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"A footnote in the file": are we Doing enough to attend to children's experiences of intimate partner violence in out-of-home care settings?

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ABSTRACT

During the past few decades, there has been an increasing recognition that many youth in out-of-home treatment settings have experienced complex trauma due to childhood experiences of intimate partner violence (CEIPV). These experiences may contribute to the internalizing and externalizing problematic behaviors that precipitate their placement in such programs. Using retrospective file review, this exploratory study aimed to explore the mechanisms within children's mental health settings for determining CEIPV, including screening, assessment and other avenues of disclosure and to consider possible avenues for addressing CEIPV. Fifty files were selected for review, and after screening for CEIPV, 26 files remained in the sample and underwent a detailed review and data extraction process. The review identified significant gaps in documentation related to CEIPV, specific to identification and assessment, which may interfere with important intervention and prevention efforts within such settings. Practice implications and recommendations for improving assessment and intervention efforts to address these issues within out-of-home care settings are discussed.

PRACTICE IMPLICATIONS

- Efficacious CEIPV assessment leads to better recognition and intervention approaches, which may promote child and youth safety.
- Specific CEIPV assessment and intervention approaches are needed to direct our work with young people.
- Revisit what it means to be "stable, safe or ready," before withholding interventions that may benefit young people in care.
- Consider incorporating ongoing risk assessment and safety planning approaches regarding CEIPV into our work with young people in care.
- Coordination and collaboration across systems (police, child welfare, violence against women services) could lead to optimal interventions and community-based linkages upon discharge from care.

KEYWORDS

Intimate partner violence; childhood exposure; child mental health

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Introduction

Childhood experiences of intimate partner violence (CEIPV), characterized by young people's witnessing or awareness of physical, emotional, financial, and psychological abuse of their caregivers (Gregory et al., 2020), are common in Canada, with one in 10 Canadians indicating that they have been exposed to violence between adults in their households (Burczycka & Conroy, 2017). The Canadian National Survey of Children and Youth found that at some point in their lives, approximately 8% of children aged 4 to 7 (Moss, 2003) and 17% of children aged 6 to 11 have witnessed violence at home (Hotton, 2003). It is estimated that close to one million Canadian children will be exposed to intimate partner violence (IPV) over their lifetimes (Trocmé et al., 2010). Globally, the statistics remain high, with up to 25% of children in high-income countries experiencing IPV between caregivers and around 30% of children in lower-income countries (Kieselbach et al., 2022). Furthermore, IPV exposure continues to be the most frequently reported form of child abuse, representing 41–48% of substantiated investigations (Fallon et al., 2015; Lefebvre et al., 2013). Risks to children and youth associated with these experiences have been well-established to the point that CEIPV may be considered a form of maltreatment depending on severity (Artz et al., 2014; Carpenter & Stacks, 2009; Kimball, 2016) and classifications of exposure, for example, seeing the abuse (e.g., hitting, threatening), experiencing direct violence, as well as seeing and hearing the aftermath of a violent incident, such as physical marks and broken furniture (Artz et al., 2014; Edleson et al., 2007; Haj-Yahia et al., 2021; Ravi & Casolaro, 2018).

The potentially debilitating long-term, negative consequences for children and youth who have CEIPV and other family-related traumas are well documented and include mental health challenges, conduct and behavioral problems, delinquency, crime, and victimization (among others) (Artz et al., 2014). More recently Haj-Yahia et al. (2021) found decreased self-efficacy and increased post-traumatic stress symptoms in young adults and suggest these are directly attributable to CEIPV. In addition, concerning linkages between CEIPV and risks for later sexual exploitation have been noted (Reid et al., 2020) and may be particularly salient for young people in care.

It is increasingly recognized that many, if not the majority of young people residing in out-of-home care settings have experiences of complex trauma (e.g., physical, emotional, sexual abuse and/or neglect, CEIPV) (Collin-Vézina et al., 2011; Moore et al., 2017) and that these experiences often underlie the internalizing and externalizing problematic behaviors that precipitated their placement in residential treatment programs (Hodgdon et al., 2013; Knoverek et al., 2013; Zelechoski et al., 2013). Rees and Stein (2016) note that "indicators of 'well-being' should not be seen as synonymous with 'outcomes' of being looked after" (p. 240)

recognizing how children in care are affected by their pre-care experiences and that adequate assessment and attention to this is paramount. Lev-Wiesel et al. (2014) bring attention to the importance of considering these experiences as part of young people's pre-care histories with their finding that 21% of children in out-of-home care have CEIPV. These authors maintain that facilitating and responding to disclosures of CEIPV may provide avenues for treatment, may prevent intergenerational transmission of unhealthy relationship patterns and reduce the risk of future victimization (Lev-Wiesel et al., 2014).

Despite knowledge of the connection between CEIPV and complex trauma, a paucity of research literature examining this intersection among youth in residential treatment settings remains (Hodgdon et al., 2013; Kagan & Spinazzola, 2013; Knoverek et al., 2013; Spinazzola & Pond, 2013; Zelechoski et al., 2013). Furthermore, the extant research, primarily based on U.S. data, points to a void within the Canadian context (Collin-Vézina et al., 2011), which is concerning given that Canadian youth in residential settings make up a considerable portion of individuals in the care of child protection services, who typically have histories of traumatic life experiences (Collin-Vézina et al., 2011; Stewart et al., 2010). Moreover, given the limited and inconsistent documentation regarding this population, developing profiles of youth in care is paramount to understanding exposure and guiding effective interventions to promote resiliency in youth within various contexts (Collin-Vézina et al., 2011).

The Developmental Consequences of CEIPV

Considering the developmental sequelae of the experiences of youth in out-of-home care settings, particularly CEIPV, is critical. Many youth in residential care settings have experiences of CEIPV spanning early childhood to adolescence, with differential impacts by developmental stage; these also may be compounded with other adversities, such as growing up in poverty, experiencing co-occurring forms of maltreatment, community violence or experiencing child protection involvement. The impacts of CEIPV are profound, interfering with normative processes related to children's emotional development, making some children less aware of their emotions and less able to process or regulate negative affect, which puts them at risk for misunderstanding the cause of their emotions and decreasing their coping abilities and experiences of self-efficacy (L. F. Katz et al., 2007). Further, CEIPV exposure during early developmental periods is particularly worrisome due to risks related to resulting developmental challenges, including brain development, emotional dysregulation, developmental delays, and sensitivity to conflict (Bogat et al., 2006; DeJonghe et al., 2005; Tsavoussis et al., 2014).

Environmental Factors

Multiple risk and protective factors influence the impact of CEIPV, such as the co-occurrence of direct child maltreatment and caregiver mental health or substance issues, which may magnify the impact by creating additional stressors and reducing the presence of protective factors (Jaffe et al., 2014). Contextual environmental stressors (such as poverty/community violence) have also been noted to create additional risks (Jaffe et al., 2014). Therefore, CEIPV needs to be considered through the lens of intersectionality (Crenshaw, 1994), a framework which highlights how differing social locations, cultural contexts, power relations and experiences (such as gender, poverty, racism) intersect to impact the lives of these children in complex ways; including access to housing, health care, education and negative experiences with state structures such as police and child welfare (Bograd, 1999; Crenshaw, 1994). For children living in out-of-home care environments, the impact of being separated from family, living in environments frequently characterized by changes (in staff and other residents) and frequently unsafe situations (for example, volatility of other residents, contagion risks for antisocial behaviors) must also be considered.

Understanding how these vulnerabilities interact with CEIPV to potentially contribute to the risk for intergenerational transmission of violence indicates apparent lacunae and unmet need for knowledge about factors that contribute to children's resiliency and either breaking or perpetuating the cycle of violence in interpersonal relationships (Gomez, 2011; Haj-Yahia et al., 2021; Heyman et al., 2020; Rivera & Fincham, 2015).

Resiliency

An exploration of resilience factors related to CEIPV among adults who identified as growing up in homes where parental violence occurred indicated that "escaping violence" by mentally or physically "leaving home" was common (Katz, 2016). The lower levels of documented IPV in adulthood among youth receiving residential care treatment than those who did not (Huefner et al., 2007) and direct interventions related to CEIPV offered in some campus-based treatment services (Stewart et al., 2010) suggest some unique benefits to out-of-home care for this population. In addition, Kennedy and Holt (2020) found that "addressing the experience of domestic violence with young people was considered an important step towards promoting their resilience" and recommend asking young people directly about their pre-care experiences (p. 23).

Given the high rate of CEIPV for youth in residential care settings this research study sought to identify how CEIPV is addressed within a population at high risk of CEIPV. The retrospective file review aimed to elucidate

opportunities for identification, assessment, and intervention to address CEIPV for young people in out-of-home care settings. The study sought to do this by asking the following research questions:

(1) What are the mechanisms within residential children's mental health settings for determining CEIPV, including routine screening, assessment information, or other avenues of disclosure?
(2) Are there connections made between CEIPV and presenting child mental health issues related to children's out-of-home placement needs?
(3) How might these findings be used to address gaps in identification, prevention, and intervention efforts in these settings?

Materials and Methods

Retrospective file review, which involves a structured process of reviewing closed case files to answer the research questions, was chosen for this study as it is considered least intrusive, relatively inexpensive, and can access large amounts of rich data (Gearing et al., 2006). After extensive training of Center research staff, we used a file review extraction protocol to conduct this review and examine experiences for young people in out-of-home care. We also considered using this method as an innovative approach in the study of CEIPV via exploration of the file data that could be consistent with a life course approach given the narrative case file data that provided information about young people's CEIPV over their lifespans. A life course perspective takes into account an individual's experiences over time (such as development, relationships, and life transitions) and intersectionalities, acknowledging that differential life experiences shape future life and wellness trajectories, and has been directly applied to the development of young adult identities (Benson & Elder, 2011). A life course approach provided a unique opportunity to track the developmental histories of these children and youth to illuminate pathways of harm and opportunities for prevention and intervention. The University of Calgary Research Ethics Board approved this study (REB14–0599), which included a waiver of consent, as the data would be extracted by The Center research staff directly and de-identified before being available for secondary analysis by the Principal Investigator. The research proposal was also approved by the Research Advisory Committee of the targeted children's mental health center in Western Canada (The Center). The client database of The Center was accessed to perform a random file selection process (using research IDs inputted into an online randomization program) of closed files wherein CEIPV had been noted as a presenting issue within the intake information form. The Center has a client information database where a check box system indicates categories of presenting issues. The inclusion criteria also included a minimum of 30 days of residency

between December 2012 and December 2017). This range was chosen as it represented a shift in the agency file-keeping process and ensured that the files reviewed would be consistent in structure (for ease of finding information). Files were excluded if they were under review by another body (accreditation or quality assurance committee) or at risk of being subpoenaed due to ongoing legal proceedings.

Further restrictions were placed on the selection process to include only 10 targeted programs (that would meet the 30-day minimum stay requirement and serve children aged 7–18 years) and be available at a specific site location due to ease of file retrieval. In the first random selection process, only 13 files were considered available for review due to various reasons related to our exclusion criteria. Due to concerns that the section about CEIPV may not always be correctly selected, additional categories that included terms such as family breakdown, family conflict, divorce/separation, relationship issues, family transition issues and child protection concerns were applied to the selection process to increase the number of files to be selected. However, this also did not adequately increase the sample size. Due to the focus of this study, we purposely selected all of those cases with CEIPV identifiers ($n = 13$). We then randomly selected another 37 (for a total of 50) cases that were not identified as having CEIPV and reviewed those for information related to CEIPV in the file. From these reviews, an additional 13 cases were found to have CEIPV present but not identified as a presenting issue. In total, the analysis includes 26 cases in which CEIPV was identified.

Once selected and in accordance with the ethics protocol procedures, files were reviewed by trained research staff at The Center using a file extraction template created for this study to guide the relevant extraction of information (both quantitative and qualitative data). Quantitative (demographics) and qualitative (which involved narratives about case intake, assessment, planning and discharge). At the point of extraction, data was de-identified and entered into a database before being provided to the PI for later qualitative and descriptive statistical analysis. To ensure intracoder and intercoder reliability, all members of The Center's research team concurrently reviewed the first five selected files, initially independently and then together as a team, to ensure that data was collected consistently, and discrepancies were discussed until the group arrived at consensus. Descriptive statistics were used to describe client characteristics.

Description of Sample

The sample of files consisted of the following client characteristics: 38% of youth were male, 54% were female, and 8% identified as other. Reported ethnicities were 46% Caucasian, 23% Indigenous, 15% mixed ethnicity, 12% Black, and 4% other. Age at admission was broken down into 1) 7 to 9 years

old (8%); 2) 11 to 13 years old (12%); 3) 13 to 15 years old (54%); and 4) 15 to 17 years old (23%). Regarding time in service and treatment, 54% of the sample was less than three months, 8% between three to six months, 15% between six to nine months, 15% of nine to 12 months and 8% of received services for over one year.

Maltreatment at the hands of their caregivers was identified in 92% of the sample; 85% reported experiencing physical abuse; 77% reported experiencing emotional, verbal, and/or psychological abuse; 27% reported sexual abuse; 73% reported neglect, and 12% of the sample described experiencing other forms of abuse. The files listed the target of abuse as the father 8% of the time, stepfather or boyfriend 4% of the time, mother 81% of the time, stepmother or girlfriend 8% of the time, grandparent(s) 4% of the time and 35% did not specify. The files listed the perpetrator of CEIPV as 85% the father, 31% the stepfather or boyfriend, 15% the mother, 8% the grandparent and 31% unspecified. Substance use (73%), mental health (61%) and both substance use and mental health (50%) were listed as co-occurring issues with the caregiver.

Analysis

The first two authors analyzed the file review summary documents using Thematic Analysis (Braun & Clarke, 2006). This qualitative data analysis method involves coding with a low level of interpretation that leads to thematic categories. Thematic analysis involves several steps, the first requiring researchers to familiarize themselves with the data and then generating initial codes and searching for themes according to patterns and commonalities in the data. A theme "captures something important about the data in relation to the research questions and represents some level of patterned response or meaning with the data set" (Braun & Clarke, 2006, p. 82). The authors then reviewed these potential themes and defined or named them using in-vivo codes from the data whenever possible. This process was initially conducted by hand, and then an online data analysis management program (Dedoose) was used.

Results

The average number of years of CEIPV for the young people in these case files is 7–10 years, with exposure being both direct and indirect and the majority of exposure happening very early in life (often from birth). For example, many files contained descriptions of children providing stories about IPV events that they were not present for that had become historical family narratives. Coding processes identified several ways CEIPV was documented: 1) identifying but not assessing; 2) observing/noting; 3) interpreting the impacts and making recommendations, all without translating into intervention. Rather,

documentation of CEIPV manifested in the form of recording and accounting for domestic violence events in files (sometimes inconsistently or with what might be termed as hesitation) on the part of the staff in assessing for and extrapolating relevant information regarding the long-term implications of CEIPV for clients navigating the system. These themes will be expanded upon and illustrated using notes from the file reviews.

Identifying but Not Assessing: CEIPV "Is Everywhere, Yet Nowhere."

Data regarding CEIPV was pervasive throughout all of the reviewed files. However, there were inconsistencies in how CEIPV was labeled or explored. For example, most files discussed IPV as being explicitly or implicitly present in the child's history but often lacked details and failed to connect treatment descriptions directly to IPV-related concerns. Therefore, it is unclear whether treatment addressed IPV directly as a presenting concern. For example, CEIPV was often labeled or documented without specific details, suggesting that further information was not explored or gathered. For example, file reviewers noted how, in some files, the presenting issue of CEIPV was identified through a check box (yes/no) system or discussed as occurring but not discussed further anywhere in the file:

> "DV is not mentioned by the child, caseworkers or staff in any capacity, only appearing as yes/no checkboxes upon admission." – File 004

> "While it is not explicitly stated that the child sought services at [The Center] due to her exposure to DV, DV is listed as one of the child's presenting concerns on the [client] database." – File 094

> "The nature of the DV is not explored." – File 061

> "DV is not mentioned in this file until the very end in the ACE Scores, which are filled out by the child and the child's mother. DV was not noted by [local health authority] during the several visits and stays the child had in hospital. DV is not mentioned in any official [The Center] forms, including intake, assessment and discharge forms." – File 029

Even when direct linkages to CEIPV were made, there remained a lack of related follow-up, either in assessment processes or intervention goals:

> "File only mentions that child was exposed to DV at a young age (4–5 years), and that mother and kids (including client) had to stay at a women's shelter several times." – File 007

> " . . . the clinician stated that the client "has experienced a tremendous amount of trauma throughout her childhood, exposure to parental drug addiction, domestic violence, periods of neglect and frequent caregivers resulting in disrupted attachment." – File 055

> "There is an indication of impact on child's relationship to caregivers due to DV." – File 031

> "The counsellor also reported that "the child had difficulty managing intense emotions such as anger and often used violence towards his mother and siblings as a way to express these emotions." In the same report, the child's exposure to DV is also linked to his aggressive behavior within his family, stating that being "witness to DV at such a critical age may have resulted in him learning aggressive behaviors" – File 046

Interestingly, in some cases, the young people themselves often make the linkages to CEIPV in their lives and behaviors for their clinicians, with one child being noted as saying:

> "Witnessing violence between my parents was a turning point for when I began to behave badly." - File 086

> "The client took 30 tabs of Prozac to overdose, and "vaguely described trigger as 'parents are always fighting and I'm fed up with it,' refusing to provide any detail." – File 023

Of some concern, the file review illustrated how often services have been involved but have yet to manage to decrease the risk of IPV. For example, in one file, it was noted,

> "CFS involvement multiple times, sometimes due to DV" (File 094), without further exploration.

In many cases, the ongoing risks of CEIPV were not recognized or addressed and sometimes even minimized in the files:

> " . . . youth choked girlfriend but "it only happened once" while later noting that multiple "assault charges were all related to the girlfriend and his jealousy" -File 059

The other finding is that child protection workers and clinicians continue to make errors in judgment around CEIPV, such as minimizing, not intervening, recommending family therapy, failing to follow-up, etc., which suggests the need for the development of staff competencies in responding to IPV in families:

> "The matter was closed as the couple was in family therapy." – File 105

For example, several files also illustrated a concerning pattern of multiple child protection apprehensions and returns related to CEIPV with no apparent interventions:

> "Due to concerns over exposure to significant domestic violence, 'the children are then returned and later apprehended again due to a domestic violence incident.'" -File 104.

Observing and Noting the Impacts of Violence:

> " . . . there is no way the kids had not picked up on this (DV) and report that, in the past, he (child) has made accusations that his mother hates his father, that his father hates his mother, that his mother kicked out his father, that his father abandoned his mother, all to suggest that he is exposed." – File 070

> "Child was born into a home with intense domestic violence, which he continued to witness for at least the first 11 years of his life." – File 059

Rampant violence between siblings was explicitly identified in 14 files, with the gendered nature of the sibling violence being particularly noteworthy, as most cases involved brother-against-sister violence.

> "Frequent conflict specifically between the child and her brother is noted. The child stated that she has experienced abuse from her brother." – File 031

> "Client has also been physically and verbally aggressive with his sisters. The child was once removed from the home due to his aggression towards his sister." – File 046

> "The child's brother was abusive towards the child, often threatening to harm or kill her, so much so that she (child) felt the need to contact 911." – File 052

Also noted was that children disclosed CEIPV to workers throughout their stays, suggesting that it is top of mind for them. However, and importantly, there remains no evidence in the files of intervention following such disclosures outside of the documentation of concerns. For example, although a trauma history was sometimes acknowledged in the file, there was little or no follow-up in terms of related mental health symptomology or treatment (e.g., the child was noted as having "episodic dreams of a bad man hurting mom") with no linkages made to CEIPV or need for intervention. In some cases, CEIPV-related topics were even avoided by the worker if the disclosure did not apply to the current intervention during which they were shared.

> "The client attempted to discuss his experiences with DV while in a group session. Unfortunately, the group session was in place to discuss drugs, and as such, the leader of the group discussion session guided the discussion away from the group discussing their experiences with DV and back onto the topic of drugs." – File 046

> "Though the client tried to talk about past abuse with a clinician, the clinician redirected the conversation back to anger management. . ." – File 105

Children were noted to be regularly checking in on or worrying about family members while in The Centre, suggesting they are still not feeling emotionally safe due to ongoing anxiety and effects directly related to CEIPV:

> "Mention is made regarding the impact the client's concern over the safety of her mother has on the client's state of mind - in particular worrying excessively about her mother's safety." – File 048

In addition, file notes often indicated that the risk of abuse/CEIPV was ongoing or did not provide enough information for that to be assessed by the reviewers. For example, plans were regularly made for children to return to homes, knowing that CEIPV was still an issue. In 73% of cases, the children were considered medium or high risk (defined as medium or high risk without current contact with DV but with likely future access or currently having

access/exposure to DV perpetrators). In 23% of cases, CEIPV was considered low risk (defined as no current or likely future access to DV perpetrators in any capacity). In 81% of cases, children had current contact with the DV perpetrators/targets, whereas 15% did not maintain continued contact. In 4% of cases, the lack of documentation prevented reviewers from determining the risk of exposure.

> "The child recently has stepped in to protect his mother, resulting in a physical altercation with his father." – File 022

> "The clinician writing the document also states that they are concerned that the child's father's "violence may escalate to the point of causing serious, even fatal, harm to his family." – File 100

Interpreting the Impacts and Making Recommendations

Although CEIPV was documented in the files, albeit inconsistently, some service providers made links to the impacts or made recommendations to address CEIPV:

> "Despite not presenting with significant trauma symptoms, the client presented with other difficulties that seem to relate, at least in part, to her exposure to violence, conflict, inconsistency and chaos, and changes in primary caregivers." – File 055

> "Due to his history of exposure to DV, the child is "more likely to perceive neutral stimuli as negative. . .which presents itself in abrupt changes in mood." – File 022

Notwithstanding the inconsistencies mentioned above, the files showed insightful observations and conceptualization in some cases regarding the links between CEIPV and the children's behavior and reason for admission:

> " . . . long and ongoing history of fear and violence related to father and culture may be impacting [the client]'s current behaviors and concerns." – File 031

> "The client eventually became violent toward the mother, it is hypothesized that the client learned this behavior from all the abuse he witnessed." – File 046

Some files made evident how the system continues to allow abusive men to maintain control. For example, clinicians wrote that fathers' control during intake and follow-up interventions kept them from ascertaining the truth of what was going on or providing appropriate interventions. Abusive men also often refused to participate in interventions, and many men were completely absent from their children's lives (Files 100 and 101).

CEIPV is often presented more as a family history than a current concern, thereby removing the opportunity to link the current situation with realities of past exposure:

> "DV is mentioned but it's never brought up as an issue, merely as something that had happened." – File 088

Documentation Does Not Translate into Intervention

Despite documentation of the presence of significant violence in the lives of the young people receiving child mental health services at The Center and linkages between CEIPV and reasons for admission or behaviors, there was little to no evidence that this knowledge translated into treatment planning or any form of intervention:

> "DV is essentially a footnote in this file. Though it (DV), is indicated within a couple forms, it is presented more as family history than a residing concern. DV is also not the focus of any recommendations, interventions, or therapies, regarding child's progress or future." – File 034

> "Though the DV is fairly well documented in the file . . . there is no treatment/therapy/protocol which is used to address the impact of this, on the client, or in the home." – File 058

Furthermore, there is a hesitancy among clinicians to explicitly link CEIPV and trauma history (whether recent or historical) to the child's current presentation and treatment needs. For example:

> "It should be noted that though witness to DV was in the file, it was often overshadowed by the child's escalating behaviors." - File 086

> "DV is acknowledged within this file, but seems to be put on the back burner, with a greater focus on the child's anxiety and emotional regulation." – File 070

Discussion

The data suggests that the very nature of problematic behaviors on the part of the youth can detract from intervention attempts or from making explicit linkages between the CEIPV and behaviors, which is concerning given the amount of documentation in the files related to trauma symptomologies such as suicidality, difficulties with peers and schooling, propensity for self-harm, substance misuse, engaging in risky behaviors, aggression, and either victimhood or perpetration of bullying and other self-isolation type behaviors which have been linked in the literature with CEIPV. Kennedy and Holt (2020) describe similar findings of the importance as well as difficulty of practitioners being able to distinguish between trauma associated with CEIPV versus other forms of harm, but part of this difficulty is the lack of inclusion of CEIPV in documentation within these settings. E. Katz (2016) also sagely notes that "domestic violence permeates the everyday lives of children to greater extents

than are often considered"(p. 49) and recommends practitioners take this experiences into account in their work with young people.

In addition, the role of intersectionality and associated vulnerabilities are unrecognized; therefore, the impacts of multiple oppressions impacting families and influencing behavior are not explicitly discussed in the files. For example, young people were identified as "being from reserve," noted as occupying refugee status, coming from a divorced family, experiencing food insecurity, and lacking access to resources. Still, connections were not made in the files with how such multiple oppressions may overlap to impact or exacerbate their CEIPV experiences.

Considering Intersectionality and Intergenerational Trauma

Throughout the files, there were indications of multiple intersectionalities that may be contributing to vulnerabilities following CEIPV, which manifest in the form of behaviors and mental health concerns that warrant intervention for these children. Extant literature indicates that intersectionality and systems of oppression are not typically considered in treatment interventions in the same way they are accounted for in interventions with adult survivors of DV (Etherington & Baker, 2018). Our study supports this assertion. Most commonly, assessment for CEIPV examines the relationship between CEIPV and adjustment variables or mental health status while failing to account for the child's social location and related adversities (Etherington & Baker, 2018). CEIPV is essentially considered in isolation from other potential factors that may influence a child's well-being and mental health, such as attachment, trauma history, social learning, identity and self-efficacy development, and developmental psychopathology. Excluding intersectionalities as contributing factors in describing the experiences and needs of children with CEIPV could result in a one-size-fits-all approach to treatment that fails to address the nuances of the vulnerabilities associated with individual and unique CEIPV experiences (Etherington & Baker, 2018).

Furthermore, it is acknowledged in the literature that women's vulnerability to DV is affected by intersecting identities. Therefore, it follows that children's exposure to DV "as well as their short- and long-term outcomes and experiences would also be affected by this intersection" (Etherington & Baker, 2018, p. 61). Intergenerational trauma also fits into the intersectional realm, and by taking multiple, systemic, and systematic forms of oppression into account for children, as is increasingly done with adults, the likelihood of comprehensive treatment increases. Berg et al. (2020) also identify a lack of "cultural humility within DV service provision" as a gap that highlights how DV-exposed children experiencing intersectionalities often fall through assessment and intervention cracks (p. 7).

It is also important to note that since the development of the ACES assessment, some intersectionalities need to be considered when assessing (mental) health outcomes and developing interventions for adults. However, this has yet to translate into practice with children (Strompolis et al., 2019). Given the high ACES scores for the young people in the files reviewed, this would be an essential area for future research.

Lack of Clear Definitions and Timing of Screening

As illustrated, our thematic analysis revealed significant gaps in knowledge of the identification and assessment of children and youth with experiences of CEIPV by practitioners within the field of child mental health. Screening for CEIPV, although part of generalized intake practices, was not universally applied, and even when CEIPV was identified, it rarely resulted in any direct intervention approaches. Consistent with other literature, conflicting definitions of IPV, myths and dominant social discourses, such as mother blaming, sibling rivalry and traditional gendered power dynamics, were also present in our findings. This leads the authors to wonder what exactly is happening within these settings: Is it a case of not conducting a thorough assessment and needing more knowledge about the importance of screening for and addressing CEIPV, or is it the case that the field still does not have well-defined methods of intervention and assessment that might easily be formulated or applied? We also need to consider the context of out-of-home care environments and whether such complex CEIPV-related cases may involve prolonged periods of crisis and extreme behaviors that are considered too destabilizing in the context of immediate care for more targeted, long-term therapeutic efforts to take place.

The extant literature suggests that a lack of consistent and clear definitions of terms and concepts, such as DV and IPV, contributes to hesitation or avoidance of screening for and documenting these phenomena in both adults and children (De Puy et al., 2019; Munger & Markstrom, 2019; Rode et al., 2019). Rode et al. (2019) specify that not only do definitional issues of concepts such as IPV and DV make assessment of the phenomenon difficult, but differing conceptualizations and confusion about the nature of specific acts of violence, such as what constitutes exposure and the nature of victimization, add to screening and documentation difficulties and hesitancy. Rodes et al. (Rode et al., 2019) go on to say that "cases involving exposure to IPV are trickier to recognize and diagnose" (p. 436). Therefore, CEIPV is forgotten, invisible or silent.

Additionally, the authors explain that while overt maladaptive coping in children exposed to DV, such as aggression, sub-par school performance, interpersonal relationship problems and substance use, are more likely to be noted in assessment, nuances of CEIPV maladaptive coping, such as pervasive

anxiety, dissociation, and a lack of self-efficacy in children are often missed or ignored in assessment (Rode et al., 2019). De Puy et al. (2019) also cite the generalized understanding of child maltreatment to be "mostly physical and forms of child abuse" (p. 372), thereby contributing to the idea that CEIPV does not require specific assessment or intervention, or that as Trickett, Mennen & Sang (Trickett et al., 2009), maintain, that the focus on these external forms of abuse may result in the failure of CEIPV to be noted by interveners and assessors. Similarly, the belief that only direct and severe physical violence harms children is identified as a barrier to assessment and intervention for CEIPV (De Puy et al., 2019). The literature identifies a broad misunderstanding by helping professionals that behavioral patterns comprised of demeaning and undermining, criticizing, and controlling are also harmful to children and result in poorer mental health outcomes and behavioral problems in children and adolescents (S. L. Clark et al., 2020; De Puy et al., 2019; Ingram et al., 2020; Rydstrom et al., 2019). For example, E. Katz (2016) noted the insidious, potentially long-term, impacts of coercive control for young people with CEIPV, irrespective of physical violence.

Other authors, such as Cohodes et al. (2019), identify the difficulty associated with the timing of screening. In other words, it is understood that early prevention and intervention in childhood exposure to trauma is essential; however, there remains a lack of clear parameters of whether screening for CEIPV should be ongoing throughout childhood and admission to treatment or more finite (Cohodes et al., 2019). Related barriers include a tendency to screen for family violence and CEIPV only via a parent or caregiver rather than by asking the child directly (Archer-Kuhn & de Villiers, 2019; Rydstrom et al., 2019).

Interestingly, several authors identify an understanding of the impact of adverse childhood events (ACEs) on poor mental health and behavioral outcomes in children and adolescents as being essential when working with these populations (Berg et al., 2020; Cohodes et al., 2019; Ingram et al., 2020), yet this understanding of ACEs does not necessarily translate into consistent screening for and documentation of said adverse events.

Lack of Screening and Documentation Training

Clark et al (2020). explicitly cite several barriers to screening for and documentation of DV in healthcare settings, which include a "lack of privacy, time, reimbursement, training, protocols and response options, as well as discomfort with the issues, fear of offending patients, and perceptions that such inquiry is outside their scope of work" (p. 5878). Although D. L. Clark et al. (2019) focus on the adult outpatient setting, these observations are echoed in the literature as being relevant to children's mental health settings (Archer-Kuhn & de Villiers, 2019; Berg et al., 2020; Cohodes et al., 2019; De Puy et al.,

2019; Fraser et al., 2019; Grady et al., 2019; Rode et al., 2019). Personal experience and understanding of DV by [mental] health professionals working with children and adolescents, who may have been exposed to domestic violence and been directly perpetrated against, is also identified in the literature as playing a role in the amount and type of documentation and reporting (McLindon et al., 2019). McLindon et al. (2019) suggest that workers with direct personal experience are more likely to incorporate IPV training into practice, perform IPV screening, and respond sensitively to survivors.

The use of checkboxes indicating CEIPV in file keeping may act as a barrier to expansion or exploration by the clinician about the nature of CEIPV and whether the CEIPV is linked to the child's presentation, symptomology and treatment needs. In addition, the authors wondered about the subjective interpretation of clinicians when choosing whether to check the boxes based on contextual factors. For example, children living in out-of-home care may be considered "safe" from CEIPV because they no longer reside in that situation, leading to a reluctance to check the CEIPV box or refraining from doing so. Furthermore, historical CEIPV may not result in the box being checked, as it is no longer currently happening, even though the impacts of CEIPV may be long-standing.

Lack of Resilience-Focused, Strength-Based Approaches

Finally, sometimes, we can learn from what is not present in our data sets. In this case, the absence of resilience-focused or strengths-based approaches to how young people had responded to or managed their CEIPV during their time in services was notable. We know that young people are not passive witnesses to the violence that has occurred in their lives, with research indicating significant sensory exposure in the realm of what children see, hear, touch and smell while violence is occurring (Fusco & Fantuzzo, 2009). We know even less about how young people have (or are continuing to) respond to their environments, even while living outside of them. Sadly, our research to date has focused on the victimization of young people and the negative impact of this exposure without understanding how young people actively respond to and cope with these experiences (Miranda et al., 2023). This appears to be similar within the practice approach as well.

Recommendations and Practice Implications

Assessing for the presence and impact of CEIPV is an important first step in changing practice in children's mental health approaches and has been noted by several researchers as a key factor in improving outcomes in young people with such traumatic experiences (Graham-Bermann et al., 2011; Mullender et al., 2002). Kennedy and Holt (2020) found that participants in their study also noted how the challenging behaviors of young people in care often leads to "how

a history of domestic violence can be buried or forgotten" (p. 16). Effective CEIPV assessment could lead to better recognition and intervention approaches, ultimately keeping children and youth safer. Creating specific CEIPV assessment and intervention approaches that clinicians can use to direct their work would be an important area of research focus. Additionally, we must revisit our notions of what it means to be "stable, safe, and ready," before withholding interventions that may benefit young people in care.

Finally, our findings indicate that much of recognized CEIPV is ongoing, so we may also need to consider ways of incorporating continuous risk assessment and safety planning approaches into our work with this population. For example, many of the files reviewed contained many of the known risk factors for domestic homicide. Finally, IPV is a complex social issue, and the literature is clear that collaborative approaches across systems (police, child welfare, violence against women services) are repeatedly called for as a requirement for ensuring short and long-term family safety. Our findings also indicate a lack of system coordination to address families where violence is occurring and to help keep young people safer. To this end, we recommend increased training and supports at the level of child mental health practitioners and the systems in which they work (child protection) that will lead to more purposeful and effective screening, less hesitancy to connect IPV-related disclosures to assessment of CEIPV, options for optimal interventions and ideally linkages with community-based agencies serving families impacted by intimate partner violence. As Dutton et al. (2015) stated, "the role of the health care provider in addressing IPV goes beyond identification" (p. 83), and also encouraged partnerships with domestic violence experts. The authors would like to go one step further in proposing a collaboration with the young people who are in our care not just to witness and document these experiences but to engage with and explore their understanding of these experiences, how they have come to be in care, and how our interventions might be more responsive to those lived realities.

Limitations of the Study and Implications for Future Research

Although retrospective file review allows for an examination of service over a period of time, it also utilizes information that was not originally collected for research and relies on the quality of documentation at the hands of multiple service providers over time and interpretation of such documentation on the part of the researchers (Gearing et al., 2006). To that end, the results might tell us more about poor record-keeping than the quality of assessment or intervention services provided. However, to minimize this limitation, the researchers chose a 5-year review period that followed an intensive revision of the current file recording system and covered a period followed by an accreditation process wherein files were routinely audited in preparation for review by an external review process, thereby ensuring reporting methods

would be more dependably consistent and rigorous. Despite this precaution, an additional concern is that even in files where CEIPV was noted, there was often minimal information, suggesting we might only be scratching the surface of children's exposure in out-of-home care settings such as these. Furthermore, as child maltreatment and IPV so often overlap in these files, it is impossible to tease out specific impacts, something that has been consistent across the literature in CEIPV to date (De Puy et al., 2019; Haj-Yahia et al., 2021; Rode et al., 2019). In addition, issues of intersectionality in the lives of these children and youth may have magnified experiences of exposure due to multiple oppressions, including implicit and explicit bias on the part of clinicians when documenting the files of children/youth from marginalized communities, which is undoubtedly an important area for further exploration. Finally, as noted previously, few instances of children's direct experiences were captured within this file review, once again leaving a critical gap in our knowledge about how best to support young people in this work.

Conclusions

Despite extensive research and knowledge of the impact of CEIPV on children and youth, mental health services for children and youth continue to experience challenges in identification, assessment, intervention, and engagement with this population. This study found a varied and inconsistent approach to assessment, response to disclosure and lack of intervention within children's mental health services connected to CEIPV. There were direct connections between children's unsafe home environments and their need to reside in out-of-home care; however, at the clinical level, these were not often explicitly stated and still overwhelmingly focused on children's behavior issues without linking them back to environmental or early childhood experiences. Essentially, an IPV checkbox in our file-keeping systems is insufficient to elicit thoughtful and intentional approaches to supporting young people in addressing their CEIPV experiences. More importantly, our findings indicate that workers more readily documented CEIPV rather than addressed it or even engaged with young people in care about their experiences. This lack of engagement has been reflected in a more recent meta-synthesis examining the nature of qualitative research with children about their CEIPV, which confirmed that young people continue to lack opportunities to have their perspectives taken into consideration (Noble-Carr et al., 2020, 2021).

Furthermore, in research with young people with CEIPV, looking at ways to improve service delivery within the context of child mental health interventions, it was found that young people had critical insights into the skills they desired most in working with those in the helping professions (Author, 2023). Still, others have advocated for inclusion models when discussing young people's lived experiences with CEIPV (Author, 2024). Although knowledge

of the impact of CEIPV on young people has increased over the decades, it has yet to be matched with a corresponding increase in intervention methods. The authors hope this exploratory study may lead to further clinical discussions within these treatment spaces to consider integrating this knowledge into optimal service approaches for young people in care.

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