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ORIGINAL ARTICLE

Co-Occurrence of Intimate Partner Violence and Child Maltreatment: Service Providers' Perceptions

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Abstract Intimate partner violence (IPV) places children at risk for maltreatment (CM). It is critical for both IPV and CM professionals to assess the possibility of the co-occurrence of both of these types of family violence, whose risk factors are nearly identical. However, little is known about the attitudes and perceptions of child welfare (CW), IPV, child protection, or other related professionals when serving families where both of these circumstances may occur. This study examined the perceptions of service providers in Hillsborough County, Florida on the co-occurrence of CM and IPV. Findings demonstrate the inequitable knowledge, training, and perceived ability to deal with the co-occurrence of IPV and CM among professionals from different employment areas. These discrepancies serve as opportunities for different agencies to collaborate in reducing knowledge gaps and increasing respondent's capacity to effectively identify and intervene with victims.

Keywords Child abuse · Child maltreatment · Domestic violence · Intimate partner violence · Family violence · Child protection · Welfare · Health providers

Research shows that intimate partner violence (IPV) places children at risk for maltreatment (Banks, Landsverk, and Wang 2008; Steen 2009). Child abuse is estimated to be present in about 40 % of IPV cases (e.g., Herrenkohl et al. 2008). Physical abuse, harsh psychological punishment, and child neglect have all been found to be strongly related to IPV (e.g., Hartley 2002; Zolotor et al. 2007). Child maltreatment (CM) and IPV may also overlap with other forms of family violence – such as sibling violence (e.g., Hoffman and Edwards 2004) and children's violence perpetration and/or victimization later in life (e.g., Edwards, Desai, and Gldycz 2009; Palazzolo, Roberto, and Babin 2010).

It is important to determine whether CM is present when assisting IPV victims, as well as when responding to CM cases. There are growing data to support the fact that children suffer increased negative outcomes when more than one type of family violence is present (e.g., de la Vega et al. 2011; Kaslow 2008), increasing the urgency for identification and intervention. System responses to the presence of more than one type of family violence could be mobilized to protect a vulnerable parent in addition to a child, or a child in addition to a parent.

In spite of the knowledge on the co-occurrence of CM and IPV, most of the available research is limited to the practices and actions taken in responding to these situations (Malik et al. 2008). Little is known about the knowledge, attitudes, and perceptions of child welfare (CW), IPV, or child protection investigation professionals when serving families where both of these circumstances of violence may occur. Yet, it may greatly affect their perspective and their ability to recognize and respond to these situations, affecting in turn the management and assistance provided to victims.

Background

Appel and Holden (1998) published a landmark literature review of studies on the co-occurrence of IPV and child abuse, and estimated its prevalence to be approximately 40 %. Edleson (1999) also reviewed 25 years of the scientific literature and found an estimated prevalence of 30 to 60 %. More recently, Herrenkohl et al. (2008) also found considerable

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evidence supporting the earlier findings of co-occurrence and estimating that its prevalence remains at around 40 %.

A variety of factors have been found to increase the risk for the co-occurrence of IPV and CM. These include poverty, alcohol or drug abuse, criminal activity within the family or neighborhood, low socioeconomic status and education levels, mental illness, young maternal age, and limited participation in a religious community (Cox, Kotch, and Everson 2003; Herrenkohl et al. 2008). It is important for service providers and first responders to be prepared to identify the presence of risk factors for both CM and IPV, yet these are often overlapping (Hartley 2002).

Under-identification of the co-occurrence of IPV and CM persists despite its frequency (e.g., Kerker et al. 2000). Some studies have pointed to the possibility that providers' attitudes may play a significant role in this under-identification and/or reporting. For example, a study of all social service agencies in Virginia found that supervisors believe child protection investigation (CPI) workers possess (and only need) overall knowledge on a limited number of IPV related issues (Button and Payne 2009). Utilizing a national sample of IPV shelter workers, Steen (2009) found that these workers believed reporting the co-occurrence of IPV and CM would have adverse outcomes if the battered woman is the one abusing the child, or if the child only witnesses IPV.

The purpose of this study was to examine the perceptions of professionals from several fields (i.e., CW, IPV, and law enforcement/CPI) on the co-occurrence of CM and IPV. Its findings will assist child serving agencies in the development of policy, training, and organizational interdisciplinary collaboration, thus helping to ensure the safety and well-being of victims, families, and communities.

Method

Research Design

In this cross-sectional research study, data were collected through an online survey questionnaire for CW and IPV service providers, law enforcement personnel, and CPS investigators serving in Hillsborough County, Florida. This study was a collaborative effort designed and implemented by the Harrell Center for the Study of Family Violence at the University of South Florida (USF), supported by the Family Justice Center of Hillsborough County and the Child Welfare/Intimate Partner Violence (CW/IPV) Task Force of Hillsborough County. The USF Institutional Review Board approved this study.

Data were collected online through a 15-item, close-ended (e.g., Likert scale) survey, which was reviewed by the CW/IPV Task Force members. It assessed participants' perceptions on: their IPV and CM Knowledge; Perceptions regarding IPV; Battered Parents; IPV and Reporting CM; Knowledge and Abilities Regarding IPV and CM; Effective Advocacy and Intervention; Training Received; and Workplace Policies. Many of its items were adapted from published instruments on actions taken in response to IPV and CM (e.g., Banks, Landsverk, and Wang 2008; Malik et al. 2008; Mills and Yoshihama 2002; Saunders et al. 1987; Steen 2009). Others were developed by the researchers to also assess providers' knowledge, perceptions, and beliefs about CM and IPV – the study's main focus, and for which no measures were identified within the peer-reviewed literature. Additional information on the questionnaire is available from the authors, upon request.

Sampling and Recruitment

This study targeted front-line workers who served in CW, IPV, CPI, law enforcement, and other related agencies. In order to alleviate anonymity concerns, the research team was not directly involved in participant recruitment. All participants (N= 140) were recruited by the local CW/IPV Task Force members from within their networks, by distributing an email invitation that described the study and included an URL link to access the online informed consent form and survey.

Data Collection and Analysis

The study's online survey was designed and administered via Checkbox 4.6. No identifying information was collected. Descriptive analyses portrayed participants' gender, age, and type of employment. Crosstab and Chi-square analyses assessed significant differences in knowledge and response to IPV and CM, by the participants' type of employment, age group, and gender.

Study Participants

Most participants were female (81.4 %), and over 60 % of them were ≤40 years old. The majority of all respondents self-identified as employed within CW services (47.1 %) or CPI (30.7 %); only 10 % self-identified as working with IPV victims. About 12.1 % specified "other" type of employment, including 3 % (n=4) who worked in law enforcement.

The majority of respondents in the youngest age groups – that is, 61.5 % of 22–30 year olds and 51.4 % of 31–40 year olds – were CW service providers. Older participants (ages 51–60 years) were more equitably represented across employment types, although the greatest proportion served as CPIs (35 %). Differences in employment type by age groups were significant (p<.05).

Years of professional experience was polarized; participants either had extensive (10+ years), or limited (<4 years) employment experience. Significant differences were found in

time of employment by gender ($p<.05$) and age ($p<.0001$). Most male respondents had ≥10 years of experience, whereas half of all female respondents had <4 years of experience in their field.

Results

Intimate Partner Violence Knowledge

Most frequently, the reason given as to why victims stay in abusive intimate relationships is related to their economic dependence on the partner (80 %), followed by lack of self-confidence (46.4 %), and fear of greater violence from the abusive partner (45.7 %). Nearly one third of respondents also believe people stay in such relationships because they have nowhere else to go, believe their children need their father or mother, or hope that the marriage will improve.

Significant differences ($p<.05$) in the reasons why people stay in abusive relationships were found by the type of employment of the respondent (Fig. 1). Most CW and IPV service providers believe victims stay because they fear greater violence from partners. Half of IPV service providers believe love for the partner is a reason why people stay in abusive relationships, compared to 11.6 % of CPI and 21.2 % of CW service providers. A small yet statistically significant proportion of CW and CPI participants think enjoyment of intense emotional experiences could be a reason why victimized partners stay in abusive intimate relationships.

Perceptions Related to IPV

Participants identified their level of agreement with several common perceptions related to IPV. The most notable findings are presented below. Only statistically significant differences ($p<.05$) by the respondents' employment type and gender are presented.

Filing for Divorce Opinions are divided on whether IPV victims should immediately file for divorce – 36 % do not think they should, whereas 23.6 % think they should. Slightly more CW (37.8 %) than CPI (34.9 %) service providers "slightly" or "strongly disagree" with immediately filing for divorce; most IPV service providers (64.3 %) "neither agree nor disagree" (25.6 and 21.2 %, respectively).

Batterers are Responsible for the Abuse Most respondents "strongly agree" (27.9 %) or "agree" (27.9 %) that batterers are responsible for the abuse. Both male (76.9 %) and female (65.8 %) respondents "agree" with this statement. Yet, females are more emphatic – 29.8 % of female respondents "strongly agree", compared to 19.2 % of males.

Batterers Intend Their Abuse While most participants (52.1 %) agree batterers intend their abuse, 23.6 % remain neutral, and 18.5 % disagree.

Arresting the Batterer Nearly half (47 %) of respondents believe the best way to deal with physical IPV is to arrest the batterer. More IPV (89 %) than CPI (40 %) and CW (38 %) service providers agree with arresting batterers for physical IPV.

If Being Beaten, the IPV Victim Should Move Out Most participants "strongly agree" (23.6 %), "agree" (29.3 %), or "slightly agree" (16.4 %) with IPV victims moving out if beaten.

IPV Victims Should Be Allowed to Decide What to Do Over half of respondents "strongly agree" (27.1 %), "agree"

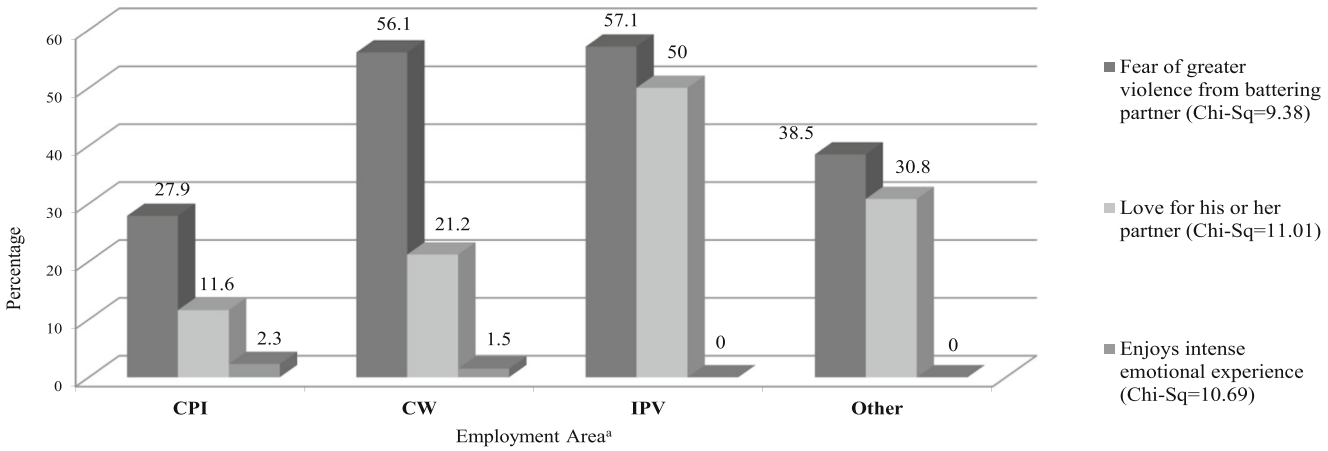

Fig. 1 Perceptions on the most important reasons why people stay in abusive intimate partner relationships, by employment area ($N=140$). *Note.* Figure only shows those reasons for staying in abusive intimate partner relationships that were significantly different ($p<.05$) across employment areas. [a] CPI = Child Protection Investigations ($n=43$), CW = Child Welfare service providers ($n=66$), IPV = Intimate Partner Violence service providers ($n=14$), Other ($n=17$)

(37.1 %), or "slightly agree" (12.9 %) that victims should decide on their immediate course of action. Most respondents (65.7 %) also "agree" that battered parents should make decisions regarding their children's wellbeing; 22.9 % "disagree".

Battered Parents

In contrast, nearly 80 % of participants "strongly agreed" (38.6 %) or "agreed" (38.6 %) with battered parents not being capable of protecting the safety of their children; 18.6 % express a neutral position on the matter. Most (81.4 %) believe IPV victims stay with their batterers because they fear their children will be taken away if they disclose the abuse to authorities.

IPV and Reports of Child Maltreatment

Twenty seven percent of participants believe that IPV workers' reporting of CM "often" damages the relationship between the IPV worker and the battered parent, but only 23.6 % think disclosing CM "often" disempowers the battered parent. In terms of children, participants think that IPV workers' reporting of CM "rarely" (36.4 %) or about "half of the time" (34.3 %) causes further child trauma, and that it protects the child "often" (41.4 %) or "always" (30 %). They believe disclosing CM discourages battered parents from seeking help about "half of the time" (43.6 %) and causes more disruption to the family "half of the time" (48.6 %) or "often" (28.6 %).

Knowledge and Abilities Regarding IPV and CM

Respondents were asked to describe on a scale of 1 (*not at all*) to 5 (*very much*) their knowledge and abilities pertaining to IPV and CM (see Table 1). Overall, participants felt they have more knowledge, are more comfortable, and capable of dealing with CM than IPV situations. Participants report knowing more about CM (M=4.3, SD=.774) than IPV dynamics (M=3.7, SD=.944), and feel more capable of identifying abused children (M=4.2, SD=.787) than battered partners (M=3.5, SD=.910).

As expected, IPV service providers are the ones who report being most capable of identifying battered partners (X^2= 34.02, p<.05), whereas CPI and CW service providers report being most capable of identifying CM victims (X^2=26.64, p<.05). Surprisingly, IPV service providers report the highest level of knowledge on both IPV (X^2=58.62, p<.0001) and CM (X^2=26.64, p<.05). In spite of the known overlap between IPV and CM, CW service providers feel the least capable of identifying IPV victims.

Effective Advocacy and Intervention

Participants feel more confident in intervening with (M=4.1, SD=.868) and advocating for (M=4.4, SD=.791) CM cases than intervening with (M=3.3, SD=.938) and advocating for IPV victims (M=3.8, SD=.983). Participants also feel more comfortable working with abused children (M=4.5, SD=.812) than battered partners (M=3.9, SD=.925).

IPV service providers feel more confidence in dealing with IPV cases, advocating for and working with battered partners. Conversely, CPI and CW service providers feel most confident in effectively intervening with CM cases, advocating for and working with abused children.

Training Received

Most participants (70 %) said they received training on the co-occurrence of IPV and CM. Of those, 29 % said they received 10 h or more of training, 25 % received 4–9 h of training, and 15 % reported receiving the least amount of training. More females (71.9 %) than males (61.5 %; p<.05) reported receiving such training.

In terms of employment, the majority of CPI (86 %) and IPV service providers (85.7 %) said they received training on the co-occurrence of IPV and CM; slightly over half of those in "other" professions (58.8 %) and CW services (59.1 %) also said they received this type of training (X^2= 13.56, p<.05). Most (57.1 %) IPV service providers reported receiving 10 h or more of training on the co-occurrence of IPV and CM, compared to 37.2 % of CPI and 19.7 % of CW service providers. Close to a third (30.3 %) of CW service providers reported receiving 1–6 h of training on the overlap of IPV and CM (X^2= 20.84, p<.05).

Workplace Policies

Most participants "agree" or "strongly agree" that their agency has policies that clearly state the criteria under which children can remain safely with non-abusing battered parents (47.9 %), and utilize an IPV screening and assessment tool regularly during intake (67.9 %) – highest among IPV service providers (see Fig. 2).

Discussion

Research has been consistent in estimating the co-occurrence of CM and IPV to be at least 40 % (Appel and Holden 1998; Herrenkohl et al. 2008). Nonetheless, the perceptions and knowledge about its co-occurrence have not been extensively assessed among professionals who respond to family violence situations. While this study's findings are limited to an unrepresentative sample of CPI, IPV, and CW service providers in Hillsborough County, Florida, they serve to underline the need for further research and interventions in this area.

Table 1 Knowledge and ability in dealing with IPV and CM cases, by employment area (N=133)

Do you feel that you… (%)	Total	Employment area[a] (M (SD))[b]				X^2
		CPI	CW	IPV	Other	
Intimate partner violence (IPV)						
Know about the dynamics of IPV	3.7 (.944)	3.8 (.821)	3.5 (.833)	4.8 (.579)	3.2 (1.235)	58.62**
Can identify battered partners	3.5 (.910)	3.7 (.734)	3.2 (.948)	4.2 (.699)	3.2 (.899)	34.02*
Can effectively intervene in IPV cases	3.3 (.938)	3.4 (.887)	3.0 (.792)	4.1 (.997)	2.9 (1.068)	46.99**
Can advocate on behalf of battered partners	3.8 (.983)	3.6 (.882)	3.9 (.860)	4.6 (.633)	3.3 (1.494)	39.57**
Feel comfortable working with battered partners	3.9 (.925)	3.8 (.871)	3.9 (.885)	4.6 (.633)	3.9 (1.214)	28.9*
Child abuse and maltreatment						
Know about the dynamics of child abuse	4.3 (.774)	4.4 (.630)	4.3 (.701)	4.5 (.760)	4.0 (1.291)	26.64*
Can identify child victims of abuse	4.2 (.787)	4.4 (.630)	4.1 (.766)	4.0 (.784)	3.9 (1.144)	N.S.
Can effectively intervene in cases of child abuse	4.1 (.868)	4.4 (.618)	4.2 (.810)	3.7 (.994)	3.5 (1.198)	34.07**
Can advocate on behalf of abused children	4.4 (.791)	4.5 (.672)	4.6 (.698)	4.1 (.770)	4.2 (1.144)	23.28*
Feel comfortable working with abused children	4.5 (.812)	4.6 (.577)	4.6 (.610)	3.9 (.949)	4.1 (1.320)	37.60**

CM Child maltreatment

[a] CPI = Child Protection Investigations (n=42), CW = Child Welfare service providers (n=60), IPV = Intimate Partner Violence service providers (n=14), Other (n=13)

[b] Mean results are based on a scale from 1 (*not at all*) to 5 (*very much*)

*p<.05; **p<.0001; N.S. = Differences were not statistically significant

Overall, participants feel they have more knowledge and are more comfortable dealing with CM than IPV cases. As expected, participants feel most confident in effectively identifying victims, intervening with, or advocating for the population they are primarily trained to work with. CPI and CW service providers feel most capable of dealing with CM. They also reported knowing about IPV, but do not feel as prepared, confident or able to deal with it as with CM. This finding is of particular importance, as CPIs – located within law enforcement – are required to investigate the presence of IPV when responding to CM reports. Lack of knowledge and comfort with this issue can be a detriment to a thorough and/or accurate assessment.

Although they feel most capable in dealing with IPV victims, IPV workers also report knowledge of the dynamics of CM. In fact, they report greater knowledge on CM dynamics than participants of other employment areas – including those who primarily serve child populations. IPV workers are also

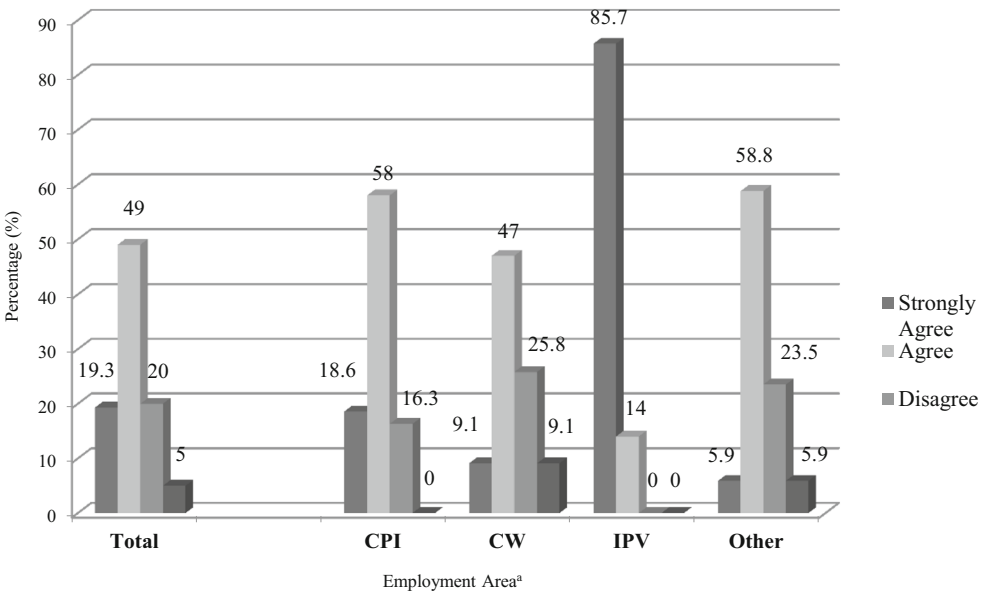

Fig. 2 Self-report of regular use of an IPV screening and assessment tool (any kind) during intake, by employment of participants[a] (N=140). *Note.* 7.1 % of the total sample did not provide a response for this survey item. This includes 7 % of CPI, 9.1 % of CWS, and 5.9 % of participants in other employment areas. Differences found by the employment type of participants were statistically significant (X^2= 52.559, p<.0001). [a] CPI = Child Protective Investigations (n=43); CW = Child Welfare service providers (n=66); IPV = IPV service providers (n=14); Other (n=17)

the ones who report receiving the most hours of training on the co-occurrence of IPV and CM; CW service providers received the least.

The vast majority of respondents (81 %) believe battered partners stay in abusive relationships because they fear their children's removal by authorities. Nonetheless, differences on the most important reasons why people stay in abusive relationships were identified across employment areas. For example, while most IPV and CW service providers believe fear of greater violence is one of the main reasons for staying in abusive relationships, most CPIs do not identify fear as an important reason for staying in abusive relationships.

The magnitude of these differences in perception is critically important as it can clearly affect the actions of the respondents. If respondents believe fear is a reason for staying, a primary response may be assurance of protection to victims. On the contrary, if they do not believe this to be an issue, they could limit efforts to protect both the victim and the child. Understanding of the powerful nature of victims' feelings of love for the perpetrator and the impact that this has on decision making can contribute to the development of more context specific approaches and interventions. Conversely, the belief that victims – even a small proportion – may stay because of an enjoyment of intense experiences might lead responders to both limit protective responses for victims and underestimate danger.

Of special note is the finding that IPV victims both stay with the batterer and fail to disclose the abuse because of fear that the children will be removed. This strongly argues for a more supportive response that is capable of protecting both victim and child in some situations, and for outreach to victims in IPV situations that allow for exploration of possible strategies without the initial involvement of authorities.

Respondents believe IPV workers' report of CM could have both negative and positive outcomes. In their view, reporting the co-occurrence of CM frequently affects IPV workers' relationships with the battered parent, sometimes prevents IPV victims from seeking further help, and regularly causes further disruption within the family. Respondents are quite evenly divided as to whether it disempowers the battered parent. Furthermore, participants strongly feel that reporting CM within IPV situations usually results in the child's protection.

While opinions are divided on whether battered parents can protect their children, respondents firmly believe battered parents should be allowed to decide on the immediate course of action regarding both themselves and their children. This finding argues for responses and interventions that maximize the autonomy of battered parents – within the boundaries of protecting the children –, empower battered parents, and help them make the most appropriate decisions. It argues for exploration of alternative approaches to case planning, such as mediation, family conferencing, and other approaches to problem resolution.

The marked differences in opinion about whether arrest is always the best response to IPV situations reflect fundamental differences in perceptions in the field of family violence. Despite findings that arrest is not always of benefit to the victim, and the knowledge that only a limited proportion of arrests lead to convictions and interventions, serious alternatives are not always available. The role of the courts in IPV responses – in family situations where both CM and IPV exist – and the impact of differing perceptions about the appropriateness of arrests are all areas needing further examination.

These study findings demonstrate the inequitable knowledge, training, and perceived ability to deal with the overlap of IPV and CM among professionals from different employment areas. This could imply the need for specialized oversight of CM co-occurring within IPV situations, and vice versa. It argues for a system that responds in a more integrated and collaborative style. Indeed, those discrepancies in service providers' knowledge, training, and perceived ability serve as opportunities for different agencies to collaborate in reducing knowledge gaps and increasing respondent's perceived capacity to effectively identify and intervene with both IPV and CM victims. These collaborations could include the interdisciplinary training of professionals from each of these agencies, as well as more specific education requirements in different professional fields on the co-occurrence of IPV and CM. Finally, the establishment of public policies that create laws and guidelines for the assessment and reporting of the co-occurrence of IPV and CM, in ways that are most likely to protect the victims, are needed.

Limitations

This report presents the findings from a relatively small, convenience-based sample from one specific county in Florida, and should not be generalized to all CPI, IPV, or CM service providers in other counties or states. Furthermore, given the low participation from law enforcement officers beyond those based in CPI – an issue worthy of further exploration –, results are not representative of this employment area and were included as part of the "other" employment category. It is important to consider that nearly a tenth of all participants (n=13) identified themselves as being from other, unlisted professions. Also, comparisons across IPV- and CM-focused employment areas are limited; there were significantly more participants employed in CM-focused areas (i.e., CPI [n=42], CW service providers [n=60]) than in IPV-focused areas (i.e., IPV service providers [n=14]). It should be noted, however, that CPIs are charged also with the determination of the presence of IPV in the families they investigate for possible CM. In fact, "failure to

protect" – a category of CM – often represents the failure of a parent to leave an IPV situation when a child is in the home. From this perspective, a significant percentage of respondents have IPV investigation as a part of their responsibility as well as CM.

Since the recruitment of participants was conducted indirectly, via the CW/IPV Task Force members, the exact number of potential participants that received the email invitation is unknown. Therefore, the response rate is also unknown.

Recommendations

While it is general knowledge that we need increased cross-training opportunities and collaboration among IPV, CW, and law enforcement professionals, we lack understanding on the current knowledge, attitudes, and perceptions of IPV, CM, and their co-occurrence. This study could serve as a platform to initiate further needs assessments across disciplines. Findings could help inform the development of needs-based training and collaborative programs to address this public health problem.

The importance of continued training on IPV, CM, and its co-occurrence is critical. In particular, training on the dynamics of IPV should be highly prioritized, and joint training across disciplines is recommended.

At the policy levels, substantive discussions on the lack of agreement of many respondents in terms of arrests being an appropriate response to IPV, and how this affects the victim's responsibility of protecting children from exposure to violence and maltreatment are recommended. Service providers' perceptions on whether battered parents should make decisions about themselves and their children could be instrumental in these discussions. While no statistically significant differences were found by employment type, over a quarter of all participants disagreed that the battered parents should decide what to do about themselves or their children. Further research into the reasons why victims should or should not be empowered with making these decisions must be explored in detail, and differences in the perspectives of service providers from different employment areas must be considered.

The National Council of Juvenile and Family Court Judges' *Greenbook* recommendations (Schechter and Edleson 1999) proposes that the CW system could lead in establishing collaborations with law enforcement and the judicial system to ensure the safety of families experiencing both IPV and CM. The role of IPV service providers must also be a component of this collaboration in order to develop responses by informed, multi-disciplinary responders and systems. Because this is an emerging field, new data on effective integrated response systems should be widely disseminated and integrated into training and practice as quickly as possible.

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