safe.

Secondly, in response to the second research question - analyses of the IPV events suggested that children's lives were marked by severe and chronic violence in the vulnerable situational context of the family home. One noteworthy finding that in 75% of records parents gave accounts of children's involvement indicating that it is important to directly ask them about child involvement. The victims in our study had already been victimized, often repeatedly, by the same partner. The violence often occurred at times when the children tended to be present, in the evenings, at night (with risks of disrupting their sleep), or during weekends. 'Events' recorded in the VMU included several assaults and abusive behavior sometimes spanning several days. Children in the early age range, 0-6 years old, were the largest age group among the victims' children. Moreover, a large proportion of the most vulnerable children aged 0-6 years had no sisters and brothers and therefore lacked access to sibling support as a protective factor (Hornor, 2005). In contrast, those with siblings might have received reassurance and protection from older ones.

Thirdly, one of the most important qualitative findings was that involvement of the children in the violent events was common, substantial and varied. As found in some other studies (Radford & Hester, 2006), discussions about the children often took place before the violence started and adults regularly called or mentioned the children during IPV events. Infants typically reacted by crying; school age children protested with cries and screams. Teenagers intervened verbally or physically. Children were quite often asked to call the police. Not only were children exposed to serious and repeated violent events, they were also fully engaged actors. Practice responses need to consider this when asking about IPV and when looking at safety and recovery plans.

Age-Related Vulnerabilities

A large number of the children involved, according to the records, were in the early age group of 0-6 years. The literature clearly indicates specific vulnerabilities regarding IPV exposure in this age group. Even though small children exposed to IPV are particularly at risk in their development, there is also evidence that older children are likely to suffer adverse consequences. Children of all ages are aware of and sensitive to their parent's psychological distress. This study showed that children over seven and especially teenagers were most likely to intervene physically during violent events and be hurt in the process. Sometimes they were asked to call the police. Children over seven were more likely to be aware of the victims' wounds. Injuries were often located on the head or limbs and difficult to hide.

Exposure Was Always Severe

As far as assessing the severity of the exposure of the children in the violent events, based on the victims' statements collected by the nurses (qualitative results), it seems that all events that occurred in the presence of the children were harmful to them in several ways. Moreover, victims' responses about circumstances surrounding IPV events (quantitative results) indicated that children were generally exposed to multiple violent events and a climate of violence and abuse. Nevertheless, a number of elements seemed to be aggravating factors that ought to alert professionals of immediate and urgent need for protection of victims and their children.

It is not just the severe physical violence that harms children but also living in a home where there is a whole pattern of behavior comprising demeaning and undermining, criticizing, controlling etc. as well as acts of violence and threats. Even if the medico-legal data collected documented in particular violent events and physical violence, these violent events in our study were often accompanied by serious threats, verbal aggressions, and disparaging remarks. The most severe types of threats made by perpetrators in our population were death threats (with a few but very preoccupying threats of suicide-homicides). Most of the other threats recorded were also grave ones. Even if the children were not in the same room, given the pattern of events described lasting over a period, it is highly likely they could have heard them. An important finding in our study was that threats were also made about the children. Threats to kill or hurt the children were the most serious ones but threats to be estranged from the other parent could also be traumatic. Further research ought to look into the effect of threats on the children and these should be considered as alarm signs in assessments.

In about one third of the events perpetrators were reported by victims as being under the influence of alcohol, victims often considered that the perpetrator's inebriation had triggered the violence and that their partner had a chronic drinking problem. In view of the body of research on ACEs, the co-occurrence of other ACEs with IPV exposure suggests that this is particularly harmful for children (Bellis et al., 2014).

Limitations

The base for our study was limited by the retrospective and secondary nature of our data, relying on statements collected from adult patients who were victims of intimate partner violence and what these said about the involvement of children. A clear limitation was the lack of direct assessment with children themselves. However, this study offers findings that are a first step in further developing child focused assessments in the clinical context. The

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emergency room of the hospital and/or the police refer many victims of violence to the VMU. This might explain why a large section of the study's population of victims came from particularly vulnerable segments of the population. This result cannot be generalized, since the patients taken into account did not constitute a representative sample of IPV victims in the general population. In comparison, the results of the Swiss population study on IPV against women showed no significant differences in victimization according to socioeconomic backgrounds or nationality (Gillioz et al., 1997). Those mothers in more privileged sections of the population might have preferred to consult their family doctor or a private clinic than to come to the hospital. Nevertheless, the study examined case files pertaining to a relatively large population of IPV victims and was not restricted to clients of social services or victim services, or to parents whose children's situation had been reported to CPS.

Our results rely on the victims' accounts and therefore reflect their subjective viewpoint on the violence sustained. It has been pointed out that "mothers tend to both under-report and over-report what their children may have seen, heard, been affected by, etc., in term of violence" (Øverlien, 2010, p. 88). When the victims come at the VMU consultation they are often overwhelmed by multiple problems including financial hardship and the children's exposure is not necessarily their primary focus. However, subjective bias in patients' reports was partly avoided by the fact that the nurses requested the victims to focus on facts in the description of the violent events and not their interpretation of what happened.

Implications for Research

The concurrent accounts by parents, as recorded by the nurses, suggested an important impact on and involvement of young children during the violent events. This important finding warrants further research on how children in this age group are affected and to inform the better identification and assessment of children's needs as recommended by Lewis et al. (2017). However, attention to the differential development impact of exposure to IPV on children and young people of different ages and genders is needed to improve the knowledge base and importantly to inform practice. The results of the present study will be the base for an upcoming study based on follow-up interviews with the victimized parents whose case files were included in the present study, and with their children. It will be important to find out about the children's trajectories and what personal, informal and formal resources both children and their victimized parent found or would have liked to find in coping with the violence and its consequences.

Implications for Professional Practices

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There is a need to overcome the traditional boundaries between IPV and child maltreatment prevention in the Swiss context in favor of providing coordinated support to both victimized parents and their children. This type of intervention has proved its effectiveness in other countries (Graham Bermann & Hugues, 2003). In the Swiss context the need to reinforce access of parents to early intervention and health promotion in favor of children aged 0-4 has been underlined – especially in socio-economically disadvantaged populations or in risk situations (substance abuse, mental illnesses) (Hafen et al., 2011). Our results support the need to recognize IPV exposure as an important risk for children's health. Indeed, their access to early intervention is often rendered difficult by the social isolation generated by IPV. There is also a need to recognize children exposed to IPV as “social actors who actively adopt strategies to respond to the violence, thereby resisting it” (Øverlien, 2017) p. 687). Assessments of the children's needs that are at present made by the CAN Team based on the information provided by VMU, after talking to the victimized parent and sometimes the children's pediatrician, should in future include seeing and talking to the children and reinforcing their own protective strategies.

In view of our results and in the context of the reinforced legislation on child protection, there is a need to build awareness about children's exposure to IPV especially among institutions and professionals working with children. This awareness needs to be placed in context with other vulnerabilities, adversities and forms of discrimination in children's lives that will affect their health and wellbeing. As reported by our population of victims, their children were not only exposed to IPV but also often to financial strain in the household, alcohol abuse of the perpetrator, or unemployment and insecure residence status of a parent. The threats that these risk factors represent for children's health are documented largely in the Anglophone literature (Bellis et al., 2014; Hughes et al., 2017) and prevention practices (Public Health Wales, 2015) but such knowledge is not common yet among Swiss professionals.

There is however scope to build on the knowledge from this study to inform recording and assessment of childhood experiences of IPV in the health care and clinical setting. There is some evidence that training nurses to administer a structured interview with victims brought a clearer focus on children's well-being as well as the nature, frequency and chronicity of IPV and the broader family vulnerabilities, resulting in an increase of referrals to support services where more specialist assessments can be made. Directly asking about child involvement in domestic violence incidents and careful assessments of the family's socio-ecological context need to be developed and tested in the Switzerland to improve current methods of needs

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identification and response. There is a need for professionals to be better informed about evidence-based knowledge regarding children's exposure to IPV. This concerns especially professionals in contact with IPV victims, with children, but also other professionals in the health and social work sectors. Developing direct and safe assessments involving children is however a priority.

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Table 1: Socio-demographic characteristics of IPV victims with children and of IPV perpetrators (N=438)

		Victims		Perpetrators	
		N	%	N	%
Gender	Female	386	88.1	48	11.0
	Male	52	11.9	375	85.6
	Male and female (if several perpetrators)	0	0	15	3.4
Ages	24 and less	37	8.4	17	3.9
<u>Victims</u> : Mean age = 35.21 St.Dev = 8.243	25-34	173	39.5	145	33.1
<u>Perpetrators:</u> Mean age = 38.82 St.Dev = 9.795	35-44	170	38.8	154	35.2
	45-54	53	12.1	95	21.7
	55-64	3	0.7	18	4.1
	65+	2	0.5	8	1.8
	Missing			1	0.2
Nationality	Swiss	151	34.5	157	35.8
	UE 28/AELE	105	24.0	112	25.6
	Third countries	182	41.6	169	38.6
Professional occupation	Yes	234	53.4	291	66.4
	No	204	46.6	143	32.6
	Missing	0	0	4	0.9
Marital status Data available only for victims	Single	85	19.4		
	Married	232	53.0		
	Widow(er)	6	1.4		
	Divorced	66	15.1		
	Separated	49	11.2		

Appendix 1: The Sections of the Patient Files

- **General data:** gender*, age*, contact information (address, phone numbers), family doctor
- **Sociodemographic data:** nationality*, marital status*, education level* and occupation
- **Data concerning the violent event that motivated the consultation:** date, time and place. Information on the perpetrator(s): number*, gender*, known/unknown to the victim*; nature of the assaults (physical, sexual, psychological violence, deprivation or neglect), threats*, nature of threats, complaint filed or intention to do so*.
- **Data concerning the clinical examination centered on the experience and context of the violence:** description of the family and social situation, data about the children* *number of children, their ages and/or pregnancy of the female patient. Assessment by the nurse or pathologist of children's exposure to the violence.* Number of medical consultations related to the violent event, type of previous violence victimization*, location of wounds*; nature of wounds*.
- **Conclusions,** copy of the assault and battery report established following and based on the consultation.

**multiple choice questions are indicated by an asterisk. The other items correspond to open-ended questions.*