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ORIGINAL ARTICLE

"*There's Got to be More to Life than this*": Resources and Needs of Children living with Parental Intimate Partner Violence

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Abstract

Purpose Children's experience of parental intimate partner violence (IPV) often coexists with other types of victimization and is associated with negative short- and long-term health and well-being outcomes in both childhood and adulthood. Research on factors that protect against these adverse outcomes is mostly quantitative in nature and limited by the lack of qualitative exploratory work in this area. This paper reports on the resources on which children exposed to IPV have relied, the barriers they have identified to talking about IPV and other victimizations, and their unmet needs.

Methods Data were collected in 2022 through semi-structured individual interviews with 20 youth aged 14–28 years who had been exposed to IPV while they were minors, and whose parent had consulted a clinical forensic consultation for IPV between 2011 and 2018. The interviews covered all major areas of the participants' lives since birth. A thematic content analysis was conducted on the interview transcripts. The study utilized Brofenbrenner's ecological framework, as adapted by Heise, and the analysis drew on Grych, Hamby and Banyard's Resilience Portfolio Model to explore children's resources.

Results Participants reported personal strengths and assets known to be particularly important for resilience: meaning making strengths, self-regulatory strengths and interpersonal assets including support from family, and especially from the victimized parent. Engaging in hobbies provided them with various benefits, as did some interactions with various professionals. However, participants rarely discussed IPV and other victimizations with professionals or with family and friends, and barriers to doing so were identified. In terms of unmet needs and advice to parents and professionals, participants argued that violence should stop, and identified their need to be heard and protected, and that IPV should not be a taboo. In their view, professionals need to be particularly attentive to changes in children, and be proactive with them. Involving children in decision-making processes was also identified as important. Finally, the analysis showed that these children's resources and needs evolve over time.

Conclusions Children exposed to IPV use a full range of resources, both personal and external to them, and demonstrate agency to cope with adversity. Professionals need to be aware of each child's specific resources and needs in order to support them. Results also suggest the need for long-term follow-up. Recommendations address prevention, detection and intervention.

Keywords Intimate partner violence · Children · Resources · Protective factors · Needs · Qualitative study

Introduction

Living with parental intimate partner violence (IPV) is a recognized form of child abuse (Council of Europe, 2014; Marshall et al., 2019) and is associated with other forms of child abuse (Marshall et al., 2019; Sadlier, 2021). In Switzerland, as found in other western countries (Finkelhor et al., 2015; Radford et al., 2011), it is estimated that one in five or more children will experience physical IPV before reaching adulthood (Baier et al., 2018). Children's experience of IPV can have detrimental consequences on children's health and

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well-being, with physical, social and mental health problems in both childhood and adult life (Felitti et al., 1998; CDC, 2019; Carlson et al., 2019; Gardner et al., 2019; Marshall et al., 2019). However, not every child living with IPV will suffer these negative outcomes (Humphreys & Mullender, 2002). In recent years, research on resilience has focused on understanding how certain individuals seem to be able to adapt, and even thrive, in challenging life contexts. Attention has been given to identifying factors that protect against adverse consequences for children who have experienced various forms of violence (Alvarez-Lizotte et al., 2020; Carlson et al., 2019). This study reports on adolescents' and young adults' own views about what helped them while living with parental IPV during their childhood and adolescence, the barriers to talking about IPV and other victimizations, and their needs that went unmet by their family and friends or professionals.

Background

Living with IPV, along with other forms of child maltreatment, is an adverse childhood experience (CDC, 2019; Berg et al., 2022), associated with detrimental impact on developmental health and well-being, with consequences across the lifespan (Gardner et al., 2019; Gartland et al., 2021; Kassis et al., 2013; Vu et al., 2016). These include physical, behavioral, emotional, cognitive, and social impairments (Afifi & MacMillan, 2011; Gardner et al., 2019). Children who have experienced ACEs are more exposed to risky behavior (e.g., smoking, drinking), chronic disease and mental disorders in adulthood (Felitti et al., 1998; Chang et al., 2019; Gardner et al., 2019; CDC, 2019). In addition, having experienced IPV as a child constitutes a slightly higher risk of IPV perpetration and victimization in adulthood (Smith-Marek et al., 2015).

Children living with IPV have an increased risk of experiencing abuse and neglect at home, as well as school bullying (Hamby et al., 2010; Holt et al., 2008; Lewis et al., 2018; McTavish et al., 2016), as was the case in this sample (Cattagni et al., Manuscript under review). As a result, the present analysis cannot, and probably should not, isolate these children's experience of living with IPV from other victimizations while examining their resources and needs, but rather acknowledge that experiencing violence at home is often a multifaceted experience (Marshall et al., 2019; McTavish et al., 2016). Furthermore, Yule et al.'s (2019) meta-analysis on resilience in children experiencing violence showed that protective factors identified by research do not differ by types of child abuse.

Resilience is a process that makes it possible for individuals to achieve healthy functioning, through protective factors, despite adversity such as stressful or traumatic events (Grych et al., 2015; Hamby et al., 2020). Resilience should not be understood as an absence of pathology or of suffering (Grych et al., 2015) and protective factors are positive qualities located within the child's cognitive, emotional, environmental, social and spiritual experience that are associated with resilience and, when combined, facilitate positive outcomes (Hjemdal, 2007; Madsen & Abell, 2010). Quantitative studies on children's resilience in a context of violence or adversity have identified various protective factors associated with resilience, whether they are intrinsic to the individual, or embedded in a family or community context (Carlson et al., 2019; Grych et al., 2015; Hamby et al., 2018; Stanley, 2011; Yule et al., 2019). Among these, a sense of self-confidence, self-efficacy, and a series of problem-solving skills are factors that help children value themselves enough to persist and do their best in the face of difficulties (Stanley, 2011; Yule et al., 2019). A sense of purpose and other meaning making strengths help children have positive expectations, self-motivate and set achievable goals (Hamby et al., 2018, 2021). Within the family system, a strong attachment to the nonviolent parent is one of the most commonly found protective factors (Hamby et al., 2020; Holt et al., 2008; Hui & Maddern, 2021; Katz, 2015; Skafida & Devaney, 2023). Siblings can also play an important role in supporting each other in this context (Åkerlund, 2017; Mullender et al., 2002). Supportive relationships with people living outside the home, such as friends, intimate partners, other family members or other adults, are other important resources (Alvarez-Lizotte et al., 2020; Grych et al., 2015). Having a trusted person to disclose IPV to is reported as a first step in understanding one's experience and receiving support and help (Alvarez-Lizotte et al., 2020; Howell et al., 2015; Mullender et al., 2002). Talking about the experience of living with violence in the home and expressing thoughts and feelings about this hardship to a trusted person allows individuals to feel heard and less isolated, potentially leading to enhanced empowerment (Alvarez-Lizotte et al., 2020; Howell et al., 2015; Sadlier, 2021). Other authors have pointed to extracurricular activities as contributing to resilience, since they provide a safe place to be and facilitate new friendships (Alaggia & Donohue, 2018; Benavides, 2015; Gonzales et al., 2012; Katz, 2016; Mullender et al., 2002). In synthesis, sources of resilience are found at all levels of the individual's social ecology (Ungar, 2013). In this paper, the term "resource" is to be understood as a potential "protective factor". We favored the term "resource" simply because, being of qualitative nature, this research cannot measure outcomes and provide statistical evidence to establish that a resource is a protective factor. Instead, it proposes to highlight the resources participants described drawing on while living with parental IPV.

Few qualitative studies have examined the self-reported needs—those essential things that children living with IPV were missing for their well-being—and did not derive from

their potential support systems, whether informal or formal. Children's need to talk about IPV with their victimized mothers was identified by McGee's early study, along with their need for moral support on the part of teachers (McGee, 2000). Action research undertaken by Humphreys et al. (2010) involving organizations serving mothers and their children experiencing IPV emphasized the importance of rebuilding mother–child communication for children's recovery. Being taken seriously by adults, family members and professionals, and having their opinions taken into account in matters that affect them, are other important needs expressed by these children in various studies (Stanley et al., 2012; Källström & Thunberg, 2019; Noble-Carr et al., 2019). Research has highlighted some professionals' limitations in responding adequately to children's needs in a context of IPV. Noble-Carr et al. (2019)'s meta-synthesis of qualitative research on these children's experiences and needs found that when children encountered professionals, they often either felt that their physical safety was prioritized while their emotional needs were unmet, or alternatively, that emotional support was provided but their physical safety was not addressed.

Justification and Theoretical Framework

When examining exposure to IPV, studies collecting information directly from children are essential since children's accounts are informed by lived experience and needs (Lapierre et al., 2016; Marshall et al., 2019; Noble-Carr et al., 2019; Arai et al., 2021). Despite a growing body of research in the field, qualitative studies that do so are relatively scarce. As a result, children's voices describing the complexity and multiple aspects of their experiences are rarely heard. Examining resources and needs from their own perspective is valuable in providing an overview of what it is like to live with parental IPV while taking into account the specificities of each experience and changes over time. Øverlien (2010) argues that giving voice to children is important not only to gather more accurate information, but also to gain insight into their understanding of the situation. According to Lapierre et al., (2016), it is necessary to move from a research model "about" to research "with" and "for" the people concerned. In practice, investigating self-reported resources and needs can direct professionals' attention to resources already present in children's lives and tailor interventions as closely as possible to their resources and needs. This is the first study of its kind to be carried out in Switzerland and it draws on participants whose parents attended clinical forensic consultations in respect of IPV. Other studies are often restricted to specific groups such as children staying in emergency shelters or receiving services following parental IPV. In contrast, the present study should provide a more diverse set of experiences, resources and needs. Indeed, these patients do not always come into contact with the police, since consultations are completely independent from filing of a complaint and patients' children will not necessarily have had contact with professionals in respect of their exposure to IPV. In addition, this study unlike others, captured the experiences of these young people from birth and in all the main areas of their lives. Finally, it was carried out a few years after IPV was disclosed by the victimized parents, giving participants some distance to reflect on their own experience, thus probably enriching the findings. This study aims to generate knowledge on potential protective factors based on self-reported resources, on barriers to talking about IPV and other victimizations, and on the unmet needs described by adolescents and young adults who experienced IPV in childhood and adolescence. By exploring their self-reported resources and needs when living with IPV, it is possible to identify resources that could help meet these needs. Not talking about IPV and other victimizations can prevent access to resources and can result in their needs not being met by their family or professionals. Identifying barriers that prevent people from talking can assist to find ways to facilitate the dialogue and better meet participants' needs. In Switzerland, support and care are not well developed for children living with IPV. This study provides knowledge on which to base recommendations for public authorities, institutions, and professionals to promote these resources and to better meet the needs of children living with IPV.

This study's aim and approach to data collection draw on the field of childhood studies, which views children as social agents and experts in their own experience (James & James, 2012; Leonard, 2015), although at the time of the interviews, two-thirds of participants were no longer minors. In addition, Bronfenbrenner's ecological system theory (1994), as adapted by Heise (2011) to capture factors involved in IPV, is used in this study to apprehend the multiple levels at which children's needs and resources in a context of IPV can be found. It encompasses individual characteristics, relationships, the community, and the macrosocial level. This theory informed the research aim, data collection, and guided the data analysis. Finally, the Resilience Portfolio Model (RPM), an evidence-based conceptual framework for organizing protective factors into a coherent and global model (Grych et al., 2015; Hamby et al., 2018, 2020), has informed the analysis of data on children's personal resources. The RPM is consistent with the ecological model in integrating protective factors at the individual, family, social, and community levels (Hamby et al., 2019). In addition, Grych et al. (2015) show that an individual's psychological health after a traumatic event is a product of the characteristics of the adversity, the resources (internal or

external to the individual) and the way in which resources interact in response to the traumatic event.

Methods

Children's own perspectives on the experience of living with parental intimate partner violence are less frequently studied, so we adopted a qualitative approach, using semi-structured individual interviews. Participants comprised 20 children of former patients who had accessed a clinical forensic service in the period 2011—2018 as victims of IPV. The participants were all minors at the time of their parent's consultation. This study was approved by Swiss Ethics (State of Vaud) on March 24, 2022 (ref.: 2022–00296).

Recruitment of Participants

To recruit the participants, we first had to obtain the consent from former patients to contact their children. Former patients, and thus their children, were removed from the sampling frame if their file indicated that they either did not wish to be contacted again following the consultation or have their data used for research. Youths who were not living with their victimized parents at the time of the consultation were also excluded. Finally, children under 14 years in 2022 when interviews were undertaken were excluded from the sampling frame, because including them would have required a different study design and additional resources. Following this initial sorting, 606 children of 422 former patients were identified as eligible for the study. Each child record was given a random ID using Excel and organized numerically, but siblings were kept together in the file. Working down the list, the research team attempted to contact 75% (319) of former patients (see Fig. 1 on recruitment stages). Later, in order to ensure a diversity of profiles, calls to certain groups were prioritized (men, non-Swiss or non-EU/EFTA, unemployed, having children under six years-old at consultation time). Ultimately, their children's participation in the study was proposed, using a telephone script, to 113 former patients. During the calls with former patients, another exclusion criterion was the children's lack of awareness that IPV had occurred or parents' unwillingness that theirconsultation be disclosed to their children. Seventy-one former patients agreed to be sent a consent and contact information form. They were given 14 days to complete and return the form if they agreed to their child/children being contacted about the study, before being called again. Thirty former patients returned the form for 42 of their children. We were able to reach 37 of these children. They were given information about the study using a telephone script. Thirty-three youths agreed to receive documentation and were sent a consent form explaining the study design. During recruitment, it was made clear to former patients and their children that no information contained in the parents' files would be shared with their child/children under any circumstances. Finally, if either a former patient or a potential participant did not seem to understand the aims and design of the study or was judged by the researcher to lack capacity, his/her recruitment would have been curtailed, but this scenario did not occur. At the outset of contact, former patients' children were told that a CHF 40 gift card to compensate for their time and reimbursement of travel expenses would be available. They were given 10 days to decide about their participation before being called back. Twenty-two youths agreed to participate. Two participants dropped out before the meeting. Recruitment ended after 20 interviews, because data saturation was considered to have been achieved.

Participants

Of the 20 participants, 14 were young women and six were young men (Table 1). Two pairs of siblings were included. At the time of their parents' consultations, two male participants were aged three and six, and all other participants were roughly distributed among the 7–12 and 13–17 age groups. At the time of the interviews, participants included six adolescents (14–17 years-old), and 14 young adults (18–28 years-old; Table 1). The proportion of male and female was the same in both age groups. Information about participants' sex was collected during their parents' consultations. Information about gender identification was not captured. The time between the parent's consultation and their child's interview varied from four to 11 years. All participants but one had siblings. The victimized parents of the participants were 18 mothers and two fathers (Table 1), which is representative of the ratios of mothers/fathers consulting for IPV. In 13 cases, the perpetrator was the father, in five cases, the stepfather or the mothers' male partner, in one case, it was the mother, and in another case, the father's female partner (Table 1). All IPV concerned heterosexual relationships even though this was not a selection criterion.

Interviews

A total of 20 live one-on-one semi-structured interviews were conducted with adolescents and young adults between June and September 2022 at the hospital where clinical forensic consultations take place. They were audiotaped and transcribed with participants' informed consent. At the beginning of the interview, the researcher reviewed with each participant the aim of the study, its modalities, the possibility of withdrawing their participation at any time and of not answering questions they did not feel comfortable with. She explained the different forms of IPV and IPV exposure. The participants were told that if any information was shared that might indicate that a minor was at risk, the situation

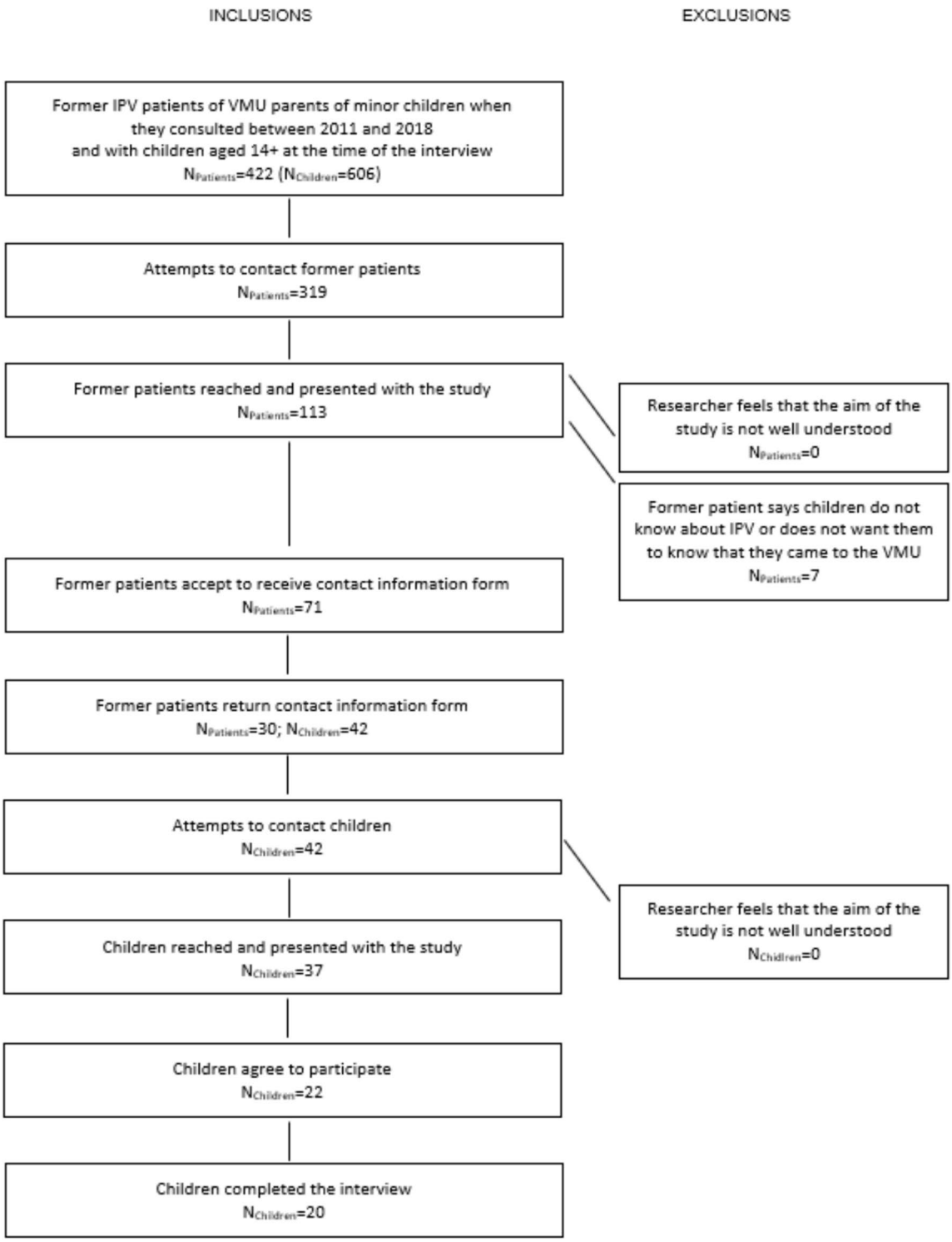

Fig. 1 Recruitment stages

would be discussed with them and the hospital's child abuse and neglect team, but this did not occur in practice. Participants were then asked to sign the information and consent form. Participants had been informed that one to two hours were needed for the interviews, but interviews lasted two hours and 20 min on average. One interview lasted 4 h10, as the participant mentioned IPV and direct violence in two households. Snacks and drinks were offered and available throughout the interviews. Participants were told beforehand that they could take a break at any time and the interviewer

Table 1 Participants' characteristics

		N
Sex	Female	14
	Male	6
Age at the time of the consultation	3–6	2
	7–12	10
	13–17	8
Age at the time of the interview	14–17	6
	18–28	14
IPV-victimized parent	Mother	18
	Father	2
IPV perpetrator	Father	13
	Stepfather or mother's partner	5
	Mother	1
	Father's female partner	1

regularly offered breaks and the opportunity to stop the interview when it went over time. Breaks were taken but only one participant cut the interview short—she announced when she arrived her need to leave for an appointment at a certain time. Interviews were conducted with the help of a written guide and a life history calendar (LHC), which consisted of columns that represented timelines and milestones, and rows that represented life domains. As anticipated (Nelson, 2019; Yoshihama et al., 2002), the LHC enabled the interviewer to follow the lead of participants in addressing different domains of their life in the order they wished. It also helped the interviewer cover every relevant period or life domains and enquire about timing or changes. The interviews covered major life domains (home and neighborhood, family history and relationships, school, friendships, romantic relationships, hobbies, contacts with professionals). In addition, participants were asked about their personality traits, their resources and needs in relation to IPV, and whether they had any advice for professionals, and parents and children living with IPV. The first question was asked about where the participants grew up, and the remaining topics were covered in no particular order, with the interviewer adapting to each participant's discourse while making sure that all topics were covered. IPV was only asked about directly if there had been no mention of it by the participants.

Analyses

Transcripts of the interviews were subjected to a thematic content analysis (Ritchie et al., 2013). Three researchers carried out preliminary analyses based on parallel readings of half of the transcripts to generate themes and subthemes, and to create an initial version of the analytical grid. Parallel coding of 15 interviews by the three researchers followed, using MAXQDA 2020 pro (VERBI software), with ongoing adjustments to the grid, to ensure coding validity. The remaining transcripts were then coded separately, with group examination as necessary. Finally, thematic syntheses were organized into a participant-by-theme matrix. The themes related to resources used for the present analysis were personal strengths and assets, supportive relationships with friends and family, hobbies, positive experiences with professionals. Other themes used for this analysis were barriers to talking about IPV and other victimizations, and unmet needs. The last three themes covered any advice participants would address to children or teenagers living with violence at the home, to parents and to professionals and their content was used to complete the analysis on resources, barriers, and needs where relevant. For each theme, changes over time were reported and thus included in the analysis.

The categorization of factors associated with resilience featured in the RPM helped organize and display findings concerning resources into three functional domains of strengths and assets: meaning making strengths, regulatory strengths, and interpersonal strengths (Grych et al., 2015; Hamby et al., 2018, 2020). As this was a qualitative study, we could not test associations between factors thought to be linked to resilience and measurable resilience outcomes. Thus, here, the RPM was simply used as a guide to identify the protective factors previously identified in the literature, and categorize them. The aim was also to explore what other specific elements participants identified as having helped them and to discover if they fitted into the RPM.

Results

Findings related to the participants' childhood resources are presented first and are mapped against the RPM framework which is explained as the results are displayed, and barriers experienced by the participants in talking about IPV or other victimizations are discussed. Findings about the participants' unmet needs come next and are organized according to whom they are linked to, i.e. family and friends or professionals. Finally, we take the analysis a step further, by proposing a synthesis where we place the results in an ecological model depicting groups of needs. Illustrative quotations are followed by information linking them to participants: participant's number, sex, age at the time of the interview, followed by age at the time of the consultation. For example, a quotation followed by "(P03 – F22/14)" means that it belongs to participant 03, who is female, aged 22 years-old at the time of the interview, and aged 14 years at the time of her victimized parent's consultation. In reporting the results, the broad term "children" is also used to include "adolescents".

Resources

Personal Strengths and Assets

Meaning Making Strengths. In the RPM, meaning making strengths represent the ability to find meaning in life, even during difficult times. They are about seeking fulfillment, often through connection to something larger than oneself, for example, through having a sense of purpose or through spirituality. Integrating traumatic events into broader beliefs and values about the self and the world can help to make sense of them (Grych et al., 2015; Hamby et al., 2018, 2020). Participants reported that understanding what they were experiencing was helpful for them at the time, although not all of them identified right away that certain behaviors from the perpetrator constituted IPV and that they were not normal. This young woman quite quickly recognized the spiral of abuse her mother had endured with her partner:

> *At the beginning of their relationship, it was "I love you, you're the best", then afterwards it was more "You're ugly, you don't do well, you suck".* (P05 – F16/12)

Others understood this very early on, such as this young man who was only six years old at the time of the consultation:

> *Well, I knew it wasn't right (…) because I could see the effect it had on my mother.* (P15 – M16/6)

Several participants considered that it was important for children to know that what they experience is not normal and that they should not accept the situation. Many participants had experienced a sense of purpose which was particularly helpful in this context; for example, a leitmotif had assisted this young woman in moving forward: "*There's got to be more to life than this [violence].*" (P06 – F22/13). Participants also identified their goals in life, such as having a healthy relationship, being married and having children, being the best person they could be, or prioritizing their education. Thus, some would advise children to focus on themselves and their own projects. One participant chose her career according to her sense of purpose, which was to help people who, like herself, faced adversity, by becoming a social worker. Similarly, a positive mindset – focusing on positive events and being optimistic about the future – constituted a making meaning strength that was described as assisting in surviving difficult times:

> *I try to get something positive out of it [her experience of violence], and if it's there, well, that's what makes me strong today.* (P03 – F22/14)

Participants would advise children in that situation to accept negative aspects of life, while staying optimistic and being patient that problems will be solved. Spiritual and religious beliefs and practices were reported to help put things into perspective. Believing in God or in other forces (e.g., "*destiny*", "*energy*", "*karma*") had provided hope, support and answers enabling some participants to get through bad experiences:

> *I think I was able to calm myself because of that [her prayers]. Thanks to prayers, giving myself over to God. From time to time, I think I pray for Him to calm my mother down... and that things will be better tomorrow.* (P18 – F28/17)

The literature points out that having a clear set of beliefs, values, and goals and the sense that life has meaning is beneficial for dealing with adversity, linking individuals to a wider faith system (Grych et al., 2015; Hamby et al., 2018). Meaning making can also foster positive affect and support sustained effort towards achieving long-term goals (Grych et al., 2015), such as the ability to reflect on personal experience and transform it into a positive element, which is described by Miranda et al. (2023) as "positive resignification".

Other strengths and assets emerged from the analyses that are not specifically identified in the RPM but that would fit into the meaning making assets category. The ability to take a step back during or after critical periods, often meaning the ability to distance oneself from the perpetrator, was a dominant theme in the interviews. This participant mentioned that, after years, she managed to tell herself that she was not responsible for the violence at home and that she could not do anything to stop it:

> *It just clicked in my head that it didn't belong to me. (P17 – F22/14).*

Taking a step back helped participants better understand their experience and put things into perspective. This aspect seems to be key in how children living with IPV cope with that experience. Indeed, Grych et al (2000) showed that these children experience less anxiety, depression, and helplessness when they have a low level of self-blame and interventions in which children are educated to understand that their experience of violence is not their fault have proved effective (Stanley, 2011). Another aspect not presented in the RPM is that if some children could recognize abusive behavior from an early age, others felt that not being aware of parental IPV protected them, at least when they were younger:

> *But…I wasn't aware of anything, I was little too, I went out and enjoyed myself (laughs). (P02 – F18/10).*

Similarly, some participants were not aware that certain behaviors towards them would be considered abusive (e.g., being left at home with her little sister for a whole weekend at age 10 with nothing to eat) and reported that they therefore were not affected by them at the time.

Regulatory strengths. In the RPM, regulatory strengths include various aspects of self-control, such as psychological endurance or self-reliance, particularly in the face of challenges. Emotional self-regulation was identified as useful in controlling overwhelming emotions, such as for this young woman, who found a way not to raise her voice rapidly when disagreeing with her boyfriend:

> *But I'm still very nervous. I'm...yeah very nervous. But I've found my little tricks, if it's really too much, I go out. I go somewhere else*. (P03 – F22/14)

One participant explained how she recently learned to take five minutes to calm down when feeling she was about to say things she would regret. These self-regulating strategies, as well as self-reliance, were often referred to as "maturity" by participants. They explained that experiencing adversity had made them grow up faster, because they got used to dealing with problems on their own and avoiding "irresponsible" behaviors (e.g., excessive drinking or delinquent behaviors). This finding echoes Banyard et al.'s study (2017) which points out that people with strong emotion self-regulation skills may be less likely to engage in behaviors that increase the risk of physical health problems. It also shows that emotion regulation increases the chances of positive health-related quality of life. In our study, self-reliance was found in the form of not talking too much about one's own problems. Some preferred to deal with their problems alone and would advise children to not necessarily talk about it in order to avoid thinking about it. Many participants described coping strategies, that is changing cognitive and behavioral efforts to manage specific issues that exceed the person's resources (Miranda et al., 2023), that they had developed over time. They included seeking help during acute IPV events, and some, contrary to what is described above, talked with someone in their social or professional network about the violence but usually late into their experience:

> *Well, during that one year, I didn't feel well and I decided to see a counselor at school to talk about it and to feel better*. (P19 – F17/9)

Persistence and motivation in the search for solutions to feel better and to achieve personal fulfillment were evident across the interviews. One participant described talking about her experiences of IPV as a self-regulation strategy:

> *Well, I think talking about it is... it allows one not to hold emotions in and not to hold a little bit of pain or irritation or things like that, that make one suddenly explodes.* (P11 – F17/14)

Similarly, some participants suggested that children should seize the opportunity to talk about IPV to someone trustworthy, and not wait too long to do so. One recommended reporting the situation to an authority (e.g., police) and persevering if one is not believed.

The ability to put oneself in a "*bubble"* is not an asset identified in the RPM but was prevalent in the results and could be identified as a regulatory strength. Many participants avoided getting involved in arguments and would advise children to do the same in order to protect themselves. For example, during acute events, they described going to their room to be alone and finding a distraction to escape reality, as also reported in Mullender et al.'s (2002) and McGee's (2000). Trying to suppress or suppressing the memory of IPV also appeared to be helpful for some:

> *It's as if I'd seen something and remembered it, but completely forgotten about it. Well, I think for a moment I just forgot about it and just wanted to enjoy it [the moment], without worrying about it.* (P02-F18/10)

Some participants left their home during altercations to go out or went to a friend's or family member's home where they could feel safe, and would advise to do the same:

> *Well, I tried not to be there, actually I didn't want to be there. I didn't want to know what was going on, so I went to her [friend's] house.* (P05 – F16/12)

Interpersonal strengths. In the RPM, interpersonal strengths comprise relational skills that enable individuals to establish, maintain and strengthen positive interpersonal relationships, and support from the social environment. The ability to overcome difficulties in trusting people, despite their negative experiences, was emphasized several times across the interviews. Being able to make friends easily was identified as an important skill, as well as showing empathy and compassion, or being a confidante for friends:

> *Well, I've always been very... I'm very good at listening to people, [...] I'm not very judgmental. […] But I'm always... well, people are always quick to trust me and I... well, I try to give them as much advice as I can. (P19 – F17/9)*

Another asset included in this category was generativity or a willingness to promote the wellbeing of the next generations. One young man described passing on positive values to younger children. Talking about friends he met in a park, he said:

> *They're younger than me. But I can bring them something bigger than them (...) I can bring them certain values. For example, (...) sometimes, some kids (...) like to fight, but..., I hold some of them back and say (...): "You know, you have to realize that maybe he's smaller than you. You shouldn't... even if he provokes*

you, you shouldn't say such and such to him. Try to be fair". (P20 – M14/3)

Caring for younger siblings also gave two participants a sense of usefulness. These results corroborate other findings that emphasize social skills as a significant protective factor against the development of depression, anxiety and behavioral problems in adolescents exposed to IPV (Benavides, 2015). In addition, being able to maintain social ties increases the possibility of receiving social support to combat adversity (Howell et al., 2018).

Supportive relationships were explored during the interviews. The victimized parent (usually the mother) was most often described as a multifaceted source of support. Types of support cited included loving, listening, protecting (e.g., physically from the perpetrator's violence), caring (e.g., offering to see a therapist), helping to find solutions (e.g., contacting the police to report father's violence to the child and filing a complaint), and doing activities together. This participant found relief in talking with her mother about difficulties she experienced at her father's home:

Luckily my mom has always listened to me a lot, I've always been able to talk (…) with her (...) because it wasn't really easy with my dad. (P06 – F22/13)

Some participants considered that their mother's decision not to discuss IPV with them until they were older had spared them distress:

She kept it to herself and it was only later, when she wanted to explain to me what was going on [that IPV led to financial difficulties], that I understood. (…) I think talking about it at 16 is a good age. I mean...I've been told about it since I was 16 and...yeah, I was quite mature. (P02 – F18/10)

Victims were also seen to have protected their children by separating from the perpetrator. Most participants said they felt very close to the victimized parent who seemed to have been the most consistent source of support. This relationship appeared central in participants' lives and this is consistent with other research (Zaouche Gaudron et al., 2016; Noble-Carr et al., 2019). The importance of the caregiver in helping to build emotional regulation skills was underlined (Bender et al., 2022), as was the value of having a reflexive discussions about IPV with the victimized parent (Naughton et al., 2019). Supportive behavior from perpetrators was also mentioned, such as shared activities or discussing personal issues, but it typically took place in the distant past, usually before IPV started or worsened. This participant described the loving relationship she had with her stepfather, who entered her life when she was four years-old, before it deteriorated following the birth of his own child:

He [stepfather] took care of me as if I were his daughter, I really didn't feel, uh... that distance, given that I didn't have a father (…) But when he [her half-brother] was born, he [my stepfather] completely changed. I was too much. I wasn't his daughter anymore. (P03 – F22/14)

Siblings' roles were also underlined as important because they shared similar experiences and could comfort or distract each other during difficult times:

Well, in the sense that the two of us were kind of in the middle, there was my dad, my mom, and we were there. We had to stick together. (P08 – F18/12)

The importance of the relationship with siblings, notably in terms of attenuating stress is underlined in previous studies (McGee, 2000; Mullender et al., 2002). Other family members (e.g., grandparents; aunt/uncle) provided constant and varied types of support, such as daily care when parents were at work, distraction, affection, listening and protection:

My aunt played an important role because she positioned us back as children by saying: "daddy and mommy are fighting, but it's not your fault." (P17 – F22/14)

Some family members were called in during acute IPV events to intervene and stop the violence. Their home was often a place of refuge during and after a critical period. Support from friends came in the form of distractions, but also in serious discussions about personal matters. Friends were sometimes participants' only confidante and played an active role in helping to understand that the situation was not normal.

We [she and her best friend] used to talk a lot, a lot, a lot. (...) I used to get things off my chest with him (...) [He] made me understand (...) about my dad, that it [direct violence] wasn't normal (...) he was like "No, that's not good, something has to be done". (P03 – F22/14).

Friends can in fact be a first choice for emotional support and are considered to be able to keep a secret (Humphreys & Mullender, 2002). Participants sometimes also found support from boy/girlfriends who listened to them, cared for them, as well as hosted them during difficult times. Intimate partners were sometimes seen as their only escape at some points, or as people who filled an emotional void. Having a healthy relationship with one's partner seemed to reduce the fear of repeating a family pattern and gave hope for the future:

Yes, I have a boyfriend and things are going really well with him. There's no problem, he accepts me as I am. He's very nice, he doesn't like to shout, he doesn't

argue. He doesn't do anything violent like him [her stepfather] when he yells and points his finger at your face. He [boyfriend] doesn't do anything like that. (…) And he's not controlling, either, in fact he's too nice. (P01 – F20/11)

Other adults (e.g., neighbors; co-workers; nannies; friends of the family) also occasionally provided support through visits or by hosting them in a calm environment or after acute IPV events. Trusting relationships with non-parental adults also emerged as a resource in Deutsch et al.'s qualitative study (2020), providing not only emotional and instrumental support, but also a relational template that models safety, empathy and other interpersonal skills and children living with IPV have reported the value of such a safe haven (Mullender et al., 2002). This participant summarized the benefits of having a supportive environment when living with violence at home:

I think it helped me to have a brother or a sister who was there and who was going through things with me, to have other witnesses, and also the fact that it wasn't a taboo, as it can often be in other families. But especially my mother, my mother's friends and both my parents were aware of what might be going on. So, I think that helped me a little bit, to know that I wasn't the only one who knew about it. (P14 – M23/15)

Other interpersonal strengths not identified in the RPM but present in the participants' accounts were the ability to set limits but also, in contrast to what is described above, not trusting people too easily. The ability to set limits with people included standing up to the violent parent. For example, this young woman challenged her father's denigration of her mother post-separation:

And often, I would bring him [perpetrator] back to reality and say: "But she [the mother] isn't here, why are we talking about her?". (P17 – F22/14)

Not trusting people easily was mentioned as another way of protecting themselves from people who might hurt them. Some talked about having an intuition or a bad feeling about newly encountered people, which they took seriously, consciously choosing their friendships or romantic partners or advising others about relationships:

My mother (…) had boyfriends afterwards...I just didn't have the right feelings about them. And then, well, I was right, there was a... a guy, and I said to her: "Mom, this isn't going to work at all, well, he's really not...". And now she listens to me. (...) I think I get hunches about people when I meet them, I don't know, sometimes I just know that things are not right. (P05 – F16/12)

Changes and Relativity in Strengths and Assets. Several strengths and assets were described as developing over the years. Some participants started to have a better understanding of the situation when violence stopped, or their parents split up:

I was thinking: "yeah, well, maybe it's actually all the kids [who experience IPV]." And it was only later that I finally began to understand the relationship between my mother and father, and I realized that it wasn't normal at all. (P08 – F18/12)

However, having come to better understand one's own experience was not seen as a resource by everyone. For some, becoming aware of the violence at home was seen as a burden with which they had to live. While some participants began to believe in God or other forces and to pray when things were difficult at home, others, to the contrary, started to question the faith that had accompanied them so far. Emotional stability was frequently attributed to the maturity that came with age. But sometimes emotions (e.g., anger) were experienced as becoming so strong that they made participants aware of the need for action or change. Not talking about the violence could be seen as a resource at one point in time but is also a barrier to accessing resources. Self-built "bubbles" had a protective function but in the long run, could lead to loneliness. This was how some started to feel the need to reduce their isolation and talk more openly about their problems:

Given that I'd been through a bit of a rough patch, I thought I'd have to break out of this shell I'd built, finally thinking I'd have to socialize a bit. (P06 – F22/13)

Such realizations often coincided with the departure of the perpetrator. Thus, sometimes, withdrawal or defensive strategies were seen as a short-term resource which could become a difficulty later on. One participant described leaving the house as a young teenager to avoid her parents' endless arguments, but this resulted in her skipping meals, losing weight and also hanging out in the evenings with bad company. Social skills as well as supportive relationships changed over time as well. Support from the victimized parent was sometimes temporarily reduced or absent but improved following separation:

And then I saw that there was nothing but good to come out of their separation. (...) I got on better with my mother because there were too many arguments, so I saw that things had settled down. (P15 – M16/6)

As noted above, many mentioned drastic changes in the quality of the relationship with the perpetrator, often coinciding with the beginning or a worsening of IPV.

Some such relationships also improved or worsened after the separation. Some relationships with siblings turned sour around and after IPV or the separation. Participants mentioned disagreements with their siblings in their understandings of the situation at home as well as siblings who at some point started to be physically and verbally violent. Friendships were sometimes affected, mainly by losing touch with friends because of the family's multiple moves or because of repeating grades at school. Supportive intimate relationships also started and ended. The ability to set limits often manifested itself during adolescence, when some participants mentioned that they were less afraid of the perpetrator or when they felt they had reached the limits of what they could endure:

> *Yeah, so with my dad, I managed to set it [the limit], but because it was really... a lot of suffering, actually. [Interviewer: "You'd reached a point of...?"] Yes, a point of... a dead point, that's it.* (P17 – F22/14)

In terms of advice participants would give to children living with IPV, the findings often revealed gaps between the advice they were formulating during the interviews and what they themselves did or did not do in the past. For instance, almost all participants suggested that children should talk about IPV, even though many of them did not talk to anyone about it for many years indicating that their perspectives had evolved over time.

Hobbies and Activities

We found that engaging in hobbies, whether group or individual activities, helped participants relax, forget about problems, and gave them a sense of freedom. Benefits were frequently identified from participation in sports, but also in other cultural or recreational activities carried out with relatives or friends (e.g., going to the museum, zoo, the movies, or catechism class). These activities made them feel part of something positive. They also facilitated the formation of friendships, improved participants' self-confidence and allowed them to let off steam:

> *It (soccer) was also a very important thing for me because these were moments when I could relax. I was calm, I let go of everything that was on my mind and concentrated on the ball and the goal.* (P04 – M17/12)

Combat sports such as Taekwondo or Kung fu were mentioned as transmitting positive values such as self-control. These activities also provided a safe place and an escape from home. One participant cited horse riding as a passion and described the riding school as a place where she, to this day, feels most at home:

> *I grew up (…) riding every week. I had friends, so I was happy because I felt good, I didn't think about anything, I was with the horses, my friends, we played all day (…). And (…) now I notice that... that if one day, someone tells me,"(...) you can't ride anymore because...", I don't know, (...), my world collapses. (…) Mentally, I couldn't bear it. And (...) I realize that yes... it's really important.* (P19 – F17/9)

As noted in this quote, group activities could also be a means of connecting with friends. In line with our results, Gonzales et al. (2012) showed that hobbies and activities allow children to make connections and provide a safe haven which compensates for children's lack of freedom and safety at home. Hobbies and activities also expose children to peers through structured and supervised activities, and this can promote self-efficacy, competence, and accomplishment (Alaggia & Donohue, 2018; Gonzales et al., 2012; Yule et al., 2019).

Individual activities, such as reading, writing, playing an instrument, listening to music and playing video games could be used as a distraction during acute IPV episodes but also in an ongoing context of difficulties at home. They were helpful in creating the "bubble" and an escape from reality:

> *Well, I read a lot, I don't know if it was an escape for me, but I had a little bit of a need to be in my own world, and then I felt that when I also watched a TV series or a movie, it was good for me to escape reality a little bit and to attach myself to these fictional universes*. (P14 – M23/15)

Writing down problems was also seen as a way to get rid of them:

> *It's putting into words what's going wrong, (…) afterwards, burning the sheet, tearing it up, like that, bam! It's over, it's gone, even if it's not going to fix it.* (P03 – F22/14)

Finally, simply being alone during these activities was seen as a resource. Some participants insisted on the importance of self-care, they would advise others to find their own means of escape, and cheer themselves up with activities they enjoy.

Positive Experiences with Professionals

Beside school staff, participants reported having been in direct contact with between one and six types of professionals during their childhood. In respect of violence at home, two participants had met social workers, three had testified in front of judges, six had had direct contact with child protection services (CPS), seven with police officers, 10 with physicians or pediatricians and 18 with psychologists

(including school psychologists). School professionals (i.e., teachers and school psychologists) were helpful in acting against bullying and offering psychological follow-up. Some teachers noticed behavior changes (e.g., falling asleep in class) and expressed their concern. One participant identified her teacher as a role model and compared her positively to her parents:

> *And then even in high school, my French teacher was so cool, like, really. I thought to myself, "Oh, you can be 35 and be open-minded" (laughs). I'd rarely seen anything like it.* (P09 – F20/11)

One participant spoke of a mentor, with whom she met weekly during her apprenticeship, as a resource because she helped her understand that she was not responsible for what was happening at home and that she had to think about herself and her future first. Reported benefits of the interactions with judges and lawyers involved making the direct violence they experienced stop and being able to be heard during divorce hearings. During contact with CPS, participants appreciated being listened to, understood and offered a safe place for contact visits with the violent parent. Positive experiences were mentioned with other social workers as well, such as staff at a shelter for victims of domestic violence, who provided a pleasant environment and distractions:

> *When I got there, it was the best days of my life, because I said: "At last, it's all over". And then, really, they helped us a lot. They took us on excursions and things like that, and we went to museums and so on.* (P01 – F20/11)

One participant felt relieved that police officers were handling the violent situation at home, so she would not have to face it alone, but also because it acknowledged her experience and legitimated her reactions:

> *It did me good too to explain. And to tell myself: "it's not me anymore, it's the police, the state, all that.*" (P03 – F22/14)

Some participants also reported feeling heard, understood, and protected by the police and in some cases they were given the opportunity to file a complaint. Physicians were helpful in referring them to psychiatrists and treating panic attacks. Psychotherapists were appreciated because they guaranteed confidentiality and gave strategies and advice, about how to react to bullying. They provided help with handling a parent's divorce or with understanding what is not normal, such as parents communicating through their children. Psychotherapy sessions also brought relief by allowing some participants to process their experience. They became able to talk more easily about it, sometimes only recently, as in this example:

> *All those things I told you about, before my therapist [consulted in the year preceding the interview], I never talked to anyone about them. So, I'm kind of past the hardest part of like...um, talking about it and like putting words to what it is, that it's not normal or whatever. And accepting that it's part of me.* (P09 – F20/11)

One participant would suggest that children talk to a professional because confidentiality is guaranteed. She explained that a professional can be more trustworthy than a relative or friend because they are neutral:

> *The fact of having someone to talk to, it's good because you talk, you talk and above all, it's someone who's not going to repeat. It's someone you don't know, so it's perfect because there's no risk of anyone knowing or things like that.* (P01 – F20/11)

Thus, participants experienced various types of support from diverse professionals. They particularly valued being listened to and taken seriously, which is a crucial need identified in other studies (Källström & Thunberg, 2019; Stanley et al., 2012).

Barriers to Talking about IPV or other Victimizations

Some participants were talking about their experience for the first time during the interview. It appears that IPV and other victimizations, notably direct violence from the IPV perpetrator towards participants, was rarely talked about, even with professionals. For example, in school, only one participant had talked about IPV and direct violence, and CPS were unaware of such direct violence for 15 participants, for whom it was a reality. In general, when multiple types of victimizations occurred, only one was addressed:

> *[Interviewer: "And the school and the psychologist, were they aware of the violence against you (…) and against your mother?"] Uh...I don't think so (…) In any case, I didn't talk to them about that. I talked more about my situation [bullying].* (P04 – M17/12)

Various types of barriers could be identified in the participants' discourses: personal barriers, barriers related to social perceptions, barriers of an altruistic nature, and barriers related to missed opportunities by professionals.

Personal Barriers

These included thinking that the situation at home was not abnormal, not feeling the need to talk about it, or being willing to handle problems alone. One participant portrayed herself as being reserved and explained that it prevented her from talking about her experience. Another one said that she minimized the severity of her experience of IPV:

Because (...) I've always told myself that there's always worse. And so, my discomfort was kind of insignificant. (P08 – F18/12)

The fear of recognizing the situation as a serious problem was expressed:

I wanted to call the police, so that someone else could intervene, but at the same time, in my head, if I called the police, it meant that something serious was going on, and symbolically it was bothering me and I never did it. (P14 – M23/15)

Some expressed the need to not get involved and to detach themselves from the experience, in order to protect themselves emotionally. Others felt they were not ready to talk because it was too hard to open up:

It's a very long process. A few years ago, I would never have told it the way I'm telling it today (...) because it's a process that takes a long time to understand, and a long time to detach oneself. (P17 – F22/14)

Barriers Related to Social Perceptions

These included feeling shame and guilt (e.g., feeling that the perpetrator's violence was due to their own behavior), as well as not wanting to be pitied. Other such barriers were the fear of not being taken seriously and of potential negative consequences such as the perpetrator hearing about it and getting angry, breaking up the family, or, for two participants, of being taken into care:

It can just screw things up and…ruin a whole family over something that could be, I don't know, maybe misinterpreted or…I don't know… (P16 – M20/10)

Some of these barriers echo those reported by adult victims of IPV, such as barriers related to social stigma and fear of the consequences of disclosure (Stanley et al., 2012). Some participants also felt that they did not have anyone trustworthy or strong enough to talk to. McGee (2000) and Howell et al. (2015) showed that children often wish to disclose, but can lack safe and secure outlets for appropriate disclosure. Doubting that they could be helped, either by a professional, any other adult or friend was another reason not to talk. Poor perceptions of CPS and psychologists also prevented some of them from talking.

Barriers of an Altruistic Nature

Wanting to respect the victimized parent's choice not to talk about IPV or not wanting to worry her/him by disclosing direct violence inflicted by the perpetrator, were mentioned:

I didn't want my mother to get angry, I don't think she would have, but I wanted her to be happy. Now, I know she was not happy when he hit her, but...I don't know... (P05 – F16/12)

This strengthens previous research demonstrating that the children often rely on adults to disclose violence and abuse, but adults may choose not to disclose for many different reasons (Lapierre et al., 2018; Marshall et al., 2019). One participant reported that her brother was a "troublemaker", so she did not want to add more problems to the family by disclosing IPV. Some participants indicated that IPV "was not something that was talked about" within the family. Sometimes, they were told by parents or other family members (e.g., grandparents) to keep IPV a secret. Feeling pity for the perpetrator was another such barrier.

Barriers Related to Missed Opportunities by Professionals

Finally, professionals missed opportunities to talk about IPV and other victimizations. It seemed that they sometimes chose not to directly address the issue with the children, for example during police interventions for IPV. But this opportunity was missed even when a participant saw a psychotherapist following some very severe physical IPV events where she had been present:

I know I had to do drawings. I mean, it wasn't something that helped me. We didn't talk directly about it. (P13 – F15/9)

One participant explained that her physician provided care in relation to panic attacks and fatigue, but without investigating their cause. A previous study on the same clinical forensic population showed that pediatricians are rarely aware of children's exposure to IPV (Dessimoz Kunzle et al., 2022).

Some participants noted changes over time in their ability or willingness to talk to professionals about violence at home. In addition to increasing maturity that enabled them to open up on difficult topics, other enablers of disclosure were identified. For some, it was because the danger had passed (e.g., perpetrator left the house), or because they could not hide it any longer, for example, when injuries inflicted by one parent were visible to the other. One participant described wanting to protect their younger siblings from the same experience:

I said no way, my sister would have to go through a quarter of what I went through. My little sister, so I, we went to the police. (P03 – F22/14)

Finally, as they got older, participants learnt new facts about their family's experience of IPV, so they acquired a better understanding of the situation, which facilitated discussion.

Unmet needs

Regarding Support from Family and Friends

Participants identified a range of unmet needs regarding the responses of friends and family and were asked whether they had any advice to offer to parents experiencing IPV. The need for IPV to stop was expressed many times and in different ways. While all participants but one identified the perpetrator as responsible for the violence, and therefore with the power to stop it, three also suggested that victims should ask for help:

> *Don't hesitate to file a complaint. (...) If it can make the person [perpetrator] realize something, that it was that serious...* (P18 – F28/17).

Some had thought that if their parents separated, IPV would stop:

> *The need I had was actually uh...maybe for my parents to be separated. The need I had was to get things back to normal.* (P15 – M16/6)

Some participants felt they should have been spared the experience of IPV or any other problems in their parents' relationship, because it caused them anxiety:

> W*hen you experience domestic violence, well, you see things you shouldn't, because adult problems are adult problems and should remain adult problems.* (P17 – F22/14)
>
> *I'm fed up with it, in fact. I can't listen to it anymore. I shouldn't be in the middle of it. I shouldn't be involved in all the mess (...) in fact, I know everything that's going on in their divorce. I mean, they tell me and I shouldn't know about it. And that's what pisses me off.* (P12 – F18/12)

The need to be spared and for the violence to stop is also documented in Noble-Carr et al.'s (2019) meta-synthesis. The need to be protected was a common theme across the interviews. Some described neighbors who they were sure had heard what was going on in their home and should have called the police but did not. The need for adults and relatives to speak out and report IPV was expressed:

> *I'd like to say (...) the other adults who might be around this couple and who see the children, okay it's not their children, but they're adults and they're just as responsible as the parents. In fact, I almost feel like saying that it's the other adults who hang out with this couple who should sound the alarm.* (P17 – F22/14).

In some situations, not being protected by their parents or family members who were aware of or witnessed IPV or direct child abuse episodes were experienced as appalling:

> *And how is it possible that his brother [the perpetrator's brother] did nothing? That's inhuman, whereas I asked him: "Help us!" Really, I said: "Help us, help us, help us!" And he didn't.* (P01 – F20/11)

The importance of being believed, defended and protected by the victimized parent in the face of direct violence by the perpetrator was mentioned several times:

> *And then Mom came home and I explained what he'd done, that he'd slapped me and thrown my glasses away, [she said]: "But [name of participant] stop, you're going too far, he can't do things like that" (...) It was the first time I had dared say something.* (P03 – F22/14)

These results corroborate Hui & Maddern's findings (2021), in which children sometimes did not feel protected by the non-violent parent and other adults.

Several participants wished that someone would have really listened and believed them regarding their experiences of violence. As found in Noble-Carr et al.'s study (2019), some relatives or friends they confided in had not responded appropriately but instead had ignored or minimized problems or defended the perpetrator:

> *Instead of: "But what are you really worried about?" I was always told: "Yeah, but it'll be fine, it'll pass". But here you are: "It'll pass", it's not like that (...). It didn't reassure me at all.* (P06 – F22/13)

Others simply had no one to talk to. A few described lacking anyone among their friends or relatives who could support them during difficult times and compensate for their parents' unavailability. Indeed, some explained that they felt rejected or abandoned, mostly by their father (perpetrator), but also sometimes, even if only temporarily, by their victimized mother, and that they lacked affection and attention:

> *Like right after the divorce. (...) I mean, I think the two [parents] were trying to rebuild their lives (…) I think there were times when they were more focused on themselves and on (...) rebuilding. Rather than on the needs of their children.* (P08 – F18/12)

The needs for distractions, to relax or rest was expressed by participants, who wished they could have had a break from taking care of younger siblings or from dealing with tensions at home:

> *And that's why I didn't dare leave the house or do anything else or go to anyone's house, my grandmother's, or spend time anywhere else, because I always felt I had to be in control of what was going on.* (P14 – M23/15)

Finally, the need for stability was noted. Some participants said that multiple moves weighed on them, or that they wished they did not have to always go from the father's home to the mother's or to regularly be sent to relatives or friends so that single parents could juggle their schedule. A need for financial stability was also mentioned:

> *But it was a really difficult time because my mother (...) had three jobs, so it was complicated for her and also for us because she spent very little time at home. Then she didn't get much money for the amount of work she did. So it was a bit complicated (...) the first year [after the separation], because we really had to cut back on everything.* (P04 – M17/12)

Others expressed the need for their parents to be emotionally stable:

> *Well, maybe it's not her fault, but she [her mother] must take her medicine, someone has to do something to make her take her medicine. [Interviewer: So that you're... safe?] That's it.* (P18 – F28/17)

The need for affection and stability is also stressed in the literature, as well as the need to be able to just relax (Cater & Sjögren, 2016; Dumont & Lessard, 2019; Hui & Maddern, 2021).

In respect of professionals

Three main categories of unmet needs regarding professionals were identified: prevention, protection, and care and intervention needs.

Prevention Needs. Participants argued that violence within the family should not be a social taboo and should be talked about at school in particular. That could raise awareness that violence is not normal:

> *We all have different family lives. But there's one thing that connects us all (…) we all end up going through it, it's school (…) it's something other than family. We create friendships [there], we create new things, we learn (…) and I find that in schools, there should be so many more things put forward.* (P03 – F22/14)

Protection needs. Some participants wished they could have been in contact with professionals acting to protect children who could have found solutions and strategies tailored to their needs:

> *Perhaps to talk about it with professionals who might have been able to intervene, and there would have been solutions that would have been within my reach and that could have been an emergency exit*. (P14 – M23/15)

Another need was to be provided with a safe place, in order to feel removed from danger:

> *But what would have been nice would have been something, some kind of center, like a space for young people in that situation, with counsellors who don't necessarily force the kids' hands. I dream of a place where no one asks me questions, just that we're welcomed. Maybe it's strange what I'm saying.* (P12 – F18/12)

Some professionals were criticized for their inaction and lack of care, for example, this participant commented on failure of police attendance at their home for IPV:

> *But in the end (…) it didn't help much. They [the police] were there to guarantee a bit of security, to put a bit of a stop to things, but in the end, they left again. The next day, it started all over again.* (P07 – M26/17)

Some participants felt that some of the professionals who knew about the violence minimized their experience of violence, whether at school or at home, or did not do anything to protect them or help them. Some wanted the perpetrator to be punished:

> *I have the impression, yeah, that he wasn't punished, nothing, that it [IPV] is a normal thing and worse than that, that it went through the cracks*. (P07 – M26/17)

Others considered that relevant professionals should remove child custody from the perpetrator:

> *[Interviewer: "So, you feel like there's... there's not much done (…) about your dad's actions?"] Yeah, nothing. A bit of distancing, and then I had to decide that... around the age of 14 that I wanted to stop seeing him.* (P20 – M14/3)

The results show that children's needs cut across all professional fields: school, child protection, police, justice and psychology, but also medicine and law. One participant said that her mother's bipolar disorder should have been better managed by her physician:

> *What was difficult was that we looked for a long time with my mom's doctor (...) to be able to have either a PLAFA [mandatory psychiatric admission], or something to put a stop to it, [the doctor] never wanted to take responsibility for it (...) It would have prevented these stories with knives [aggressive behavior on the part of her mother] (...) and wouldn't have had so much impact on us either.* (P10 – F24/16)

One participant argued that the law should make it easier to protect victims of violence:

I would need... not to be listened to, no. I'd need... an act. An act that would say this is wrong! (…) And I would have needed someone to say, 'That's clearly not right" and it has to be like a strict law that's written down. We can intervene at any time, even if we don't have proof! (P20 – M14/3)

Care and Intervention Needs. Participants recognized the challenges involved in communicating with children about IPV and stressed the need for professionals to be proactive and encourage children to talk to them, while at the same time, respecting their wishes if they do not want to talk:

In schools (...) you'd have to have someone neutral, someone who's not a nurse or a psychologist, someone who comes into the classrooms on purpose, (…) to take the children one by one, ask questions and try to dig deeper because (…) It's never a child who is going to talk [first]. (P03 – F22/14)

As described above, the ability to talk about violence and the understanding that is not normal changed over time. Sometimes the moment was not right for participants to talk and thus they advised professionals to acknowledge that potential for change and to repeat attempts:

They [CPS] opened a case, and they quickly closed it because I couldn't open up. (…) They were asking me questions, I wasn't ready to answer (...). I hadn't thought about it yet. At that time, I couldn't accept that my parents were separating and that they were asking me questions about it.… I would close up. I didn't want to answer, I just stopped talking. As a result, things shut down pretty quickly (…) I said there was no more violence at home to... put an end to it, in fact. Because I didn't feel like going to appointments anymore. (P12 – F18/12)

Professionals also needed to pay attention to children and to any signs of IPV or other victimizations, such as changes in behavior:

You can tell when someone has problems at home. [Interviewer: "How does it show?"] I don't know (...) their behavior, even if they hide, it shows because (...) maybe, I don't know, they used to be a nice person, but then they became too aggressive or something like that. (P01 – F20/11)

Children also required attention and care during professionals' meetings with IPV victims. One participant who had experienced interviews at home with two psychologists in the presence of her siblings and her victimized mother thought she would have benefited from repeated visits and from being seen individually:

Well, we already had the psychologists who came to the house, but (…) maybe they could have come a bit more (...). Well, because they were there once or twice, maybe if we'd continued, and maybe (...) not with my two other sisters and my mother there. (P05 – F16/12)

When the children find the courage to talk, professionals were urged to take their words seriously and ensure confidentiality:

I wanted to talk to the school nurse. (...) and, in fact, it was a disaster (...) I remember saying to the nurse, 'I don't want my father to know'. Because we're afraid there'll be reprisals. And in fact, my parents and I were summoned. There was the headmaster. And I swear it's true. The headmaster was one of my father's school teachers. In fact, there was a moment of friendliness. And I said to myself: "Where the hell are we?" (P17 – F22/14)

Similarly, Källström & Thunberg's research (2019) involving interviews with teenagers exposed to family violence explored what they valued in counseling and highlighted that establishing a trusting and confidential relationship with the counselor was a central element for these young people.

Finally, it was recommended that professionals involve children in the decision process. As noted in previous research (Lapierre et al., 2022; McGee, 2000), children often want to be informed and involved in decisions. For example, this participant criticized CPS's decision to award custody of her half-brother to his father [the perpetrator]:

For example, [professionals] can sometimes say: "Yeah, we know, we're adults, but you're children, you don't know". I think you have to get rid of that at all costs in that kind of situation. Because children are going to say things, even if they don't say them with the right words. (P06 - F22/13)

Synthesis

Resources can help meet needs. But not talking about the violence can prevent access to resources. Based on needs that were identified both as unmet (i.e. from the result section on unmet needs) and in relation to resources that were mentioned (i.e. from the result section on resources), four main groups of needs can be identified (Fig. 2): *Safety and protection* (Diagram a) includes the following sub-themes: stop violence; be defended/protected from perpetrator; punish/treat perpetrator & remove custody; protect victim; be spared; and speak out/report. The *Care and affection* group of needs (Diag. b) includes affection/love; attention/care; distraction/relaxation/rest; and stability. *Talking about the*

violence (Diag. c) comprises having someone to talk to; be listened to and believed; and confidentiality and neutrality. The last group of needs is *Understanding and coping (*Diag. d) and encompasses knowing that the violence is not normal; knowing that it is not your fault; understanding your experience; and solutions and strategies to protect yourself. Figure 2 shows, for each of the four groups of needs, where people or institutions were reported as failing to meet needs (in black) and those who acted as resources (in green) are located in the ecological model. Barriers to talking about the violence are situated as well (in red) and sometimes belong both to the relational and community levels. These models can assist in identifying where improvements can be made in meeting each group of needs.

The first general observation is that for each group of needs there is a potential for mobilizing resources at the individual, relational and community levels to support children. Unlike other people and institutions, the victimized parent, friends, and school were identified as resources in all groups of needs. Hobbies also hold a place that may have been previously undervalued, as we can locate them as a resource in all groups except for *talking about the violence*. While unmet needs are found in respect of professionals in each group, professionals of various types also appear as resources in each group, and are the most constant potential resource at the community level. Perpetrators appeared as a resource only in the *care and affection* group (Fig. 2, Diag. b), but that relationship often deteriorated in line with the beginning or the worsening of IPV. *Safety and protection* needs (Fig. 2, Diag. a) comprise the most diverse set of persons and institutions related to unmet needs and compared to the other groups of needs, these needs are the most spread out across the ecological model, touching on three different levels. It is noteworthy that if the justice system was a resource in terms

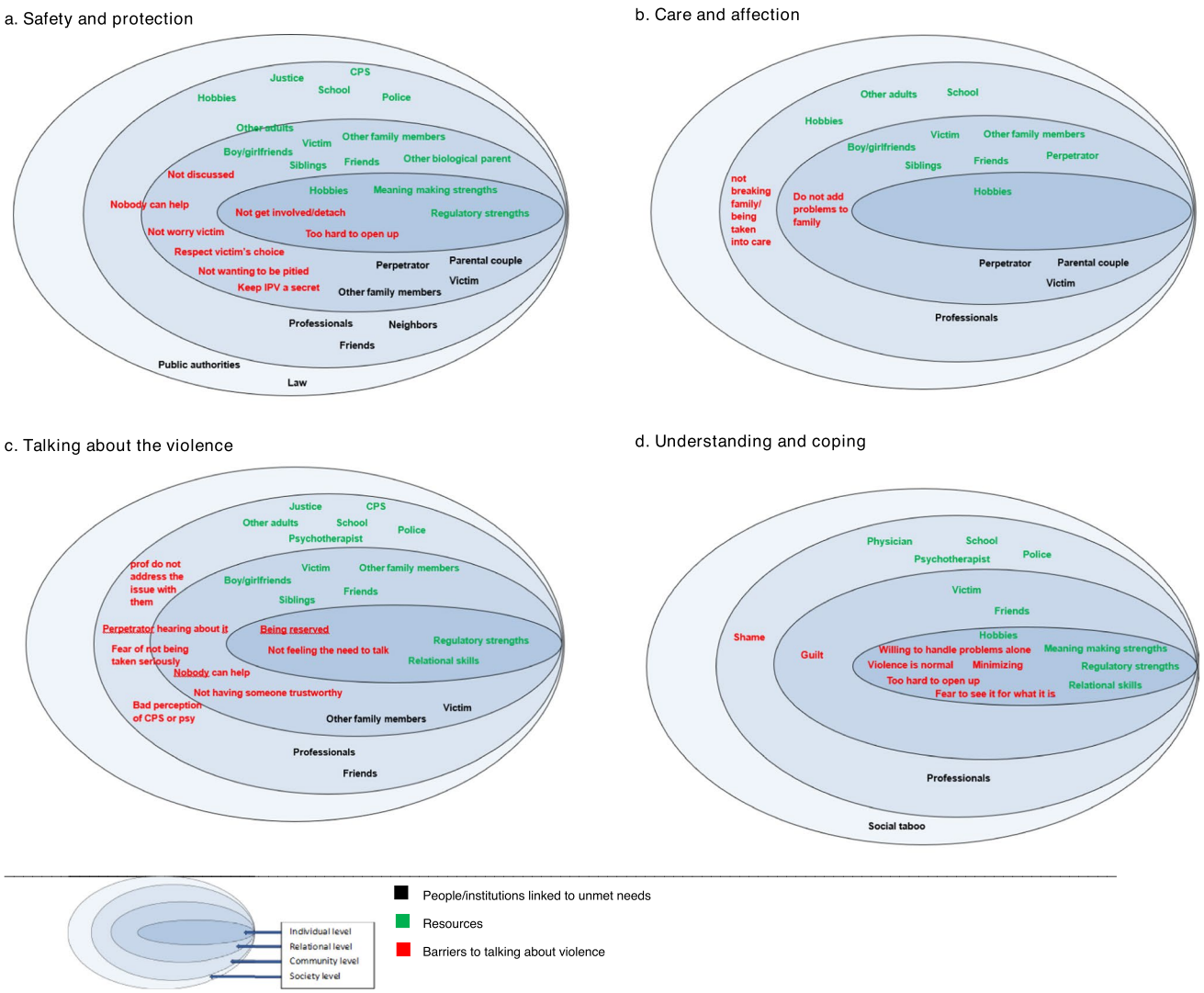

Fig. 2 Resources, barriers, and failure to meet needs, by groups of needs

of protection, it was not identified as such to meet the need to punish or treat the perpetrator (detailed data not shown on Fig. 2, Diag. a). Many of the barriers related to *safety and protection* are located within the relational level (Fig. 2, Diag. a). In the *talking about the violence* group of needs (Fig. 2, Diag. c), we note that many barriers are located at the community level. In Fig. 2, Diagram d, *Understanding and coping* needs, locates resources essentially at the individual and community levels, mainly through different professionals, while no family members other than the victim were cited. Besides feeling shame (community level) and guilt (relational level), all the other barriers are located at the individual level in that group. Resources related to *care and affection* needs (Fig. 2, Diag. b) can potentially be very diverse and go beyond relatives, for example extending to friends and school, but can also be found at the individual level through the practice of hobbies.

This use of the ecological model illustrates how the levels and the elements within them can interact with each other. For example, hobbies can reinforce meaning making, regulatory, and interpersonal strengths. Conversely, participants linked the social taboo around IPV and the fact that children can live with IPV without thinking it is abnormal; this constitutes a barrier to talking about it and thus also to accessing additional resources.

Groups of needs are shown separately in Fig. 2 to offer a clearer view of the potential for meeting them. However, this should not mask the fact that responding to one need may also assist in meeting another. For example, feeling safe and protected, notably because the violence has stopped, will help to address the three other groups of need. Indeed, some participants reported that after the perpetrator was no longer living with them, their understanding of the situation improved, they were able to talk about the violence, and that their relationship with their victimized mother was stronger. Finally, one should keep in mind that, as noted above, needs, resources and barriers are not static but evolve with time.

Discussion

This study is one of the few to have explored the experiences of children living in a context of IPV from their own viewpoints and is the first of its kind in Switzerland. Its retrospective nature has allowed us to capture the views of participants with several years of insight into their experiences and also to grasp the evolving nature of those experiences. It brings new knowledge by examining the resources and needs of these children at every level of the ecological model. According to Austin et al. (2020), prevention and intervention strategies tend to focus on the interpersonal level. This study will help rethink intervention models at each level of the social ecology and match them as closely as possible to existing resources and children's needs.

A large number of resources appeared to assist children to work through the experience of IPV and other victimizations. They encompassed personal strengths and assets, which include supportive relationships, hobbies and activities, and support from diverse professionals. However, access to resources was probably limited because participants rarely disclosed or discussed IPV and other victimizations, despite the presence of available family members, friends and professionals. Barriers to do so were identified at different levels of the ecological system. Numerous unmet needs were also identified and categorized into four groups: *safety and protection*; *care and affection*; *talking about the violence* and *understanding and coping*.

The three categories of strengths and assets, identified in the RPM as meaning making, regulatory, and interpersonal strengths, were also identified by our study and helped build these young people's agency in dealing with IPV and other victimizations. But this research also may have brought to light new potential protective factors not previously identified in the RPM. Personal strengths and assets have been shown to have buffering effects on the detrimental impacts of adversity (Banyard et al., 2017; Hamby et al., 2021). Moreover, social-emotional competence (social competence, emotional regulation; empathy) has been proven to be an indicator of well-being and Bender et al. (2022) highlight this competence as an important focus for interventions. Supportive relationships helped participants cope with IPV and other victimizations, especially through listening and offers of help. Katz (2016) found that children exposed to IPV are likely to have a smaller social circle and be more socially isolated than average. Therefore, their family is the first source of support and safety, whether with parents, siblings and other family members (Åkerlund, 2017). The support provided by victimized parents has been shown to attenuate harmful effect of IPV on their children (Anderson & van Ee, 2018; Claridge et al., 2014; Hamby et al., 2020; Holt et al., 2008; Hui & Maddern, 2021; Katz, 2015; Skafida & Devaney, 2023; Zaouche Gaudron et al., 2016), and our results give an insight into the different forms this support can take. Participants also found comfort in siblings simply in knowing that they were sharing the same experience and through distracting and consoling each other around acute IPV events. Similarly, support from friends was also reported to be important. Other adults outside the family provided care and positive models. Future research on natural mentors, for example sport coaches, and supportive non-parental adult relationships may offer a promising pathway for nonclinical interventions with children experiencing IPV, because they focus on developing the potential of naturally-occurring support persons who are already present in their lives (Deutsch et al., 2020).

Some of these resources were identified as such by some participants but as an impediment by others. For example, understanding IPV could be experienced as a burden and talking about it could lead to overthinking. In stressing that strengths and assets differ between children, our findings corroborate those of Hamby et al., (2018) and demonstrate that when it comes to resilience, it is not so much the presence of specific strengths or assets, but rather their density and diversity that is important. Moreover, the retrospective nature of our method enabled us to capture the changes in the participants' resources and perspectives about these resources. Some may have been perceived as helpful at a given moment, but detrimental in the long term as the participants grew older, or because of a changing context. For example, while not being aware of violence, not talking about violence, and creating a bubble were considered as protective at one point in time, the results showed that they also proved problematic, especially in terms of disclosing and asking for help, which probably limited access to other resources. Thus, some resources may seem less adequate in the long-term, leaving opportunities to access others that seem helpful and adaptable to the situation. This demonstrates that resources, and therefore resilience, are not static but are part of a multi-level and multi-dimensional dynamic (Spini et al., 2017).

Individual or group hobbies and activities were also beneficial in all groups of needs. The relationship between hobbies/activities and resilience are less studied than other protective factors (Yule et al., 2019). Gardner et al.'s study (2012) reports a negative association between high levels of participation in extra-curricular activities and internalizing symptoms problems among adolescents living with violence at home. Thus, it seems that engaging in hobbies and activities, especially outside the home, could reinforce personal strengths by offering opportunities for achievement, social contact and the increased confidence consequent on validation. The need for validation from professionals expressed by the participants in our study is identical to that expressed by adult victims of IPV, and which, unmet, could be a deterrent to seeking help (Stanley et al., 2012).

However, our results demonstrate that participants rarely talked about IPV and other victimizations, despite the presence of available family members, friends and professionals. Our study identified barriers to talking about the violence and showed that they are set at different levels of the ecological system; further, they are similar to those described by adult victims of IPV (Stanley et al., 2012). However, children in our study encountered additional barriers, such as not wanting to disclose IPV out of respect for their victimized parents who, children assumed, would be able to deal with the situation. Adult victims tend to silence IPV to protect their children, who for their part, minimize experience of IPV and adverse effects on them to protect the parent (Lapierre et al., 2018). It is thus often not discussed within the family, and as a consequence, children have reduced opportunities to make sense of their experience (Georgsson et al., 2011; Marshall et al., 2019). This dynamic of secrecy can result in experiencing emotional isolation, notably from the parents. If the child's experience remains unintegrated, it may impact on development (Marshall et al., 2019; McIntosh, 2002). Disclosure of IPV is most likely to occur when children feel secure and can trust those in whom they are confiding (Stanley, 2011). Our analysis of children's longitudinal retrospective accounts shows that willingness and ability to talk about IPV and other victimizations should be conceived as evolving over time, whether because of a changing context or the increasing maturity that comes with age (Lapierre et al., 2018).

As found in other studies, participants would have liked to be spared the experience of IPV or for it to end earlier (Noble-Carr et al., 2019), and they sometimes felt insufficiently protected by the non-violent parent and other adults (Hui & Maddern, 2021). Not being believed or feeling that the violence towards them was minimized was also an issue (Noble-Carr et al., 2019). In some cases, young people felt neglected or poorly looked after by professionals who failed to address the issue of violence with them. Münger and Markström (2019) shed light on school staff who find issues of domestic violence particularly difficult to manage. They may be unfamiliar with discussing and dealing with children living with IPV. This is also true, to some extent, for other practitioners. Münger and Markström (2019) also point to an unclear division of responsibilities between different professionals in schools. With regard to the police, it has been shown that they may still not recognize the children as full victims, because police work focuses heavily on criminal justice processes that render the child's experience of IPV invisible (Elliffe & Holt, 2019). In addition, pediatricians are rarely aware of children's experience of IPV (Dessimoz Kunzle et al., 2022). They did not enquire about the reasons behind symptoms in our study. This may be linked to a reluctance to discuss the wider subject of child abuse, fearing that intrusive questions could make them lose contact with the children because their parents would leave their practice (Savioz et al., 2012).

Implications for Practice

It was striking that nearly all our participants would advise children living with IPV to talk about it, while they themselves often took a long time to do so, if they did. Analysis of the barriers to talking about violence shows that, while it is often a need, it cannot be achieved if the context does not allow it. Firstly, young people emphasized that IPV should not be a taboo in society, because children who do not know any other reality need to understand that what they

are experiencing is violence and that violence is not acceptable. As interviewees noted, schools are places that can reach almost all children. Teacher training and information campaigns on IPV exposure could be initiated in this setting and reinforced by media campaigns to raise awareness (McTavish et al., 2016; Montserrat et al., 2022). In terms of preventing deleterious impacts on the health and well-being of children living with IPV, the need to depart from the idea of eradicating risk factors and adopting instead a strength-based approach is increasingly emphasized, since it has been shown that resources have more impact than risk factors on outcomes (Hamby et al., 2021). This could be done through educational programs in school geared towards reinforcing strengths and assets related to resilience. Those identified by both our findings and other studies include: a sense of purpose, self-reliance and prosocial skills. Improving access to extra-curricular activities for all children, could also make a considerable difference. The creation of a "safe place", an idea which was put forward by several participants in this study, should also be seriously considered as an innovative practice that could build on strengths and provide opportunities for children to discuss IPV and other issues in a safe environment. Such programs and safe places would benefit all children facing different types of adversities.

As some participants advised, primary health care providers and other professionals in contact with children who notice signs of suffering should think of exposure to IPV as one possible cause (Graham-Bermann & Perkins, 2010; Dessimoz Kunzle et al., 2022). Distress is not visible in everyone, so professionals should pay special attention to changes in children's behavior and be proactive in asking questions. Training on children's experience of IPV and its implications for mental and physical health is required in order to direct patients to appropriate services (McTavish et al., 2016).

As for interventions, Romano et al. (2021) showed that child-centered IPV interventions are beneficial for improving emotional and behavioral well-being. Professionals should be mindful of children's perspectives, agency and resources and tailor interventions to their needs and preferences. As our results show, not only can different children have different needs, they cannot be categorized as thriving or vulnerable for continuous periods. Vulnerability and resilience are dynamic processes that change over time, therefore interventions should be planned and reviewed over the long term. Findings from the present study confirm the importance of the victimized mother–child relationship. Interventions supporting that relationship should be encouraged since they have proven to be critical to children's long-term recovery (Katz, 2015; Zaouche Gaudron et al., 2016; Anderson & van Ee, 2018; Noble-Carr et al., 2019). Our results also underscore the importance of role models outside the family.

Limitations

This research is not without limitations. Participants were recruited in clinical forensic consultations so the results may not reflect the situation of families where IPV was never disclosed to professionals. However, the recruitment process probably provided a more diverse set of situations than most similar qualitative studies. This study relies on adolescents and young adults' recollections of their experience of IPV as children and adolescents sometimes many years later and we cannot rule out the possibility of discrepancies between their experiences as they occurred and their memories of them. Nevertheless, the use of the life history calendar mitigates this limitation, as it not only improves recall of events, but also establishes temporal order (Hayes, 2018). Finally, children's experience of IPV in family structures other than those based on heterosexual relationships was not examined.

Conclusion

This qualitative study provides an overview of the resources and needs of children living with parental IPV as well as the barriers to talking about violence which can limit the former and increase the latter. It shows that they can be located at all levels of the ecological system, with some differences between needs related to safety and protection, care and attention, talking about violence and understanding and coping. In responding, it is essential that professionals identify and take into account both the portfolio of resources and the full range of needs specific to each child, while being aware that they can evolve over time. In terms of preventing negative impacts, this study points to possible pathways for action, notably through information and educational programs in schools, as well as through access to extracurricular activities. The victimized parent, school, friends and hobbies appeared to be the external resources most consistently identified by our young informants. They should be the focus of strength-based approaches along with the development of personal strengths and assets. Future research should investigate resources that have been less studied but which may be important protective factors, such as the ones not already included in the RPM which emerged from this analysis. This study also highlighted the dynamic and evolving nature of children's experience of IPV and shows that changes and turning points in their experience, resources and needs require further study.

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Data Availability Not applicable.

Declarations

Ethical Approval This study was approved by Swiss Ethics (State of Vaud) on March 24, 2022 (ref.: 2022–00296).

Consent to Participate Written informed consent was obtained from all individual participants included in the study.

Competing Interest The authors have no conflicts of interest to declare.

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