



Article

Psychosocial Professionals' Perspectives and Practices Regarding Children Exposed to Intimate Partner Violence in Belgium's French-Speaking Community

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Highlights

Public health relevance—How does this work relate to a public health issue?

- Major consequences of children's exposure to intimate partner violence, including health-related outcomes, have been well documented in the literature. This issue therefore represents an important public health concern.

Public health significance—Why is this work of significance to public health?

- This study highlights limitations in the response of psychosocial and child protection systems to these children. These structural issues are of direct relevance to public health systems, as they affect equity, accessibility, and quality of care.

Public health implications—What are the key implications or messages for practitioners, policy makers and/or researchers in public health?

- This study underscores the need to strengthen training for practitioners working with children and for those working with adults experiencing IPV.
- Our findings suggest that greater attention should be given to the development of targeted interventions for children exposed to intimate partner violence, informed by both child-centered and trauma-informed approaches.
- It further emphasizes the importance of considering children's safety, the long-term consequences of IPV exposure, and the recurrence of IPV across generations.

Abstract

Despite growing evidence of the serious impact of intimate partner violence (IPV) on children, research on intervention practices in the psychosocial sector remains limited. This study investigates professionals' perspectives on children exposed to IPV and how they address this issue in their practice. Using a sequential mixed-methods design, an online survey (N = 129) was followed by semi-structured interviews (n = 13). The findings reveal major limitations in interventions targeting children exposed to IPV, which help explain a significant gap between professionals' perspectives—where children are recognized as victims of IPV and its substantial impact—and what is implemented in practice. In this context, children exposed to IPV often appear secondary both to children victims of other forms of abuse and to adult victims of IPV. Overall, these results underscore the need for specialized training and the development of targeted interventions to better address the specific needs of these children.



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Keywords: child exposure to domestic violence; children as witnesses of violence; intimate partner violence (IPV); child protection systems; psychosocial interventions

1. Introduction

Over the past decades, Intimate Partner Violence (IPV) has been recognized across countries worldwide as a major social and public health issue. As this type of violence occurs in the family, children can frequently be exposed to IPV. Children exposure to IPV (EIPV) encompasses “direct exposure”, such as seeing or hearing violence between their parents or other caregivers in the household and “indirect exposure”, such as observing the consequences and the aftermath of the violence [1–3]. Global prevalence of EIPV remains difficult to obtain. Whitten et al. estimates that the global prevalence of children exposed to IPV varies between 5.4% and 38.3%. However, this study only considers exposure to physical IPV [4]. Prevalences of children exposed to other types of violence remain unclear. A more recent study on a representative sample in Canada found that 35.3% of children had been exposed to IPV [5].

Research has demonstrated numerous impacts of experiencing IPV as a child. It has been linked to internalized behavior (depressive symptoms, anxiety, withdrawal), externalized behavior (aggressive behavior) and post-traumatic stress symptoms (nightmares, hyperactivation) [3,6,7]. It is also considered as a source of serious developmental and health issues [8,9]. Several studies have also linked EIPV and perpetration of IPV or victimization in adolescence and adulthood [2,10–12]. These impacts have led to the recognition of EIPV as a form of abuse and a major public health issue involving multiple sectors and professionals, including healthcare settings, schools, law enforcement, the justice system, child protection services, and organizations supporting victims of IPV, children, and families [13–15].

While the impacts of childhood EIPV are increasingly well documented, far fewer studies have examined interventions and practitioners’ perspectives. Only a limited number of studies have focused specifically on interventions for children exposed to IPV. These interventions typically consist of support groups or programs aimed at strengthening the mother–child relationship. Researchers have also collected perspectives from both children and mothers to better understand what is most beneficial to them. In these studies, children emphasized the importance of sharing their experiences, feeling heard and supported, and having opportunities to discuss other aspects of their lives [16–19]. Anderson and Van Ee conducted a review of 17 interventions designed to support mothers experiencing IPV and their children. Their findings suggest promising outcomes, particularly in reducing internalizing and externalizing symptoms. However, it remains unclear whether the mothers participating in these interventions had separated from the abusive partner. Moreover, there is limited understanding of how best to support children whose parents are not engaged in such programs [20].

Beyond the identification and treatment of the consequences of EIPV, understanding how professionals can effectively support these children requires consideration of the broader frameworks guiding professional practice. Research on adverse childhood experiences has highlighted the importance of carefully assessing children’s histories of trauma, particularly as exposure to IPV may co-occur with other forms of trauma within and outside the family context [21–23]. This perspective underscores the importance of considering children’s experiences of violence within a broader trauma-informed framework. Trauma- and violence-informed care recognizes the high prevalence of experiences of violence and trauma among individuals receiving services and emphasizes the potentially

interconnected and cumulative effects of different forms of violence and trauma [24]. Such an approach is particularly relevant when working with children exposed to IPV, as their experiences may involve multiple and overlapping forms of adversity. Furthermore, some research has shown that trauma-informed interventions targeted more outcomes [25–27]. In parallel, Ecological Systems Theory conceptualizes human development as being shaped by the interactions between individuals and the multiple interconnected environments in which they live, and by the influence of these environments on psychological development [28,29]. This perspective is particularly relevant to EIPV, as children's experiences and well-being are influenced not only by family relationships, but also by interactions with schools, healthcare and social services, child protection systems, and other relevant environments. Taken together, these perspectives provide a useful conceptual lens for examining professionals' practices, including how they understand children's needs, involve children in decision-making, collaborate with parents and other professionals, and navigate the different systems involved in supporting children exposed to IPV. Nevertheless, although these frameworks have been applied in research and practices concerning adverse childhood experiences and adult IPV [30,31], to our knowledge, they have not yet been specifically applied to understanding professional practices with children exposed to IPV.

Similarly, only a limited number of studies have examined professionals' perspectives, practices and the challenges they face when working with children exposed to IPV. These studies highlight feelings of helplessness, insufficient training, and difficulties in intersectoral collaboration. Practitioners also report feelings of discomfort when dealing with situations involving children exposed to IPV [32]. However, most of this research has focused on professionals working in schools, healthcare settings, or law enforcement. As a result, the primary emphasis has been on the identification of children exposed to IPV and reporting practices [33–38].

Studies focusing specifically on child protection workers and services remain scarce. Existing research has primarily examined collaboration between organizations supporting adult victims of IPV and child protection services [37,39–41].

1.1. Belgian French-Speaking Community's Context

In the French-speaking community of Belgium, the child welfare system provides individualized support to vulnerable children and young people experiencing difficulties, at-risk situations, or involvement with the justice system, as well as to their families and significant others, through educational, preventive, supportive, and protective interventions. Regarding child maltreatment or exposure to IPV, several accredited youth welfare services may be involved, including services specialized in assessment, family support, and out-of-home placement.

In parallel, several services in Belgium provide support to adult victims of IPV (primarily women), including assistance with housing, psychological support, and legal support. Some of these services may also provide support to children accompanying their mothers.

However, to our knowledge, there has not been any study on children exposed to IPV in the Belgian French-speaking community context.

As in many European countries, these services currently face increasing demands and significant resource constraints [42], which provide important contextual elements for interpreting professionals' perspectives.

1.2. Current Study

Taken together, the existing literature highlights important gaps in our understanding of how children exposed to IPV are supported in practice. Very few studies have explored the perspectives of professionals likely to support these children. Although some specific

interventions have been reviewed, it remains unclear how children exposed to IPV are integrated into broader service systems designed to support them. The wide-ranging consequences of EIPV therefore raise critical questions about how children can be supported, particularly when parents are not necessarily seeking help and given the scarcity of targeted interventions outside these specific contexts.

In light of these gaps, the present study focuses on psychosocial professionals' perspectives and how they address EIPV in their practice. Specifically, it aims to gather insights from a range of professionals who are in a position to support children exposed to IPV, with a focus on their approaches to providing care and assistance, rather than solely on identification and reporting. By exploring professionals' perspectives, this study seeks to shed light not only on the challenges they encounter, but also on how different conceptual principles of care are translated into practice.

2. Materials and Methods

2.1. Study Design

As there has been no prior research on interventions for children exposed to IPV in Belgium's French-speaking community, we adopted a sequential exploratory mixed-methods design to gain a comprehensive understanding of professionals' perspectives, combining both quantitative and qualitative data collection [43]. Using a mixed-methods design allowed us to integrate both macro- and micro-level perspectives, enabling a more comprehensive analysis of the complexity of professionals' views and practices. At the same time, it allowed us to include a broader and more diverse sample of professionals from different backgrounds, organizational settings, and regions of Belgium [44]. The quantitative phase aimed to document professionals' perceptions, representations and practices. Findings from this first phase informed the development of the semi-structured interview guide. Consequently, the qualitative phase was designed to further explore, contextualize, and deepen the interpretation of the quantitative findings.

2.2. Participants and Recruitment

2.2.1. Quantitative Component

The quantitative component targeted professionals working in the psychosocial sector who were likely to encounter children exposed to IPV in their professional practice. This sector was selected to focus on interventions and support for children exposed to IPV, rather than on the identification and reporting of such cases.

Eligible participants included professionals working directly with children as well as professionals primarily supporting adult victims of IPV who may identify children's exposure through their professional practice. Participants represented a wide range of services, including child protection services, domestic violence services, school counseling services, mental health services and community-based organizations.

Participants were recruited using a convenience sampling strategy. The questionnaire was disseminated through professional networks, service mailing lists, and social media platforms rather than being sent to an identified list of eligible professionals. Consequently, the exact number of contacted professionals and the response rate could not be determined.

Initially, 203 professionals completed the questionnaire. Seventy-four questionnaires were excluded due to insufficient data for meaningful analyses, resulting in a final analytical sample of 129 professionals.

2.2.2. Qualitative Component

At the end of the questionnaire, participants were asked whether they wished to take part in a follow-up interview. Only professionals who provided consent to participate for the qualitative phase were contacted for this part.

In accordance with the objectives of the qualitative component, purposive sampling was used. Only professionals working directly with children exposed to IPV were recruited for the qualitative phase. Unlike in the quantitative phase, professionals working primarily with adult victims of IPV were not included, as the objective was to obtain detailed accounts of interventions directly involving children.

In qualitative research, sample adequacy is determined by the richness and relevance of the data rather than statistical representativeness. Data collection continued until additional interviews no longer generated substantially new themes relevant to the research questions. The final sample consisted of 13 professionals, including psychologists, social workers and educators. This sample size is consistent with methodological recommendations for qualitative thematic analysis [45,46].

2.3. Data Collection and Instruments

2.3.1. Study-Specific Questionnaire

The quantitative component consisted of a study-specific online questionnaire developed for the objectives of a broader research project. The questionnaire was designed by adapting questions from previous studies investigating professional practices [47,48] to the context of professionals working with children exposed to IPV.

The questionnaire comprised 42 questions in French and required approximately 30 min to complete. It was administered through a secure online platform developed and managed by the IT Department of the Faculty of Psychology, Speech Therapy and Education Sciences at the University of Liège (UDI-FPLSE). The questionnaire included multiple-choice questions and five open-ended questions. It was divided into six sections: (1) sociodemographic and professional characteristics (i.e., In what kind of structure are you currently working?); (2) professionals' representations of children exposed to IPV (i.e., According to you, what are the impacts of EIPV for a child age between 3 and 6 years old?); (3) intervention practices, perceived difficulties, and professional needs (i.e., Overall, when working with cases of IPV involving children, to what extent do you feel that you face difficulties?); (4) training and available resources (i.e., Did you receive any specific trainings on children exposed to IPV?); (5) practices of professionals working directly with children exposed to IPV (i.e., As part of your work with children exposed to IPV, could you briefly describe the interventions you provide?); and (6) practices of professionals working primarily with adults while identifying and responding to children's exposure to IPV (i.e., When intervening in a situation involving IPV, for what reason(s) do you not specifically provide support to the child?) (see Supplementary Materials for the full questionnaire).

In addition, participants completed the validated 10-item Work Self-Efficacy Scale [49]. This scale was included as part of the broader research project investigating professionals' perceived self-efficacy. As it was not directly related to the objectives of the present study, its results are not reported in this article.

Evidence supporting the questionnaire's content validity was obtained through review by a panel of four experts, who assessed its relevance, clarity, comprehensiveness, and consistency with the study objectives. The questionnaire was subsequently revised based on their recommendations.

As the present manuscript primarily reports descriptive and exploratory findings derived from individual questionnaire items rather than standardized multi-item constructs, psychometric indices such as Cronbach's alpha were not appropriate for most of the

variables analyzed. Accordingly, we report on the questionnaire development process and the procedures undertaken to support its content validity.

2.3.2. Semi-Structured Interviews

To deepen and contextualize the quantitative findings, a semi-structured interview guide was developed following the analysis of the questionnaire results, in accordance with the sequential mixed-methods design. The interview guide was specifically designed to further explore the themes emerging from the quantitative findings and to gain a richer understanding of professionals' experiences and practices. Broad open-ended questions addressed professionals' perceptions of children exposed to IPV, intervention practices, challenges encountered, available resources, interprofessional collaboration, and suggestions for improving practice. Participants were also invited to illustrate their experiences by describing concrete situations involving children exposed to IPV.

The interviews lasted between 40 and 80 min and were conducted either face-to-face or via Microsoft Teams. All interviews were audio-recorded with participants' consent and then transcribed.

As the interview guide served as a qualitative data collection tool rather than a standardized measurement instrument, conventional psychometric properties were not applicable. Instead, methodological rigor was ensured through the transparency of the interview procedures and the systematic analytical process.

2.4. Data Analysis

2.4.1. Quantitative Analysis

For the quantitative part, statistical analyses were performed using RStudio 2026.01.1. Descriptive statistics were used to summarize participants' perspectives, interventions and practices. Comparative analyses were performed between practitioners working primarily with children and those working primarily with adults. The Shapiro–Wilk test was used to assess the normality of the data, and Levene's test was used to assess the homogeneity of variances. As the data were not normally distributed (see Supplementary Materials), the Wilcoxon rank-sum test was used for continuous variables. For categorical data derived from closed-ended questions, Pearson's chi-squared test was used to assess differences between the two groups. Statistical significance was set at $p < 0.05$. A summary table of the statistical analyses and the R code is provided in the Supplementary Materials.

Thematic analysis [50] was employed to analyze the open-ended questions from the questionnaire, with the aim of identifying recurring themes in professionals' perceptions, interventions, needs and professional challenges. For the open-ended questions, responses were examined separately for the "child sector" and "adult sector" groups to identify sector-specific patterns and characteristics.

2.4.2. Qualitative Analysis

The transcripts of the interviews were analyzed using thematic analysis [50] which involves identifying recurring themes across participants' verbal accounts and organizing them into broader conceptual categories.

The transcripts were first read repeatedly, in their entirety, to develop familiarity with the material and gain an overall understanding of each participant's account. The researchers then systematically identified meaningful units related to the research objectives and assigned descriptive codes that remained as close as possible to participants' words and accounts. Coding was conducted inductively, without applying a predefined theoretical framework or predetermined coding categories. Similar or related codes were progressively grouped into subthemes and broader themes through an iterative process involving repeated movement between the raw data, codes, subthemes, and themes. Both

recurring patterns and variations across participants were considered throughout the analysis. To enhance the trustworthiness of the analysis, two interviews were independently coded by two researchers. Their coding was then compared and discussed until consensus was reached. The remaining transcripts were analyzed using the emerging coding structure, while allowing codes and themes to be modified or refined when new elements emerged. Finally, a cross-case comparison was conducted to identify commonalities and variations across participants' experiences.

The researcher has a background in psychology and previous experience in child protective services. The research team had also previously conducted research on IPV, identifying a lack of interventions for children exposed to IPV [48,51]. This background may have influenced the interpretation of participants' responses and the identification of themes. Throughout the analysis, the researcher critically reflected on these potential influences, revisited emerging interpretations against the original data, and considered alternative interpretations to ensure that the findings remained grounded in participants' accounts [52].

3. Results

3.1. Questionnaire

3.1.1. Sample

Our sample ($n = 129$) consisted primarily of practitioners working directly with children (66%). Other participants were from services supporting adult victims of IPV (27%), services providing interventions for adult perpetrators of IPV (2%), or the medical field (5%). Participants included psychologists, social workers, educators, child protection service delegates, psychiatrists, and nurses. The majority of the sample were women (88%), with a mean age of 38 years and an average of 10 years of professional experience (see Table 1). Practitioners were also asked to indicate whether they worked primarily with children exposed to IPV or with adults, victims (or perpetrators) of IPV. Overall, 60.5% indicated that they worked mostly with children, while 34.1% worked primarily with adults, most of whom were victims of IPV. The other 5.4% did not fall under either of those two categories.

Table 1. Professionals' characteristics.

Professional field	Child services	66% ($n = 85$)
	Adult victims of IPV	27% ($n = 35$)
	Medical Fields	5% ($n = 6$)
	Adult perpetrators of IPV	2% ($n = 3$)
Profession	Psychologist	33% ($n = 43$)
	Social workers	22% ($n = 28$)
	Educators	12% ($n = 16$)
	Protective delegate	7% ($n = 9$)
	Nurses, doctors	5% ($n = 6$)
	Others	21% ($n = 27$)
Gender	Male	12% ($n = 15$)
	Female	88% ($n = 114$)
Average age		38 years old
Average years of experience		10 years of experience

3.1.2. Practitioners' Perspectives: Consequences of EIPV and the Needs of the Children Exposed to IPV

Participants were first asked to assess the impact of EIPV on children and the need for specific intervention. On a 5-point scale (1 = no impact; 5 = very strong impact), participants rated the impact of EIPV on children at a mean of 4.95, indicating that they perceived exposure to IPV as having a very strong impact on children. Using a similar scale, they estimated the need for specific intervention at a mean of 4.74. For these two questions, no statistically significant differences were observed between the “child sector” and “adult sector” groups (Wilcoxon rank-sum tests: impact, $W = 1668$, $p = 0.657$; need for interventions, $W = 1692.5$, $p = 0.868$).

Open-ended questions then provided a deeper understanding of practitioners' perspectives.

First, when asked about the words that come to mind when thinking about children exposed to IPV, most participants mentioned “victims,” “abuse,” and “trauma” (see Figure 1).



Figure 1. Illustrative word cloud of the most salient words reported by participants in response to the open-ended question on children exposed to intimate partner violence (IPV).

Participants were invited to report their perceptions of the consequences typically observed among children exposed to IPV across three developmental periods (0–3 years, 4–10 years, and 11–18 years), based on their professional experience. Overall, responses from participants in the children's sector tended to be more detailed and comprehensive regarding the consequences observed in children exposed to IPV.

For children aged 0–3 years, participants reported developmental and attachment-related difficulties. Children exposed to IPV were often described as quiet, insecure, and anxious. The child sector group mostly mentioned the child as being quiet, while the adult sector group mentioned equally that the child could be quiet or agitated. Some participants also mentioned agitation, hypervigilance, sleep disturbances, and feeding difficulties. For children aged 4–10 years, participants emphasized the presence of aggressive and violent behaviors, as well as withdrawal. Participants in the adult sector group emphasized violence reproduction. Many also reported school-related difficulties and ongoing developmental concerns. Sleep disturbances, attachment issues, and anxiety remained present. In addition, consequences related to family dynamics emerged in participants' accounts, including parentification and loyalty conflicts, with children sometimes perceived as taking a more active role in the dynamics of violence. For adolescents aged 11–18 years, participants continued to report violent behaviors, along with delinquency and risk-taking behaviors. Withdrawal was still observed, alongside depression, anxiety, and self-harm. School difficulties remained prominent, with some participants also mentioning school dropout. Professionals mentioned relational difficulties, which were not reported in earlier

age periods. Loyalty conflicts and parentification are also identified. Sleep disturbances and eating disorders were reported less frequently at this stage. Overall, two main patterns emerged regarding the perceived consequences of EIPV. First, practitioners frequently reported developmental delays in children aged 0–3 years. These difficulties appeared to evolve into school-related problems between the ages of 4 and 10 and were sometimes perceived as leading to school dropout during adolescence. Second, behavioral patterns seemed to shift with age: in infancy, exposed children were often described as unusually quiet or passive; in middle childhood, withdrawal appeared less prominent, with increased reports of aggressive behaviors; and in adolescence, participants more frequently reported violence, delinquency, risk-taking behaviors, and self-harm.

When asked about the needs of children exposed to IPV, practitioners emphasized the importance of protection and safety, particularly for infants and young children. This concern was mentioned less frequently in relation to adolescents. However, practitioners who advocated for removing children from the family environment tended to do so across all age groups. These professionals were typically directly involved with children in intervention settings. In contrast, the perceived need for individual psychological support increased as children grew older, becoming more prominent during adolescence. Across all age groups, practitioners, specifically in the “children group” sector, underscored the importance of involving parents in the intervention process. Similarly to the consequences questions, participants working in the children’s sector tended to provide more detailed accounts.

3.1.3. Practitioners’ Perspective on Their Interventions: Difficulties, Needs, Training and Tools

First, participants were asked to briefly describe how their service operates and how they position themselves regarding interventions for children exposed to IPV. None of the participants worked in services specifically dedicated to supporting children exposed to IPV. Professionals included in the sample were either professionals in frontline services (e.g., school counselors, community-based support services, nurses, or physicians), staff from organizations mandated by child protection services, or practitioners working with adult victims or perpetrators of IPV. In first-line services, interventions primarily focus on providing emotional support, guidance, prevention, and psychoeducation. In contrast, services commissioned by child protection services often intervene within the family system, with a focus on working with parents. Their involvement is generally time-limited, and they are unable to guarantee the child’s safety, which limits the extent to which they can address the child’s trauma. Practitioners working with adults generally reported not directly involving themselves with children. Additionally, 27% of them reported that the children they encountered were already receiving support from other services. A quarter (25%) stated that they did not feel adequately trained or skilled to intervene directly with children. Additionally, 5% reported a lack of time to work with children, emphasizing that their priority was to support mothers, who are often victims of IPV. Despite these challenges, 62% of practitioners working with adults reported advising parents and referring them to appropriate child-focused services. Half indicated that they first assessed the level of risk to the child. Based on this evaluation, 22% reported filing a report with police or social services, while 27% reported taking no further action following the risk assessment.

Regarding difficulties, participants were asked to evaluate, on a 5-point scale, the extent to which they struggle with specific aspects of their work. Three main areas of difficulty emerged: collaboration with parents (mean = 3.65), parents’ lack of recognition of the impact of IPV on their children (mean = 3.62), and managing the emotional burden associated with supporting children exposed to IPV (mean = 3.23). Other aspects that pose challenges include lack of time (mean = 2.93), difficulties in collaboration with other

services (mean = 2.77), lack of guidelines (mean = 2.65), and insufficient knowledge and skills (mean = 2.47).

No statistically significant differences were identified between practitioners working primarily with children and those working primarily with adults for any of the assessed difficulties (Wilcoxon rank-sum tests, all $p > 0.05$; see Table 2).

Table 2. Between-group comparison of reported difficulties among practitioners working primarily with children and adults.

Difficulty	W	<i>p</i>
Collaboration with parents	1920	0.127
Parents' lack of recognition of IPV impact	1773	0.506
Emotional burden	1513	0.373
Lack of time	1703.5	0.863
Collaboration with other services	1548	0.623
Lack of guidelines	1545	0.616
Insufficient knowledge and skills	1356.5	0.111

The needs of practitioners were explored through open-ended questions. Regarding their main needs in relation to interventions with children exposed to IPV, practitioners emphasized the importance of access to services that can take over and continue interventions once their own involvement has reached its time limit or when more specialized support is required. Participants also highlighted the lack of available services or appropriate placement within existing services, as well as the need for effective collaboration between services. These findings primarily reflect the perspectives of participants from the children's sector, as responses from the adult IPV sector were generally more brief.

Most of the training-related questions in the questionnaire revealed a lack of opportunities for practitioners to develop their knowledge and skills regarding children exposed to IPV. Specifically, 87% of participants reported that their initial training did not include any module dedicated to this issue. Although all respondents had encountered situations involving children exposed to IPV in their professional practice, only 57% reported having received specific training on the topic after their initial education. No statistically significant differences were observed between practitioners working primarily with children and those working primarily with adults for either of these questions (initial training: Pearson's chi-squared test, $\chi^2(1) < 0.001$, $p = 1.000$; further specific training: Pearson's chi-squared test, $\chi^2(1) = 1.118$, $p = 0.290$).

In addition, practitioners reported a lack of practical tools to support their interventions. Only 29% indicated having access to tools to work with children exposed to IPV. These tools primarily consisted of books or hand puppets used to facilitate discussions about violence. Some participants also reported using more general resources, such as emotion-focused tools (e.g., emotion cards and emotion wheels). Regarding tool access, there were not any significant statistical differences between the two groups (Pearson's chi-squared test with Yates' continuity correction, $\chi^2(1) = 0.181$, $p = 0.671$).

3.2. Interviews

3.2.1. Population

A total of 13 professionals were interviewed, all of whom work directly with children exposed to IPV. Participants included psychologists ($n = 9$), a social worker ($n = 1$), educators ($n = 2$), and a school nurse ($n = 1$). They were employed in child protection assessment teams that intervene when child maltreatment is suspected ($n = 2$), early childhood family

support services (n = 1), community-based services for children and adolescents (n = 2), family support services (n = 3), school-based psychosocial health services (n = 2), psychological support services providing assistance following police intervention (n = 1), general psychological services for children (n = 1), and a shelter for women experiencing intimate partner violence and their children (n = 1).

Interviews lasted between 40 and 80 min and were conducted either via Microsoft Teams or recorded with an audio device during face-to-face meetings. Pseudonyms are used when reporting excerpts from the interviews.

3.2.2. Thematic Analysis

Following the thematic analysis, the sub-themes were grouped into four main themes: professionals' representations of children exposed to IPV and their families, professionals' perspectives on their interventions with children exposed to IPV, struggles and difficulties related to interventions with children exposed to IPV and resources for professionals (see Table 3).

Table 3. Themes and sub-themes of the thematic analysis.

Themes	Subthemes
Professionals' representations of children exposed to IPV and their families	A variety of profiles between two extremes
	Consider the child's position in the family dynamics
	Transgenerational aspect of IPV
Professionals perspectives on their interventions with children exposed to IPV	The child's symptoms as an entry point for intervention
	Importance of assessing the situation
Struggle and difficulties linked to interventions with children exposed to IPV	Lack of specialization
	Access to therapeutic care
	Collaboration with parents
Resources for professionals	Working as part of a team

3.2.3. Professional Representations of Children Exposed to IPV and Their Families

A variety of profiles between two extremes. The professional interviewed indicated that there is no specific profile for children exposed to IPV. However, they identified two distinct behavioral patterns. On one hand, some children tend to be quiet and withdrawn; on the other hand, some exhibit extreme agitation and violent behaviors. Several participants also observed that these patterns are often linked to the child's gender, with girls more often presenting withdrawal and boys more frequently displaying aggression. These behaviors are often understood as manifestations of the trauma experienced by children exposed to IPV. The practitioners therefore emphasize the importance of assessing each child individually and how EIPV affects them.

“So, I would say that we have—and I don't have statistics—but still, particularly among boys, more externalizing difficulties in terms of behavioral problems.” Laura, school counsellor

Consider the child's position in the family dynamic. Practitioners explain that children exposed to IPV may occupy different roles within the family system. A child might align with one parent, act as a protector for a parent, or attempt to reduce tensions between caregivers. Regardless of the role, the child steps outside the typical boundaries of childhood and assumes an active part in family dynamics. It is therefore essential to consider the child's position and perspective on the family interactions. These roles often

result in feelings of guilt and helplessness. Professionals also emphasize that violence frequently continues after parental separation, during which children may be used by one parent to exert pressure on the other or to convey messages.

“But we have, for other symptoms, other types of issues—children who are caught in very significant loyalty conflicts, who are neither truly well on one side nor the other, and who, at least, can’t allow themselves to feel okay on either side. We know it’s also complex to allow these children to, at some point, find a way to settle.” Damien, social worker

Transgenerational aspect of IPV. Most professionals highlight the transgenerational nature of IPV. They report frequently working with parents who have themselves been victims of abuse or exposed to IPV during their own childhood. Practitioners also note that children often identify with dysfunctional role models, which can lead to difficulties in their own relationships and a lack of social skills. In most families, IPV remains a secret and a taboo subject. Consequently, professionals emphasize the challenges involved in discussing violence openly and implementing effective prevention measures.

“We see adolescent girls who reproduce, with their partners, behaviors. . . risky behaviors with partners who already display violent behaviors. So, when I say ‘intergenerational,’ I really mean mechanisms of repetition. Even if they don’t want this, and they realize it’s not what they want, this is where they find themselves”. Sandra, educator

3.2.4. Professional Perspectives on Their Interventions with Children Exposed to IPV

The child’s symptoms as an entry point for intervention. Most practitioners reported that they rarely encounter families or children because EIPV has been explicitly identified. Instead, children are typically referred due to the consequences of EIPV, which often lead them to be perceived as “symptomatic children” and, at times, as the source of difficulties within the family. IPV is then identified over the course of the intervention. On this subject, professionals expressed concern about children who do not exhibit noticeable symptoms, or whose symptoms remain unidentified. They also acknowledged the difficulty of determining how many children remain unidentified as being exposed to IPV, as well as the range of symptoms they may exhibit.

“When we’re asked to intervene for a child, it’s because the child isn’t doing well—not because they’re living in a context of domestic violence. That. . . that’s still quite rare. The entry point is usually: this child isn’t doing well.” Line, psychologist

Importance of assessing the situation. Many professionals emphasize the importance of taking sufficient time to thoroughly assess the family situation. Given that they encounter families facing a wide range of difficulties, they often note that they do not always have full knowledge of what occurs within the family, including instances of violence. Several practitioners explain that this assessment is essential to evaluate the child’s safety, which is a prerequisite for certain interventions.

“It’s really about taking that time to go through the full history of interventions, to create a timeline, to understand the family’s story—how did they get here? Why does a parent become violent? And how can we protect the child if we already sense that the impact is significant?” Emily, psychologist

3.2.5. Struggle and Difficulties Linked to Interventions with Children Exposed to IPV

Lack of specialization. All participants reported that their organizations and interventions are not specifically specialized in supporting children exposed to IPV. Instead, they address a wide range of family-related issues. As a result, professionals have not necessarily received specific training on this topic. Most of the time, practitioners adopt a family-centered approach.

“Here, intimate partner violence is just one issue among many, so no, we don’t have a specific protocol—because it’s not the main focus of our work.” Louise, psychologist

Access to therapeutic care. On the one hand, most professionals explained that their interventions are time-limited. After a certain period, they are required to refer children and their families to other services. On the other hand, several participants noted that, during their interventions, the child’s safety is often not guaranteed, as the child may remain exposed to IPV, including in situations where parents are separated or divorced. Consequently, most practitioners are unable to initiate in-depth therapeutic work addressing the traumatic experiences the child may have undergone. As a result, all participants reported a lack of available services with adequately trained professionals to support children exposed to IPV, ensure their safety, and provide appropriate care. Child protection services are already operating beyond capacity, and in this context, children exposed to IPV are not always prioritized. Furthermore, many of these children come from families facing financial constraints, limiting access to therapeutic services. Free services are often oversubscribed. These barriers are particularly pronounced in rural areas, where services are scarce and difficult to access, and reliance on public transportation further restricts access to care.

“Sometimes we really need... well-trained therapists to take care of children who [. . .]... but those are issues... not mine, it’s the system that [. . .] ... we need hospitalizations, we need assessments, we need child psychiatry follow-ups that we don’t have, and we just don’t have the skills or the time to do that.” Marie, psychologist

“Now, if the parents keep tearing each other apart, there’s not much we can do. We have to make sure the child is safe—safe enough to be able to start working with us.” Pierre, psychologist working in evaluation team

Collaboration with parents. Most practitioners report difficulties in collaborating with parents. Many noted that parents often fail to recognize violence or its impact on their children, which hinders appropriate support. Several professionals therefore advocate for greater prevention and awareness among parents, professionals, and the public. When parents are separated, implementing therapeutic care can be challenging, as both must provide consent, and the offending parent may disrupt follow-up (e.g., by requesting a change of therapist). Some professionals also reported that parents may discontinue their own therapy due to custody concerns, limiting opportunities for parent–child dialogue. In shelters, some mothers relocate out of fear of losing custody, disrupting continuity of care. However, most professionals emphasize the necessity of involving parents in interventions and addressing their difficulties in parallel with this type of situation.

“Parents [. . .] who deny it, who simply are not aware of it, in fact, and in cases of violence there is sometimes also a lack of awareness. There is. . . the children, we don’t even know where they were, the children were never touched. . . but there is a kind of minimization of their anxiety and of what they have experienced.” Marie, psychologist

3.2.6. Resources for Professionals

Working as part of a team. Working as part of a team is one of the most important resources for professionals intervening with children exposed to IPV. The team provides emotional support, facilitates reflective practice, and aids in decision-making. Practitioners often work in pairs, which helps ensure continuity of contact with families and prevents gaps in intervention.

“I think the biggest advantage we have is that we work as a team, and that’s incredibly valuable. Sitting down together to think through a situation—with four people instead of being alone—that really makes a difference. We’re not on our own; we analyze, we take

a step back, and we try to come up with something that actually makes sense.” Laura, school counselor

4. Discussion

The main objective of this study was to understand professionals' perspectives on children exposed to IPV and how they address this issue in their practice. A sequential mixed-method design was employed. This approach allowed for the collection of quantitative data from a larger number of participants through an online questionnaire, while also capturing the complexity of interventions and challenges through semi-structured interviews. In total, 129 practitioners completed the questionnaire, and 13 follow-up interviews were conducted.

First, the questionnaire results indicate that professionals appear to be generally well aware of the consequences of exposure to IPV. Most respondents consider these children to be victims in their own right within the context of IPV. Four major themes emerged regarding the consequences: developmental and academic difficulties, attachment and relational difficulties, aggression and violent behaviors, and withdrawal and anxiety. These consequences were also reported in the interviews. However, participants further explained that withdrawal was more commonly observed among girls, whereas aggressive or violent behavior was more frequently observed among boys. These observations are consistent with the existing literature [53]. Participants interviewed in the qualitative phase emphasized both the diversity of consequences observed in children exposed to IPV and the complexity inherent in each situation. Concerning the needs of these children, professionals highlighted the importance of conducting thorough, case-by-case assessments. These findings are consistent with a trauma-informed care framework and previous research, which emphasizes the importance of carefully considering children's histories of trauma when assessing their needs [21]. Although most professionals recognize children as victims of IPV, there was less consensus regarding the level of protection required, particularly in cases involving adolescents.

With respect to interventions, our analysis reveals that professionals across sectors report a lack of sufficient training, tools, and clear guidelines to effectively address children's exposure to IPV. The issues were raised both in the questionnaire and in the interviews. These findings are consistent with previous research. For instance, similar results can be observed in the medical sector with general practitioners, who considered EIPV as a situation posing a risk of danger, but, despite feeling concerned, expressed discomfort and perceived their training as inadequate [32]. Other studies also underline the urgent need to integrate IPV, social intervention training and trauma-informed care into all health-related educational pathways, as well as the lack of training among first responders [21,23,54–56]. Professionals interviewed in this study further noted that IPV is rarely addressed in training programs focused on child maltreatment. This observation is in line with previous research and an ecological systems perspective, highlighting the importance of coordinated collaboration among the multiple systems and professionals involved in responding to children exposed to IPV [22,40].

Regarding the challenges faced by professionals, questionnaire data revealed three main difficulties: collaboration with parents, identification of IPV impact by the parents, and management of the emotional burden associated with these cases. The interviews provided deeper insight into how these challenges manifest in practice. As many participants explained, their services are not specialized in supporting children exposed to IPV, and children are often referred for other presenting difficulties. As a result, IPV may go unrecognized or may be misinterpreted as parental conflict. Consequently, professionals stressed the importance of allocating sufficient time to conduct careful and comprehen-

sive assessments. Other authors have highlighted the challenges professionals face in distinguishing between high-conflict parental relationships and intimate partner violence, underscoring the importance of thorough assessment. They further emphasize interdisciplinary collaboration as a key resource in conducting such evaluations. Indeed, this facilitates the pooling of diverse knowledge and competencies, as well as coordinated efforts, enabling continuous and more comprehensive assessment of the situation [57].

The professionals interviewed placed relatively limited emphasis on the emotional burden experienced by children exposed to IPV. Instead, they primarily highlighted the importance of team support as a key resource in addressing this issue. However, interviewees consistently described several limitations that were less thoroughly captured in the questionnaire, including time-constrained interventions, lack of specialized training, insufficient resources, and the limited availability and accessibility of services. Most practitioners reported feelings of helplessness in response to these challenges. These issues have been widely documented in the existing literature and appear to be pervasive across multiple sectors, including schools, child protection services, healthcare, and law enforcement [35–38,57]. Furthermore, the overburdening of the child protection system is a well-established concern in Belgium. Similar patterns have also been identified in international studies, which highlight the scarcity and inaccessibility of services, often due to long waiting lists and geographical barriers [58,59].

No statistically significant differences were identified between the “child sector” and “adult sector” groups. We hypothesize that these findings may reflect a relatively widespread awareness of the impact of IPV on children, alongside an overall lack of specific training and limited specialization among practitioners working with children in the context of IPV interventions.

When analyzing more specifically the “children sector” and “adult sector” groups, we note that participants from the adult IPV sector generally provided less detailed accounts. This may reflect the fact that they encounter fewer children exposed to IPV in their practice and may therefore have had fewer experiences or concrete examples to draw upon. Alternatively, they may have perceived themselves as less directly concerned by the topic addressed in the study.

Participants from the adult IPV sector more frequently mentioned children’s agitation and the reproduction of violent behaviors. One possible explanation is that these behaviors may create difficulties in the parent–child relationship or affect interactions with the adult victim, making them more visible to professionals primarily working with adult victims of IPV.

On the other hand, the removal of children from the family home was mentioned primarily by participants from the children’s sector. This may reflect differences in the professional roles, practices, and priorities of the two sectors. Professionals working with children may be more directly confronted with situations in which concerns about child safety require consideration of out-of-home placement, particularly as ensuring children’s safety is a primary concern within child protection services. In contrast, professionals working with adults may primarily focus on supporting the adult victim. Previous research has shown that professionals working with adult victims of IPV may be reluctant to involve child protection services or consider the removal of children from the home. Such concerns may include fears of damaging the relationship of trust with the victim or of child protection involvement having unintended negative consequences for the victim and their children [39,60,61].

Our results underline how, in many ways, in Belgium’s French-speaking community, children exposed to IPV do not seem to be treated as a priority compared to other forms of abuse. This occurs despite most professionals demonstrating awareness of the substantial

impact of children's EIPV and acknowledging children as victims in their own right, rather than merely indirect witnesses. However, our results highlight divergent views among professionals regarding the level of protection needed for these children. Furthermore, the overload of the child protection system seems to prevent any possibility of removing a child from their family environment for protective purposes, even when exposure to IPV is severe. Practitioners report several limitations in their work with these children: the frequency of their interventions appears insufficient given the complexity of the situations, their actions are restricted in time, and they often report lacking the skills necessary to address the child's trauma effectively. Similarly, some practitioners explain that training on child abuse may overlook exposure to IPV, with a stronger emphasis placed on direct forms of violence against the child. Although our study focuses exclusively on the Belgian context, the issues identified resonate with findings reported in studies conducted in various countries, suggesting that many of the challenges surrounding support for children exposed to IPV extend beyond national boundaries. As Jenney et al. point out, even when IPV exposure is mentioned in a child's file within the child protection system, it rarely leads to specific support or intervention [62]. Other international studies have shown that when families seek support for IPV, the focus is often placed primarily on the adult victim, with limited attention paid to the child's experience and needs [40,63].

4.1. Implications for Practice

As discussed above, one of the main findings of this study highlights the need to invest in and strengthen the child protection system. In addition, adequate training, practical tools, and clear guidelines are essential for practitioners working with children exposed to IPV. This observation is supported by previous research emphasizing the importance of integrating trauma-informed care into professional practice [21,23,26]. Some professionals also emphasize the need for specialized services that can support both children and parents and address the child's trauma once safety is ensured.

Raising awareness and prevention is also crucial across all sectors and within the general population. Interviewed practitioners stressed the importance of raising awareness among medical and school staff, as they are often on the front line for identifying IPV exposure. They also pointed out that awareness should target the general population, particularly parents experiencing IPV, who are often unaware of its impact on their children.

Finally, several recommendations can be drawn from the participants' experiences. It appears essential to consider the child as an active partner—capable of protecting themselves, participating in family dynamics, and finding solutions. Children need opportunities to express their experiences and emotions, as well as to find space outside the family environment. Practitioners working with children also emphasize the need to ensure the child's safety. These findings highlight practitioners' emphasis on adopting a child-centered approach in their interventions. Prevention and awareness as children grow are also necessary to prevent the reproduction of violence. At the same time, working with parents, opening dialogue with the child, and explaining the consequences of IPV exposure are key components of intervention. However, these recommendations should be understood as reflecting practitioners' perceptions of their own practices in the French-speaking community of Belgium rather than the results of an objective evaluation of those practices and their effectiveness.

4.2. Research Perspectives

Firstly, our research highlights the need for further studies on children exposed to IPV using multidimensional approaches that incorporate not only professionals' perspectives but also those of the children themselves. Such research could contribute to a better

understanding of children's experiences of interventions—what is helpful, what is not, and what is actually implemented in practice.

Further research should also examine intervention practices in order to establish clearer guidelines and develop practical tools for professionals. Our findings indicate that practitioners often lack adequate training and guidance.

Many participants also reported that children may reproduce the violence they witness in their social or future intimate relationships. A similar pattern was observed among mothers who are victims of IPV, with professionals noting that some had themselves experienced abuse or exposure to violence during childhood. Future research should therefore explore the intergenerational transmission of violence, the underlying mechanisms, and potential gender differences.

Finally, it is essential to further investigate prevention practices in schools and health-care settings, as these sectors are often at the forefront of identifying children exposed to IPV. Many participants emphasized the need to strengthen prevention efforts and raise public awareness.

4.3. Strengths and Limitations

First, the generalizability and transferability of these findings are limited, as the sample was not necessarily representative of all professionals concerned with IPV and children exposed to IPV. In particular, some professional groups were underrepresented or absent from the sample, including early childhood professionals and perinatal care providers, whose perspectives may differ from those captured in this study.

Regarding the quantitative component, the representativeness of the sample cannot be guaranteed, and a response rate could not be calculated because a convenience sampling strategy was used. In addition, because participation was voluntary, professionals with greater interest, experience, or awareness regarding IPV may have been more likely to participate, potentially leading to self-selection bias. As a result, professionals who encounter children exposed to IPV less frequently or who may have different levels of knowledge and training regarding IPV could be underrepresented. Nevertheless, the final sample included professionals from a broad range of services involved in child maltreatment and IPV-related interventions, allowing perspectives from multiple professional contexts to be captured.

The study-specific questionnaire also has several limitations. Although participants completed one validated scale, its results were not directly related to the objectives of the present study and are therefore not reported. Consequently, evidence supporting the questionnaire is limited to content validity, and no reliability indices (e.g., internal consistency) could be calculated, as the questionnaire primarily comprised individual items rather than standardized multi-item scales. Additionally, because most questionnaire items were designed to assess specific aspects of professional experiences and practices rather than latent constructs measured through multi-item scales, traditional reliability analyses were not applicable.

Furthermore, it was not possible to conduct a formal pilot study of the questionnaire. While an expert review was undertaken to assess the relevance, clarity, and comprehensiveness of the items and to support content validity, expert review does not substitute for formal pilot testing with members of the target population. A pilot study could have provided additional information on respondents' understanding of the items, the acceptability and feasibility of the questionnaire, and any potential difficulties encountered during completion.

The analyses comparing the "child sector" and "adult sector" groups should be interpreted with caution, given the small and unequal sample sizes. In addition, the

group-specific characteristics identified through the analysis of the open-ended questions should not be interpreted as statistically established differences, as no inferential statistical comparisons were performed for these qualitative responses.

Regarding the qualitative analysis, full double-coding of the entire dataset was not feasible. However, a subset of the interview transcripts was independently coded by two researchers to enhance the trustworthiness of the analysis.

Additionally, professionals from other sectors, such as the medical field and the judicial system, were not included in the study, as the focus was specifically placed on psychosocial intervention. However, examining their perspectives would also be important, as these professionals remain frontline actors in the identification and support of children exposed to IPV and their families.

Our findings reflect only the perspectives of professionals, and discrepancies may exist between practitioners' reported practices and their actual practices. Participants emphasized the complexity and diversity of the situations they encounter, in which exposure to IPV may represent only one of several challenges affecting the family. It therefore remains unclear whether the practices described are consistently implemented across different cases of EIPV. Furthermore, children and parents were not included as participants in this study and may perceive the services and support provided differently from practitioners. Finally, this study did not directly evaluate interventions for children exposed to IPV or assess the quality or effectiveness of practitioners' interventions; rather, it relied on practitioners' accounts of their own practices. However, the sequential mixed-methods design used in this study allowed for an in-depth examination of interventions with children exposed to IPV. The integration and triangulation of quantitative and qualitative data strengthen the reliability of the findings.

Finally, as this study adopted an exploratory research design, the findings should be interpreted with caution.

5. Conclusions

The main objective of this study was to capture psychosocial practitioners' perspectives on children exposed to IPV and how they address this issue in their professional practice. A sequential mixed-methods approach was employed to provide both a broad and in-depth understanding of the phenomenon.

Our results highlight a significant gap between practitioners' representations of children exposed to IPV and what they report to implement in practice. Most participants considered children exposed to IPV as victims and viewed such exposure as a form of abuse, emphasizing its substantial consequences. However, regarding the needs of these children, our findings reveal divergences among professionals in their views on the degree of protection required. Furthermore, practitioners reported numerous challenges that severely constrain their interventions.

Overall, our findings suggest that, although practitioners are aware of the consequences of children's exposure to IPV and the needs of affected children, they perceive a lack of interventions and services specifically equipped to address children's experiences of trauma. From practitioners' perspectives, children exposed to IPV appear to receive less specific attention than other forms of child maltreatment or the adult victim, who more often remain the primary focus of intervention.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/ijerph23091109/s1>, File S1: Full questionnaire (in French); File S2: Synthesis statistical analysis; File S3: R code.

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Abbreviations

The following abbreviations are used in this manuscript:

IPV Intimate Partner Violence
EIPV Exposure to Intimate Partner Violence (Children)

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