Children’s exposure to domestic violence is well established as an adverse childhood experience (ACE). Much is known about the impact of this exposure, but efforts to ameliorate its effects are too often unsuccessful. Reconsidering our response requires a candid assessment of whether convening large and disparate systems leads to the best outcome.

We are no longer surprised by the common occurrence of domestic violence. For all of the social ill and devastation that results, it is both stunning and frustrating that our response and prevention efforts are not further developed and better resourced. A lack of consensus on how to navigate the complexities of violence in an intimate relationship continues to plague our innovation and stymie our success in reducing it. There are competing ideas about how to reduce the incidence of violence and assist families in recovering from its effects. A deeper chasm of consensus exists when children are involved (and when victims and perpetrators are parents). And children are very often involved [1].

Challenges
Why is it so difficult to reach consensus when faced with helping children who are impacted by domestic violence? History, competing philosophies, varied clinical and programmatic expertise and approaches, and the absence of reliable prevalence and impact data form a compelling backdrop to the development of innovative, effective solutions.

History
This country’s historical views have been fueled by denial and an unchallenged notion of parental authority and privacy regarding the impact of exposure to domestic violence on children. These views include the belief that children are unaffected if they are not within sight or sound of a particular violent act and that parents are responsible for addressing whatever damage results.

Collectively, we have evolved in our thinking about the potential impact of exposure (ie, how trauma is developmentally expressed in children and the cumulative impact of violence exposure when accompanied by other ACEs, including poverty, community violence, or an incarcerated parent). Gains have been made within North Carolina’s child welfare system, where trauma exposure is more routinely assessed and addressed. A recent study found domestic violence to be the primary form of trauma exposure for children in North Carolina’s child welfare system [1]. Some programs are becoming more responsive to the impact of domestic violence given the toll it takes on overall results of maternal and child health programs. The Nurse-Family Partnership (NFP) Home Visitation Program [2] has been working for years to improve prenatal health and pregnancy, child health, and developmental outcomes, as well as other quality of life indicators for families. Eckenrode and colleagues showed that, among mothers reporting more than 28 incidents of domestic violence (21% of sample) over a 15-year period, the NFP did not significantly reduce child maltreatment [3]. Later studies of the NFP home-visiting model showed a greater emphasis on reducing domestic violence among other focused priorities, such as assuring the baby has a safe and healthy home, improving child physical care, emotional care, play skills, communication skills, and maintaining maternal health behavior gains [4].

Philosophy
Deep philosophical differences on this issue often relate to determining what responsibility a victimized parent has to protect their child. These views converge with opinions about the responsibility of the abusive parent for his or her own violence. Simply put, who is responsible for the exposure and for stopping it?

There is disagreement on how to consider and balance any benefits of a relationship with an abusive parent against the physical and emotional safety of children and the victimized parent. Some people believe that abusive parents have “lost the right” to a relationship with their children and that the children will always be at risk of harm. Others believe that when monitored and guided, the parental relationship can be paramount to child well-being and that parenthood can serve as an important motivator for change by the abusive parent.
Clinical/Programmatic Approach

Clinical and program staff use a variety of professional and informal techniques to assess damage and the impact of exposure to violence on children. Some of these techniques are developmentally informed and others are not. Some are trauma-informed and others are not. Some rely more heavily on personal expertise and formal training than others. The validity of all of these strategies for assessment can be compromised by a fear of retaliation and family loyalties—fear that telling the truth will cause harm to oneself or other family members, or cause the child to be separated from the family or the family to be otherwise separated.

Disagreement exists about what children who are exposed to the abuse of their parent need and from whom. Some oppose “pathologizing” children and the victimized parent and believe restoring a victimized parent’s ability to parent is the fairest and most opportune place to start. Others believe that the potential damage requires a comprehensive assessment of impact and the delivery of tailored interventions that recognize this exposure as trauma. Once assessed, there is a lack of agreement about whether children require a specialized set of clinical or programmatic services, or whether a set of practices and competencies should be integrated and provided in the broader service community. The quality of interventions also varies, as does access to those clinical or programmatic services. If a wealthy philanthropist wanted to invest significant funding to improve access to treatment, they would be faced with a staggering task of vetting and investigating a program’s clinical strategy, evidence base, and practitioner experience and capacity.

Data

Domestic violence is prevalent, and children are often involved. Data systems exist to varying degrees within systems, but a statewide, integrated, meaningful picture of prevalence and the impact of interventions is not within sight.

Building, and Building Upon

It is much more difficult to retrofit than to proactively design a system to account for something as harmful, complex, and common as the exposure of children to domestic violence. Building a response into an existing system requires determining how and why it is relevant to that system; designing policy and processes that include a continuous feedback loop for fidelity and information about impact and improvement; getting buy-in from and training people already working in and entering the system; and adopting a workplace policy that acknowledges employees who may be victims or perpetrators of domestic violence. It is important to convey within the system that domestic violence thrives in secrecy, is significantly underreported, and carries with it great risk upon disclosure. It is also necessary to continually check for bias against all members of the family.

Which System(s)?

Think about some of the systems that touch families experiencing domestic violence—criminal justice, health care, child care, early intervention, mental health, and the service networks for victims and perpetrators of intimate partner violence. Each system has legal and ethical responsibilities and each has different relationships with each member of a family (ie, client, caregiver, defendant, plaintiff, victim, perpetrator). Often, the children do not have their own agency within that system. In addition to the varied relationships between the system and each member of the family, each system has different perceptions about each member of the family, like the family member’s accountability and culpability for the violence, their victimization, and their ability and willingness to change themselves, others, or their conditions.

A reconsideration of our systems’ responses requires identifying which systems are relevant, how those systems interface with members of the family, and what we expect in a response. Consider possible cases, like the police officer who discovers the 3-year-old covering in her closet; the sheriff’s deputy who serves a defendant at his job as a pastor; the judge who is asked to decide custody and visitation arrangements in a domestic violence protective order hearing; and the juvenile court counselor whose assessment of a 12-year-old suggests the youth is consumed with protecting his siblings from his mother’s abusive boyfriend. There is the child protective services worker [1] who interviews an abused parent who refuses to relocate to a shelter, and the domestic violence shelter that does not have the capacity to shelter all siblings, or whose rules prohibit sheltering a 14-year-old male child. Consider the nurse who is told by a mother that her husband forbids vaccinations or follow-up medical visits for the children, and the ER doctor who treats a child for a broken arm and observes injuries on the child’s parent. Imagine the day care director who is told by a 5-year-old that he has to go home because he is worried something bad will happen to his mother, or the school teacher whose student’s grades are falling just after her father has moved back into the home.

Moving the Needle

There continue to be historical and philosophical challenges to addressing children’s exposure to domestic violence. It is clear that there are efforts to be more responsive and that people care about doing better. But how do we truly move the needle?

Is the scope of the problem so enormous and the approaches and their attending processes and policies so different that it is not realistic to create a united, coordinated response? How much time and effort should be spent assessing our current efforts given the lack of integrated data? Is it sufficient to work within each system to implement
a shared set of guiding principles and allow work to occur on a community level based largely on shared agreements that outline how systems will interact with one another? Is it feasible to identify a single organization with the requisite authority, responsibility, leadership capability, and necessary influence to convene disparate, isolated, and often conflicting systems in order to craft and measure the impact of solutions for children living with domestic violence?

Despite the complexities and the inherent challenges, the path forward must include collaboration between and across systems that can be supported by data. We cannot continue to rely on isolated community or system efforts and speculate about our success. The stakes are too high.

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