CHAPTER TWO  THE RESEARCH EVIDENCE ON CHILDREN AND YOUNG PEOPLE EXPERIENCING DOMESTIC ABUSE  Cathy Humphreys and Claire Houghton

This review of evidence on the impact of domestic abuse on children and young people provides the context for understanding the child protection, provision, participation and prevention issues involved. The emergent qualitative literature that provides recent evidence from children’s own perspectives is reviewed in Chapter Three. A number of issues in relation to prevalence, conceptualisation and impact are pertinent to a discussion which explores both resilience and harm.

The prevalence of children and young people living with domestic abuse

The most significant challenge in responding to children and young people affected by domestic abuse lies in recognising that this is a widespread, chronic and serious social problem. The numbers are alarmingly high. Based on the British Crime Survey (Walby and Allen, 2004), the Department of Health estimated that at least 750,000 children in England and Wales were living with domestic abuse (Department of Health, 2002). While there is no Scottish study to draw from, an English national prevalence study of 2,869 young adults indicated that 26% had witnessed violence between their parents at least once, and for 5% the violence was frequent and on-going (Cawson, 2002). These figures reflect closely the Australian population based study of 5000 young Australians which showed that 25% reported witnessing violence against a parent (Indermaur, 2001).

The evidence suggests that domestic abuse is not only highly prevalent but also shows gendered patterns within the data. Reports of domestic abuse incidents and recorded crime show overwhelmingly gendered patterns, with 87% of incidents involving a female victim and a male perpetrator (Scottish Executive, 2006a). However, it has been argued that reported incidents bias the data against men who, it is said, are less likely to report abuse. Turning to population based surveys however shows similar, though more nuanced, patterns emerging.

Within the UK, the most comprehensive survey is the British Crime Survey - a nationally representative sample of 22,463 men and women (aged 16-59), which contained a confidential self-completion section on interpersonal violence (Walby and Allen, 2004). A superficial analysis shows significant numbers of both women (13%) and men (9%) subjected to at least one incident of domestic violence in the past year. However, when the frequency of attacks, the range of forms of violence and the severity of injury are considered, women are overwhelmingly the most victimised. Among people subjected to four or more incidents of domestic violence by the perpetrator, 89% were women and 81% of all incidents were attacks on women (Walby and Allen, 2004). At least 54% incidents of rape and serious sexual assault are perpetrated by a current or former male partner (Walby and Allen, 2004). Domestic abuse is also a significant

\footnote{The Canadian prevalence survey (Statistics Canada, 2005) suggests that men and women call the police when abuse is severe and that the different proportion of men and women reporting violence reflects the differences in severity.}
aspect of the mortality figures for women. In 2001, of the 125 victims of domestic homicide, 82% were women (Home Office, 2001). Of the 90 homicides in Scotland in 2006, 18% were committed by a partner or ex-partner and 11% by a relative (Scottish Executive, 2006b).

Crime surveys and prevalence surveys clearly provide a strong message about the extent and seriousness of domestic abuse. However they have limitations which arise from their incident based focus which will often fail to pick up coercive patterns of dominance and control which lie at the heart of the most severe forms of domestic abuse (Robinson, 2003). Risk assessment protocols (Robinson, 2004) and health and mental health research provide greater attention to these dimensions of domestic abuse. The recent and comprehensive study of the health consequences and response to domestic abuse (BMA, 2007) has outlined the significant and negative health impact on women. When the health issues are considered, women are twice as likely as men to be injured (Mirrlees-Black, 1999), a finding supported by Gadd et al. (2002) who analysed the Scottish data on male victims. This conceptualisation is supported by other research studies such as the Australian longitudinal population health study (Vichealth, 2004), which found that the highest risk factor in determining the physical health of women under 45 was whether they had experienced intimate partner violence. The health burden contributed by intimate partner violence was significantly greater than any other risk factor, including other well recognised contributors such as smoking and obesity (p.25).

However, acknowledging this dominant, gendered pattern of violence can give rise to problems in identifying minority patterns of abuse, many of which may be very dangerous to children and the adults involved. Women’s violence towards their male partners, women’s abuse of children, the abuse of women by other female relatives or the man’s new partner, women’s violence in lesbian relationships, male violence in gay relationships, relationships in which both the woman and man are violent and abusive towards each other, abuse by carers of disabled women, and non-domestic violence by unrelated people (usually, though not always men) all impact on children living in neighbourhoods where violence and abuse are common. Failing to acknowledge the diverse forms of violence in families and communities may limit professionals’ capacity to safeguard children.

The risks of direct abuse and exposure to domestic abuse

The prevalence data suggests that there are very high numbers of children living with domestic abuse and that it is difficult to protect children from exposure to the effects of this violence. For instance, the reports from two different studies which interviewed adult participants reported 86% and 85% respectively of children either in the same or adjoining rooms during an incident of domestic abuse (Abrahams, 1994; Brookoff et al., 1997). Other studies from the US have suggested that there may be greater variation than this. The overview of evidence by Edleson (2004) suggests that while there are very real dangers for children exposed to domestic abuse, there is also wide variation in children actually witnessing or hearing the violence. Studies varied from all children in Hughes’s study based in a refuge (1988), through to 45% of children based on anonymous interviews with mothers (Edleson et al., 2003), and numerous differences in between.
It is not only the exposure to living with domestic abuse that creates vulnerability in children and young people. Children living with domestic abuse are also more likely to be directly physically or sexually abused. Numerous studies report on this problematic co-occurrence. The meta analysis by Edleson (1999) of 31 high quality research studies showed that between 30% and 66% of children who suffer physical abuse are also living with domestic abuse. The variation is largely dependent upon research site and methodology. The severity of violence is also relevant. Ross (1996), for example, found that in a US study of 3,363 parents that there was an almost 100% correlation between the most severe abuse of women and the men’s physical abuse of children.

Studies of child sexual abuse are less common. However, clear evidence is emerging that a significant group of children suffer child sexual abuse within a wider atmosphere of fear created through domestic abuse. Several UK (Farmer and Pollock, 1998; Hester and Pearson, 1998; Forman, 1991) and Australian studies (Tomison, 1994; Goddard, 1981; Goddard and Hiller, 1993) have explored this co-occurrence and have shown significant levels of child sexual abuse in qualitative case file studies. For instance the case tracking, hospital based study by Goddard and Hiller (1993) showed that 40% of sexually abused children were also living with domestic abuse.

However, there are problems which arise from drawing ‘false’ distinctions between exposure to, or witnessing domestic abuse and direct abuse, rather than responding holistically to the child’s experience (Edleson et al., 2003; Mullender et al., 2002). Research is now showing that children are involved in a myriad of ways when they live with domestic abuse. For instance they may be used as hostages (Ganley and Schechter, 1996); they may be in their mother’s arms when an assault occurs (Mullender et al., 2002); they may be involved in defending their mothers (Edleson et al., 2003). Stanley and Goddard (1993) and Kofch (2006) also refer to violence within the community of people surrounding the family which may also instil fear and may contribute directly to the abuse of the child and the impact on well-being. Irwin et al., (2006) point out that describing this range of violent experiences as ‘witnessing’ fails to capture the extent to which children may become embroiled in domestic abuse.

Other issues also highlight the inadequacy of the division between direct child abuse and witnessing domestic abuse. The issue of violence during pregnancy is a case in point. This form of ‘double intentioned violence’ (Kelly, 1994), is both a form of child abuse and a serious aspect of domestic abuse and is supported by data which shows that there is more extensive injury to breasts and abdomen for women who are pregnant (cited BMA, 2007). The data on the extent of abuse during pregnancy varies. The Confidential Maternal and Child Health Enquiry in England and Wales indicates that 30% of domestic abuse began during pregnancy, while an Australian population survey (ABS, 2006) shows that 41% of women who experienced domestic abuse reported violence during pregnancy, and that 20% of these women who experienced domestic abuse reported that their first experience of violence was during pregnancy. This concurs with the study by Taft et al., (2004) which draws on a longitudinal study of women’s health which shows that pregnancy was a time of increased risk with a significant association between pregnancy, pregnancy losses and births and physical or sexual violence. The increase in miscarriage is shown in studies by Campbell (2002) and Schornstein (1997). The latter study showed that women subjected to domestic abuse in pregnancy were four times more likely to
miscarry than women who were not abused. In this sense, some aspects of violence during pregnancy represent the most serious forms of child abuse and the risks posed by these perpetrators to both women and the unborn child need to be taken extremely seriously.

The impact of living with domestic abuse

It is now evident that many children living with domestic abuse may be at risk of significant harm\(^3\). Throughout the 1990s, these risks to the well-being of children living with domestic abuse began to be documented and a comprehensive body of knowledge started to develop with substantial overviews provided in the UK (Hester et al., 2000), Canada (Ministry of Children and Family Development, 2004) and Australia (Laing, 2001; Gevers, 1999). While there are some inconsistencies in the evidence, the research shows that children living with domestic abuse have much higher rates of depression and anxiety (McCloskey et al., 1995), trauma symptoms (Graham-Bermann and Levendosky, 1998), and behavioural and cognitive problems (O’Keefe, 1995) than children and young people not living with these issues.

While some studies show that children who are directly abused are more likely to show more severe impacts on their health and well-being (Carlson, 2000; Edleson, 1999; Hughes et al., 2001; Crockenberg and Langrock, 2001), other research shows little difference between witnessing domestic abuse and actual abuse (Mertin and Mohr, 2002). In this latter study, the experiences of 56 children living with domestic abuse were divided according to children witnessing abuse; being involved in the violence; and being a target of the violence. Little differentiation was found. Perhaps the most substantial evidence is provided by the meta-analysis of 118 studies by Kitzmann et al., (2003), which evaluated the psychosocial outcomes of children living with domestic abuse. It showed significantly poorer outcomes on 21 developmental and behavioural dimensions for children witnessing domestic abuse than those not witnessing abuse. However, the witness outcomes were similar to those where children were also directly physically abused.

It would seem that issues such as age and severity may be intervening variables. For instance, the ‘LONGSCAN’ longitudinal studies in the US suggest that for children under 8, witnessing abuse towards their primary care giver is deeply traumatic. Psychological tests indicate children found this more disturbing than the effects of direct physical maltreatment (Runyan, 2006). Other research shows that problems for children can compound over time as they live with the multiple problems associated with the destructive effects of domestic abuse. A summary is provided by Rossman who states:

“Exposure at any age can create disruptions that can interfere with the accomplishment of developmental tasks, and early exposure may create more severe disruptions by affecting the subsequent chain of developmental tasks” (Rossman, 2001, p.58).

The impact on children at different developmental stages shows the broad range of ways in which children react to their environments. Babies living with domestic abuse are subject to high

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\(^3\) ‘Significant harm’ is often used in a legal context to denote a threshold of harm which requires statutory intervention. It is recognised that this is not a clearly defined concept, but it is used in literature to denote a high level of seriousness and concern.
levels of ill health, poor sleeping habits and excessive screaming (Jaffe et al., 1990) and disrupted attachment patterns (Quinlivan and Evans, 2005). While children of pre-school age tend to be the group who show the most behavioural disturbance (Hughes, 1988) and are particularly vulnerable to blaming themselves for adult anger (Jaffe et al., 1990), older children and young people are more likely to show the effects of disruption in their school and social environments, particularly if they are the ones who are constantly ‘on the move’ (Mullender et al., 2002).

An approach which takes into account developmental stage and vulnerability is compatible with the emerging evidence on the interaction between the child’s environment and their neurological development (Teicher, 2002; Perry, 1997). This research draws attention to the vulnerability of babies in utero and infants to the effects of trauma. Potent chemicals are released in the brain in response to fear which creates an over-active stress response. This over-arousal interferes with the development of other parts of the brain which mediate the development of more reflective emotional responses (Schore, 2003). It is important to note, that in spite of these early biological effects, that these ‘baby’ studies also suggest that development is recoverable with early intervention in which babies are no longer in such a stressful environment (Perry, 1997).

It needs to be remembered that, at its most extreme, children (O’Hara, 1994) or their mothers (Hendricks et al., 1993) may be killed. This highlights not only the lethality of abuse but also the trauma associated with children witnessing such events, even if not so extreme. More recent research highlights the symptoms of trauma in children and young people (Graham-Berman and Levendosky, 1998; Kilpatrick and Williams, 1997) though it has been pointed out that trauma in young children may be more difficult to identify when children are unable to describe their experiences. Instead, younger children may show more generalised anxiety, regression and loss of previously acquired developmental skills such as toilet training; sleep disturbance; separation anxiety; and constantly repeating themes of trauma incidents in their play. A significant issue lies in directly asking children themselves about their symptoms rather than relying on the indirect reports from their mothers (Kilpatrick and Williams, 1997). Recognition also needs to be given to factors which may protect and ameliorate the experience of trauma such as strong family support, less parental distress and the level of physical proximity to the traumatic event (Hughes et al., 2001).

An attack on the mother-child relationship

Attacks during pregnancy highlight a further issue. This is the emerging conceptualisation of domestic abuse which recognises that the tactics of abuse and violence used against women can significantly undermine their relationships with their children (Irwin et al., 2002; Radford and Hester, 2006; Mullender et al., 2002; Humphreys et al., 2006a). In this sense, domestic abuse represents an attack on the mother-child relationship and goes beyond understanding the effects on children as due to witnessing domestic abuse.

The reports by women in three studies (Mullender et al., 2002; Irwin et al., 2002; Humphreys et al., 2006) document the indirect and direct strategies through which mothering is undermined. Women described the ways in which high anxiety and depression affected their ability to care for
their children, and highlighted their pre-occupations with trying to control the domestic environment so that the man’s needs were prioritised at the expense of the children’s. Other studies have identified the ways in which, either in the short or long term, women have been disabled by the severity of the violence they have experienced, either needing hospitalisation or being temporarily unable to provide physical care (Stark and Flitcraft, 1996; Radford and Hester, 2001). Belittling and insulting a woman in front of her children undermines not only her respect for herself, but also the authority which she needs to parent confidently. Women describe being sexually assaulted and humiliated in front of their children. In Abraham’s (1994) and McGee’s (2000) studies, 10% of women interviewed reported that they had been raped with their children present - a disturbing violation of boundaries which seriously distorts the environment in which mothering occurs (not to mention fathering).

There is also controversy about the extent to which women who are being abused themselves are inclined to be more abusive and neglectful of their own children. Some studies suggest that women living with domestic abuse are no more likely than other women to abuse and neglect their children (Holden et al., 1998; Radford and Hester, 2006), while other research shows that, in households where there is domestic abuse, both mothers and fathers are more likely to physically abuse their children (Ross, 1996). This needs to be placed in the context of research (Holden et al., 1998) which suggests that parenting can show very significant improvements in the first six months following separation if the abuser’s violence is curtailed.

This conceptualisation of the attack on the mother-child relationship can also be taken a step further. This is namely, that the violence may force women and children to leave their communities and families and hence can represent an attack on their cultural identity and location. These are issues raised by indigenous (Thiele, 2006) and black and minority ethnic research (Mullender et al., 2002) and require addressing in the aftermath of domestic abuse.

**Children’s ‘Resilience’**

The lengthy discussion of the harmful effects of domestic abuse on children, and their relationships with those around them, appropriately highlights the significance of taking their vulnerability and risks to their safety seriously. However, within the evidence base, studies are emerging that also highlight children who are doing as well as other children, in spite of living with the serious childhood adversity created by domestic abuse. Sometimes this is referred to as ‘resilience’ (Margolin and Gordis, 2004). Such terminology suggests an individual trait and hides rather than elucidates the fact that children live in different contexts of both severity and protection. Laing (2001) in her overview of research draws particular attention to the incomplete state of our knowledge of protective contexts for children. Higher rates of distress shown across a range of clinical measures should not be conflated with the notion that all children show these elevated levels of emotional distress and behavioural disturbance. It highlights the maxim that ‘correlation is not causation’ (Magen, 1999).

The point is exemplified by research that shows that in any sample of children there are generally about 50% who do as well as the control group (Magen, 1999; Edleson, 2004). This is a slightly different proportion from Kitzmann et al., (2003) who, in a meta analysis of 118 studies, showed
63% of children witnessing violence doing worse than those who do not witness violence, but 37% whose well-being is comparable or better than other children. The study by Hughes and Luke (1998) of 58 mothers living in a refuge showed 26% of children with few behavioural problems, high levels of self-esteem and no anxiety recorded. There was also a group (36%) who had mild anxiety symptoms and above average self-esteem. Other research studies point to similar findings (Margolin and Gordis, 2004; Sullivan et al., 2000; Hughes et al., 2001; Jaffe et al., 1990).

This research data seriously challenges over-pathologising all children living with domestic violence. There is a substantial proportion of children who are managing in a situation of adversity. This must not be read to mean that children do not have a right to live free from violence or need a service in these circumstances. However, it does raise questions about whether all children need a statutory referral or referral to the Reporter.

There are many factors which moderate the risks and experiences of children. Children will be affected by the severity of violence with which they are living and for a particular group of children, whether they are being directly abused (Edleson, 1999), as well as by the extent to which their needs have been neglected (Brandon and Lewis, 1996). The mother’s ability to maintain her parenting abilities under such adverse conditions and mothers who are perceived by their children to be positively supportive are particular important moderators of the abuse impact (Cox et al., 2003). ‘Resilience’ may be strongly influenced by the level of family and community support which children experience and this factor is particularly evident for black and minority ethnic children (Mullender et al., 2002; Blagg, 2000).

A number of studies point to the mother’s mental health as a source of resilience for children (Moore and Pepler, 1998). For example, an overview of three studies of children’s resilience when living with domestic abuse showed that the children of women who did not experience moderate or severe depressive symptoms showed much fewer emotional problems (Hughes et al., 2001). Children also may learn very positive aspects of ‘survivorship’ from those mothers who model assertive and non-violent responses to violence (Peled, 1998).

Like their mothers (Holden et al., 1998), many children will recover their competence and behavioural functioning once they are in a safer more secure environment (Wolfe et al., 1986) and with support have even proved to be effective social and political actors in securing resources for similarly affected children and young people (Houghton, 2006). In particular, children who are not continually subjected to post-separation violence (Mertin, 1995) and protracted court cases over child contact (Buchanan et al., 2001) show a much stronger pattern of recovery.
Summary

This overview highlights some of the issues which impact on children living with domestic abuse and has implications for intervention

• It suggests that there are thousands of children in Scotland who have lived with, or are living with, domestic abuse

• Many of these children are living in fear and show very negative effects evidenced in their cognitive, emotional and behavioural development, while others will be in a context of protective factors where they are able to show resilience in the face of this form of childhood adversity

• The division between direct and indirect abuse of children living with domestic abuse may not be the most effective means of assessing risk and severity

• Pregnancy is a time of increased vulnerability and assault at this time represents a dangerous form of both women abuse and child abuse

• The attack on the mother-child relationship which is an aspect of domestic abuse highlights the need to link the protection and support of women with the protection and support of children

• In any sample which looks at the impact of domestic abuse on children, there is a significant group who are doing as well as control groups. It is important to resist over-pathologising all children living with domestic abuse and also to recognise the capacity of children and their mothers to recover from the effects of domestic abuse in safe, secure, violence free environments
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