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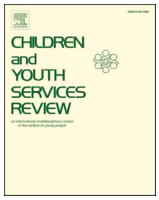

Swiss young people's experience of living with parental intimate partner violence and other adversities

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ABSTRACT

In Switzerland, approximately one in five children experience intimate partner violence (IPV) in their parents' relationship. The aim of this article is to discover what it means to grow up in a home with IPV, so that professionals understand this experience from children's perspectives. In 2022, we conducted 20 individual semi-structured interviews with adolescents and young adults who had lived with parental IPV while minors and whose parent had attended a Swiss clinical forensic service as a consequence of IPV. Semi-structured interviews, supported by the use of life history calendars, covered all major areas of their life since birth. A thematic analysis was carried out on the interview transcripts. As well as physical violence, participants identified psychological, sexual and economic IPV. Their experience was usually measured in years. They described being very involved during and around acute IPV events, physically and emotionally and took an active role in protecting their victimized parents, siblings, and themselves. Multiple victimizations occurred for most of them, in and out of the home and included direct violence from the IPV perpetrator and school bullying. Other adverse childhood events (e.g., alcohol abuse, parental mental illness) were frequently reported. Children are not mere witnesses but victims who demonstrate agency in the context of IPV. Their situation is made more complex by other victimizations and adversities. Recommendations are made in terms of detection, screening and intervention.

1. Introduction

A child is living with intimate partner violence (IPV) when one parent is victim of IPV or uses violence against his or her partner. Living with IPV is a form of child harm (Marshall et al., 2019) and is defined as an adverse childhood experience (ACE) with potentially damaging consequences for health and well-being (CDC, 2019). In Switzerland, it is estimated that one in five or more children will experience parental IPV before they reach adulthood (Baier et al., 2018), a rate similar to that found in population studies in other Western countries (Finkelhor et al., 2015; Radford et al., 2011). However, because they are based solely on being present during a physically violent event, these rates are most probably underestimates (Marshall et al., 2019).

Identification, support and care for children and adolescents living with IPV are not well developed in Switzerland, probably because until quite recently they were rather considered as mere witnesses. This study aims to find out what growing up in a home with IPV means for children and young people. By giving a voice to young people who have lived with IPV, this study should provide institutions and professionals who work with children and adolescents, with a deeper understanding of their experience, needs and resources. Twenty in-depth interviews were conducted with adolescents and young adults, children of former patients who had consulted the Lausanne University Hospital's Violence medical unit, a clinical forensic consultation, as victims of IPV. It is the first study of this kind to be conducted in Switzerland. This paper focuses on children's experiences of IPV while two further papers discuss the impacts this experience has had on these young people, their unmet needs, and the resources they could rely upon (Cattagni, Semlali, Stanley, & Romain-Glassey, 2025; Semlali, Cattagni., Cavalli, Stanley, & Romain-Glassey, 2025).

1.1. Background

In earlier quantitative work, we found that the experience of living with parental IPV could be counted in years and did not always stop with parents' separation, as other studies have shown (De Puy, Radford, Le

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Fort, & Romain-Glassey, 2019; Dessimoz Kunzle, Cattagni Kleiner, & Romain-Glassey, 2022; Harrison, 2008; Katz, 2019; Romito, 2011). Our research also confirmed previous research findings by showing that coercive control by IPV perpetrators permeates all aspects of family life (Cattagni, Semlali, Stanley, & Romain-Glassey, 2025; Haselschwerdt et al., 2019; Katz, 2016; Stark & Hester, 2019). Finally, it showed that children were present in 75 % of the incidents that triggered the clinical forensic consultations for IPV but also that the vast majority of these children's pediatricians were unaware of the violence at home (Dessimoz Kunzle et al., 2022).

Over the past 20 years, thanks to a small body of mainly qualitative research, children living with IPV have started to emerge in the scientific literature as agents, rather than mere "witnesses," who respond to these acute events in a variety of ways (Arai et al., 2021; De Puy et al., 2019; McGee, 2000; Mullender et al., 2002; Överlien & Hydén, 2009). They may react emotionally, intervene verbally or physically, seek outside help, or try to protect themselves, their victimized parent, or siblings from that experience.

Adverse Childhood Events (ACEs), which include living with IPV, are potentially traumatic events experienced during childhood (CDC, 2019). They can have many negative effects for children's development, health, and well-being (Berg et al., 2022; Carlson et al., 2019; De Puy et al., 2019; Gardner et al., 2019; Holt et al., 2008; CDC, 2019; Stanley, 2011; Vu et al., 2016; Wolfe et al., 2003), but harmful effects also occur in adulthood. Studies have shown that experiencing one or more ACEs is associated with unhealthy behaviors (e.g., smoking, drug use, alcoholism) and physical and mental health problems (e.g., obesity, diabetes cancer, heart disease, depression, suicide attempts) in adulthood, and that association is particularly robust when several ACEs have occurred (Bellis et al., 2019; Chang et al., 2019; Felitti et al., 1998; Gardner et al., 2019; CDC, 2019). It is therefore all the more important to stress that children victims of IPV are actually at higher risk of other forms of victimization, both inside and outside the home, such as neglect, psychological, physical and sexual abuse, and bullying (Hamby et al., 2010; Holt et al., 2008; McTavish et al., 2016). Child abuse is statistically associated with living with IPV (Liel et al., 2020) and it is estimated that between 40 % to 60 % of IPV perpetrators who have children are also violent towards them (Romito, 2011). In addition, there is a weak but significant association between living with IPV as a child and perpetrating or being a victim of IPV later in life (Smith-Marek et al., 2015).

1.2. Justification and theoretical framework

There is a growing number of quantitative studies on children living with IPV, measuring its prevalence, risk factors and outcomes. Given the large prevalence of children and youth living with IPV in Switzerland, the duration of that experience and at the same time, limited local data, it is important that research continues to gather knowledge on this issue, but also that it does so from the point of view of the experts, that is the people having a lived experience of it. Researchers and legal experts alike stress the importance of listening to children whether for research or practice, pointing out the diversity of experiences and the deeper and more nuanced understanding this approach brings (Arai et al., 2021; Lapierre et al., 2016; Marshall et al., 2019; Mullender et al., 2002; Överlien & Hydén, 2009). Yet, qualitative studies are much less numerous than quantitative ones, especially those that collect children's own perspectives, and none exist in Switzerland. Our study's aim, approach to data collection, and analysis draws on the field of childhood studies which considers children as social actors and experts on their own experience (James & James, 2012; Leonard, 2015). Previous qualitative studies were often limited to specific populations, typically children living in temporary shelters or receiving services following IPV (Arai et al., 2021; Lapierre et al., 2016; Mullender et al., 2002; Noble-Carr et al., 2019). In concluding their 2019 *meta*-analysis of qualitative research about children's experiences of domestic violence, Noble-Carr et al. (2019) point out that studies focusing on children outside service setting and in the longer term are needed to complement what has been done so far. Recruiting interviewees via their parent's clinical forensic consultation means that participants have not necessarily sought or received professional help and their views and understanding of their experiences are more likely to be unmediated by professional perspectives. In doing so, we are likely to have interviewed individuals from a wider range of contexts than if they were all recruited from a support service. In addition, previous studies have often focused on children's recent experiences. This study benefits from covering entire childhoods and the teenage years, and was conducted several years after the interviewees' parents disclosed IPV. This approach has captured the first-hand experience of children and teenagers and enriches the data by allowing participants to take some distance to reflect on their experiences.

2. Method

In summer of 2022, we conducted 20 semi-structured qualitative individual interviews with adolescents and young adults who had lived with parental IPV whilst minors and who were at least 14 years old at the time of the interview. Their mothers or fathers were among the Lausanne University Hospital's Violence medical unit's patients who came to the consultation following IPV victimization between 2011 and 2018. This study was approved by Swiss Ethics (State of Vaud) on March 24, 2022 (ref.: 2022–00296).

2.1. Recruitment

First, we had to collect former patients' consent to contact their children. At the end of each consultation, we routinely ask patients if they have a safe phone number, if they agree to be contacted again and if their consultation data can be used for research. Patients who responded negatively to any of these questions were excluded, as were those who were not in contact with their children at the time of the consultation (e.g., children living abroad). After these exclusions, 606 children of 422 patients were eligible for the study.

Each child record included their patient-parent contact information and was randomly assigned an ID and organized numerically, but siblings remained grouped in the file. Going down the list, we tried to reach 319 patients at least once and a maximum of five times, initially following this list and later, to ensure a diversity of profiles, prioritizing calls to specific groups of patients (men; third party country nationals; unemployed; with very young children at the time of the consultation). Finally, 113 former patients were told about the study and our request to be able to contact their children to give them the opportunity to participate. Another exclusion criterion identified during these telephone calls was children's unawareness of IPV or patients' unwillingness to disclose to them that they had come for a clinical forensic consultation. Seventy-one former patients agreed to us sending them the documentation and thirty of them returned the contact form, allowing us to try and contact a total of 42 of former patients' children. Of those, we were able to reach 37 of them and 33 agreed to be sent the documentation. The researcher could stop recruitment if she considered that a patient or their child did not have the capacity for discernment or did not understand the study's goals and design, but this did not occur. Patients and their children were told that no information contained in the parents' records would be disclosed to the children. A CHF40 gift card, as compensation for the participants' time, was offered and travel expenses reimbursed. Twenty-two former patients' children agreed to participate but two dropped out before the interview. We stopped recruiting after 20 interviews because it was estimated that data saturation was reached.

2.2. Participants

Participants were 14 females, six males, including two pairs of

siblings (Table 1). Information on sex is based on the data that was collected during the consultation with their parents and no information on gender was asked. Participants were two to 17 years old at the time of their parents' consultations and 14 to 28 years old at the time of the interview. The intervening period ranged from four to 11 years.

All but one had siblings. Four of them had spent their first 3 to 9 years abroad, and three of them did not speak French when they first arrived in French-speaking Switzerland, where the study took place. However, all were perfectly fluent at the time of the study. Eighteen participants were recruited through their victimized mother, and two through their victimized father, which is representative of the mother/father ratio of parents who come to the medicolegal consultation for IPV. Perpetrators were the fathers (13 cases); stepfathers or mother's partners (5 cases), mother (1 case), and the father's partner (1 case). All IPV took place in heterosexual relationships. At the time of the original consultation, most parents were Swiss nationals, and one quarter were EU/AELE-country nationals. Most victimized parents were at least partially employed at the time, and they were about equally distributed in terms of level of education, ranging from compulsory schooling to higher education.

2.3. Interviews

One-on-one interviews were conducted with the young people, lasting an average of 2 h and 20 min (min. 1h11m, max. 4h10m), and were audiorecorded. Before the interviews began, the researcher went again over the study's aims, the confidentiality, and the possibility of withdrawing at any time. She explained the different forms that IPV and exposure to IPV can take. She told participants that if any information was shared that could indicate that a minor was in danger, the situation would be discussed with them and with the hospital's child abuse and neglect team. However, this situation did not arise. Participants were offered snacks and drinks and were told they could ask for a break or stop the interview at any time. Participants were asked to sign the consent form before the interview started. An interview guide and a life history calendar (LHC) supported the interview process. LHCs support interviewer-interviewee rapport, facilitate participant recall and help interviewers navigate between events and time periods, enhancing the chances of gathering relevant information (Nelson, 2019; Yoshihama et al., 2002). The LHC was made up of vertical timelines that could refer to age, years but also to any milestones in participants' lives that could help them situate other events in time. Lines of the LHC represented major areas of life. Interviewer and interviewees noted key words on the LHC as the interviews progressed. The interviews covered all major areas of the participants' lives (home and neighborhood, family history and relationships, friendships, school, hobbies, romantic life, contact with professionals) as well as their personality, resources, needs and any advice they had for other children or young people experiencing IPV. The first question was about where participants grew up and the rest of the topics were addressed in no particular order, the interviewer adapting to each participant's account while ensuring that all topics were covered. IPV was asked about directly only if it was not brought up by the participants. At the end of the interview, the researcher told participants that they could contact her to discuss a referral to appropriate services if they felt the need to speak to a professional. However, this situation did not arise.

Table 1
Participants by sex and age group at consultation and interview times.

	Age at consultation			Age at interview		
	3–6	9–12	13–17	14–17	18–20	22–28
Females	0	8	6	4	5	5
Males	2	2	2	2	2	2

2.4. Analyses

A thematic analysis was conducted on the transcripts of the interviews (Ritchie et al., 2013). Although the thematic analysis tends to be descriptive, it aims to provide a faithful representation of participants' experiences, which was an important objective. First, preliminary analyses were done by three researchers based on parallel readings of half of the transcripts to identify themes and sub-themes and to establish a first version of the coding grid. This was followed by parallel coding, using MAXQDA 2022 (VERBI Software, 2021), of three quarters of the interviews to ensure the validity of the coding, with ongoing adjustments to the grid. Once coding consistency among researchers was achieved, the remaining transcripts were coded separately by two of the researchers, with group discussion as required, that is when one of them felt unsure about the coding. Table 2 illustrates the process and includes the questions asked, the raw data, and the themes identified. Thematic syntheses were completed for each interview and entered into a participant-by-theme matrix. The themes used for the present analysis were IPV (description, perpetrator, timing), experiences around acute IPV events (before, during, after), turning points in IPV, other victimizations, and other ACEs. IPV in a parental relationship other than the one around which the interview was initially organized was mentioned in four interviews, and these situations were included in our analyses.

3. Findings

Verbatim quotations included in the findings section are followed by the participants' number, their sex (F = female; M = male), age at interview/age at parent's consultation.

3.1. Description of IPV

3.1.1. Types

All participants mentioned or described at least one episode of physical violence such as slapping, punching, kicking, choking with bare hands or with a belt, stabbing attempts, pushing down the stairs, throwing objects at the victim, cutting the victim's hair or scratching the face.

> *One night he [her father] came home, he was drunk, and my mother came to sleep with me that day, and then he got angry because he couldn't find my mother in their bedroom. (…) and then he hit her. (…) It was in the dark, I only saw the blow, then she said she fainted for a few seconds and I saw because her hand fell, her arm fell a bit like that.* (*P01-F20/11*)

Sexual violence against mothers was reported by two participants in the form of rapes or being "*forced to do things*". Psychological violence was mentioned in such terms or through descriptions that evoked this type of violence: prohibitions, belittling, blames, insults, destruction of objects, various threats, stalking, or harassment over the phone post-separation.

> *He [her father] had his cigarette and he was burning the [her mother's] clothes with it. (…) I also remember that… my mother was wearing clothes that night and he was tearing them up. Then he'd ask her to put her clothes back on. She'd put her clothes back on, and he'd tear them up again. And he'd do that over and over again.* (*P13-F15/9*)

> *It was mainly my father who reproached my mother for not being good enough or putting her down very constantly. I know he told her that (…) she wasn't allowed to go out, that she couldn't find a job and make money because my mother didn't have a job at the time. (…) And she wanted to work, but my father wouldn't let her. And yeah, I'd heard an argument about that. (P02-F18/10)*

A few also said that the perpetrator used to disparage their mother to them. Economic abuse was also described, such as in the example above, living with the consequences of unpaid pensions, or thefts of family

Table 2
Examples of the analysis process from verbatim quotations to themes.

Question asked	Verbatim quotation	Code	Sub-Code1	Sub-Code2	Sub-theme	Theme
You didn't mention violence or how you felt about it. Can you talk about it? [Question asked only if violence was not mentioned spontaneously]	*Then he grabbed her by the neck, as if he wanted to strangle her. There was a wall in front of the door, and he banged her head against it. (P07-M26/17)*	IPV	Description	–	Types	Description of IPV
	One day my mother went to sleep, she had nothing on her face, the next day she came back, she had scratches all over her face. (P01-F20/11)	Experience of acute IPV events	Aftermath	Sightings of injuries	Aftermath	Experience around acute event
How did your schooling go in terms of academic results and life at school?	*I was never called by my first name, so it was always nicknames that were, how should I put it, pejorative, yeah. demeaning things like that. And then, physically, well, they'd, uh, spit on me, they'd- they'd prick me with the compasses, (…). On the playground, well, I hid because otherwise I'd get, I'd get beaten up and stuff like that (P06-F22/13)*	Relations	Life at school/ work	Violence at school/ work	Bullying	Other victimisations
[no question asked]	*When he drank, he got much angrier. He drank a lot of wine. (P10-F24/16)*	Other ACEs	Problematic substance use from the perpetrator	–	Alcohol and substance abuse	Presence of other ACEs

belongings upon separation.

The range of forms of IPV identified demonstrates that children's experience of IPV is not restricted to physical violence. Rather, it is an ongoing process that unfolds in a climate of coercive control in which belittlements, insults, prohibitions and isolation permeate the lives of both victimized parents and children (De Puy et al., 2019; Katz, 2016; Mullender et al., 2002).

3.1.2. IPV perpetrators and victims

Although participants also sometimes evoked fond memories of moments spent with them, male IPV perpetrators were described as being manipulative, narcissistic, deceitful, aggressive, lacking self-control, strict, cowardly, negligent or often absent. However, a few participants specified that these traits were only visible at home, while outside the home perpetrators presented a positive image and were appreciated for their pleasant personalities.

> *Uh… outside, he [her violent father] was an angel. Ah but everyone said, "ah he's generous, oh look he gives his children toys." (…) People who didn't know him thought he was a wonderful man. Great. Except for those who really knew him. (P17-F22/14)*

These results are consistent with the findings of Hui & Maddern's (2021) qualitative synthesis on children's perceptions of their parents in the context of domestic violence. Perpetrating parents (mostly men in the studies covered) are described by their children as overpowering and controlling, and manipulative, who do not meet their children's needs and are uncapable of change or varying in their character (e.g. nice to children and mean to mother) (Hui & Maddern, 2021).

Female perpetrators, who were a small a minority in our sample, were portrayed as being critical, unstable with quick mood changes, aggressive, lying, mentally ill, and alcoholic.

Sometimes participants described violent behaviors perpetrated by the victim while still considering her/him as a victim; such behavior was described as self-defense or was not considered abusive because of the imbalance in intensity and frequency between the behavior of the victim and the perpetrator. This participant described what happened after his mother discovered his father's extramarital affair:

> *My mom (…) pulled his sweaters a little, tore his clothes (…). So, there was a bit of violence (…) Then he grabbed her by the neck, as if he wanted to strangle her. (…) Then he banged her head against the wall a bit. (…) Then, uh, from there, well, the violence already started. (…) Then uh, a little bit every day, there were insults from time to time, all that. My [an adult male relative] (…), well, I thought his reaction was a bit normal and he told my father that "if he had a problem, something, he wanted to hit someone, well he needed someone to come against him, well of his age and build, not a defenseless woman." (P07-M26/17)*

One participant, however, did not view her mother, who had consulted the medico-legal consultation, as an IPV victim because she considered that the slap in the face her father had inflicted on her mother was in response to her mother's violence towards her. She went on to describe her mother as being violent towards both her father and the children.

3.1.3. Timing

Experiencing parental IPV lasted from a few months to several years. Because the interview covered the participants' entire childhood, they were able to provide information on when they noticed IPV started and may have become worse. Some participants knew that it was already present at birth or in infancy. Some of these interviewees and others reported that IPV continued in their father's relationship with a new partner. Others experienced it at an older age, when IPV started at the beginning of a new relationship or following events such as marriage, a family move or financial problems, a separation or the discovery of an affair. The violence could intensify with a pregnancy or with the parents starting a business together. Daily arguments or insults were often reported as a precursor to physical IPV.

While about a third of the participants could recall one single physical IPV event, most mentioned repetition of such violence twice a month to three times a week. This frequency could increase during the pre-separation period. Other types of violent events occurred daily for some. Violent events could last a few minutes, an evening, an entire day or night, or up to an entire weekend. Some experiences of IPV situations ended right before or after the victim and perpetrator separated. A few lasted beyond that time, because the couple continued to see each other occasionally, during transfers of the children between parents, through denigration of the mother to the children, or through stalking or uninvited visits to the home. While some turning points were identified by some participants, others described IPV as a phenomenon that began and ended gradually. This gradual shift resembles the picture reported in Arai et al.'s (2021) qualitative systematic review.

3.2. Children's personal experience during and around acute IPV events

Participants' accounts, particularly around acute IPV events, shows

the high potential for trauma that living with IPV invokes for children.

3.2.1. Anticipating acute IPV events

Before an acute IPV event took place, some had sensed *"a strange climate"* or quickly anticipated that something was going to turn for the worse. Other accounts emphasized the unpredictability of events.

> *We're afraid of putting him in a bad mood. (…) so that afterwards it could lead to… something else (…) we don't know how he'll react. And it's weird because, as a child, you think… all of a sudden, he's nice and all of a sudden, he's not. So, in fact, it's… we don't know. It's really, no, we don't know. We're… we're doing the best we can, we're walking on eggshells… (P17-F22/14)*

Participants often identified triggers as child-related, such as disagreements about the children, things the children had said or because the victimized parent tried to intervene when the perpetrator was being violent with the children. This participant conveys a sense of responsibility in his account of physical IPV incidents:

> *I'm partly to blame (…) I was being a jerk [outside of home]. As a result, I got beaten up. My mother hated it, so she got in the way, and then it was my mother who got hit. And then my little brother would cry because my mother was getting hit, and he'd see that… and then he'd get hit. Anyway, it didn't stop… (P16-M20/10)*

The perpetrator's alcohol consumption was another identified trigger.

Some children tried to prevent violence by behaving in a certain way, for example by making an extra effort to behave well so as not to upset the perpetrator, or by talking to him. Post-separation, other strategies included avoiding talking about the victim; and reluctantly agreeing to deliver messages between parents to avoid direct communication, as well as standing watch or being alert to the possibility of violence.

> *I always had the same fear, anyway. When I saw my mom going out with the dog, well, I looked at the window, I looked at my mom, things like that (…) I watched a lot, yeah, to make sure everything was going well. (P06-F22/13)*

This illustrates how the experience of IPV goes beyond acute events but notably also encompasses the daily stress and fear experienced in the anticipation of these events. In Callaghan et al. (2015), children and adolescents described how they constrained their actions, noise levels and use of space so as not to trigger the abuser.

3.2.2. Experience of acute IPV events

During acute IPV episodes, children were typically in the room where the violence occurred or in their bedroom, often alternating between the two. They took refuge in their bedroom after witnessing or hearing the beginning of the altercation or, alerted by the noise, they left their room to see what was happening. A combination of these scenarios also happened, for example when they rushed to see what was happening but then took a younger sibling away from the scene.

> *I think, I was there for a whole minute, and I can still see myself, uh… "What's going on here?" and my little brother screaming (…) it's like I hear nothing for 10 s and then all of a sudden, I get my brother's scream and I'm like "My God, he's here!" I take him, I go into the bedroom. I calm him down, I try not to let him hear the screams (…) I held him in my arms, I held him like a, like a baby, you know. I tried to distract him, so he wouldn't hear. (P03-F22/14)*

Sometimes they were sent to their room by the victim or the perpetrator. One participant, worried that her friends would hear the *"row,"* moved her visitors to a nearby park.

Actions taken by or directed at siblings to protect one another were reported a few times. They took the form of removing younger siblings from the scene; hiding under the bed together; putting on music to cover the noise; or distracting each other by playing in the bedroom or reading a story. Other behaviors included talking about other things; making up a story to answer younger siblings' questions about what was happening; comforting each other; and inviting siblings to pray together.

> *He [his older brother]'d tell me "Let's pray" (…) he'd tell me that if I did that, it would pass (…) More like saying we want it to get better and all that. And then it's more of a way of passing the time (…). A way to stop thinking about it, to get away from it all. (P15-M16/6)*

When they were alone in their bedroom, some wanted to monitor the situation by listening from a distance, while others tried not to listen and would put some loud music on. Other strategies included distracting themselves by playing or drawing.

Some participants said that they wanted to monitor the scene by being present in the room in case things went too far, and they would need to take action to protect their mother. Many recounted how they intervened during a physical IPV event, even when 7 years old.

> *My father had my mother on the bed, and he'd hit her. And first I sat on my mother, because…hum… to protect her. (P13-F15/9)*

Direct interventions took the form of getting between the victim and the perpetrator to separate them or to protect the victim; pulling on the father who was trying to stab the mother; trying to talk the parents out of it; threatening to call the police; and finding a way to escape the home with the mother. One adolescent was kicked in the stomach in the process. Seeking help was reported by several participants, either on their own initiative or at the victim's request. They called or fetched a family member living nearby, asked a neighbor or stranger to help or call the police.

> I went out and found a lady (…) and I said, "Madam, call the police," crying, you know. Like, I was in my pajamas and everything. (P20-M14/3)

One participant said she used to audiorecord violent incidents in case evidence was needed later.

Here and as observed in Överlien & Hydén's (2009) study, such actions were taken at a very young age, showing that agency in this context is not confined to older children.

During these acute IPV events, children, whether in the same room or not, also heard suicide and death threats to the mother; threats to ruin the mother's reputation; threats to kidnap a sibling; very loud *"rows"* with screaming and insults; cries; blows to the victim; the victim's calls for help; broken or thrown objects; denigration of their mother; and the perpetrator forbidding the victim to do certain things, such as to work.

Fear for their parents or themselves during these events, feelings of powerlessness, shock, and/or *"just a lack of understanding"* of what was happening also characterized their experiences. Finally, crying and screaming were reported. One participant explained that "every time something happened, well, I felt the same way she [his mother] did.".

Memories of acute IPV events were either very vivid and detailed, even 10 years later, or, on the contrary, blurred or completely absent. In the example below, the participant seems to imply that not remembering that experience was a way to protect herself from the trauma.

> *One time my mother came to pick us up at my father's and frankly, I couldn't say what happened (…) there's a blank, like, at that point (…) we put our stuff in the car and everything. Yeah, I wouldn't know what happened, but I know that we ended up at the police station (…) Because then, she wanted to press charges against my father (…) Like really, I have the before and after, but I don't have the… (…) I don't know, I think my brain suppressed the information. (P08-F18/12)*

Some remembered the scene but not where they were or how they felt, or what happened immediately after.

3.2.3. Aftermath of acute IPV events

Following a physical IPV incident, sightings of bruises, cuts, broken

bones on the victimized parent, with or without blood were reported. Interviewees also mentioned seeing the victim sad and crying. One participant explained that it was the recurring pain in his mother's arm that first alerted him that she was being physically hurt. Broken objects or furniture and torn clothing were also part of what they saw following acute IPV events, along with the police or extended family coming over.

There were only rare mentions of violence being discussed afterwards. However, some participants reported that the perpetrators lied to them or tried to manipulate them about what had just happened, such as in this example, immediately after the victimized mother was taken away in an ambulance:

> *And then I leave with my father and during all the ride [to the hospital], that's where the manipulations are going to start. He says, "You know, I just wanted to go for a run. Look, I put my sneakers on to go for a run, she started it, it's…" (…) He's already trying to put me against my mother and I, I'm 9 years old, I don't understand what's going on. (P19-F17/9)*

One young person also heard his mother lie to people around her to explain the scratches on her face. Children could be reprimanded for calling for help, asked not to tell other family members, or received an apology from the victim for having had to witness the violence.

Helping or offering to help the victim by planning an escape, advising her to call the police or to take picture of the wounds were some of the actions children took afterward. Some left home, either alone to collect themselves, or to go to a relatives' or friends' home, with or without the victim.

> *For example, after a fight, I'd go out, etc. I'd go back in, I wouldn't talk to anyone, I'd always have my headphones on.* (*P12-F18/12)*

Going to the hospital or police station with the victim could also be part of the experience. One mother shared a participant's bedroom for several months to avoid sexual assaults by her husband.

3.3. Other types of victimization

The interviews revealed that living with IPV was not the only victimization that participants had experienced. The vast majority suffered at least two other types of victimization, and a quarter of them mentioned five or more forms of victimization. Only one participant did not report any other type of violence. Other victimizations included direct violence inflicted on the child by the perpetrator, sometimes by the victim, by a brother or sister, and other exposure to violence in the home, such as between a father and a brother. Bullying at school, violence by a boyfriend, or exposure to other violence outside of the home were also part of their experiences. The most common other victimizations reported in this sample were direct violence by the IPV perpetrator (15 out of 20) and school bullying (12 out of 20).

Quantitative studies have shown that children living with IPV are at increased risk of other types of victimization, notably within the home (Hamby et al., 2010; Romito, 2011). In a nationally representative sample of children aged 0–17, 56.8 % of children who had lived with IPV had also been victims of other maltreatment in their lifetime, compared with 11.2 % of children who had not experienced IPV (Hamby et al., 2010). In our sample, direct violence by IPV perpetrators against the participants is overwhelmingly present. In some cases, this topic overtook IPV in terms of interview time, level of detail and impact. Direct violence by the perpetrator could take a variety of forms. It included physical violence, such as punching, kicking, hitting with objects, slapping, spanking, choking, or forcing the child to kneel for two hours without crying. This participant recounted what happened with his stepfather after an argument with his sister when her mother was at work:

> *He got angry with both of us (…) It was a metal spoon anyway, uh quite big. So he took it. (…) Then he, I was on my bed, he took me, he turned me over, gave me four or five good blows in the buttocks and then also in the arm. (…) Then, after he'd hit me and left, well, I stayed in my room, then I didn't move all afternoon, night. (P04-M17/12)*

Tongue washing with soap was also mentioned, but it was specified that it, along with slapping, was not considered really violent in comparison with the other types of physical violence suffered. Psychological violence took the form of constant pressure and punishment, degrading remarks, belittling, intimidation and insults, threats to place the child in state care, threats of suicide, harassment (by telephone or in person), or manipulations aimed at turning children against their mother. Destruction of objects dear to the child, playing violent games or watching horror movies in front of the child, or not caring that children were present during IPV were also reported. Neglect can also be identified in those accounts, such as throwing a child out of the house or showing no interest in the children.

> *Because my father was… well, he… he was a partier, he didn't come home… (…) I saw him very little. (…) On weekends a little more, but he slept, in fact. (…) It wasn't my father who helped me with my homework, it wasn't my father who ate with us, it wasn't my father who cooked for us, it was my mother, in fact. (…) It was almost normal. I knew he wouldn't come home. (P17-F22/14)*

Leaving a young child alone with an even younger sibling for the weekend and without food or delegating the care of younger sibling to the child were other forms of neglect identified. This participant, who also suffered insults, denigration and later physical violence from the perpetrator, gave an account of what it felt like:

> *I was already doing a lot, well almost like a little mother in fact (…) changing the diaper, giving the bottle, it could be uh…taking care of him, playing with him, when he cried it was (…) [imitation of stepfather:] "go see what's wrong with him," (…) it was a lot of orders. In fact, I was I don't know, a slave (…) I was 8–9 years old when I did all that, well that's young. (P03-F22/14)*

Children were also co-victims of the economic violence mentioned above, and one participant reported that her father had stolen her sister's scholarship money. No participants mentioned sexual violence, but the question was not asked directly. Sometimes acute IPV events and direct violence against the children occurred simultaneously.

3.4. Presence of other ACEs

In addition to IPV, other victimizations both within and outside the home, and parental separation or divorce, many other ACEs were present in the lives of these youth, such as alcohol and other substance abuse (by IPV perpetrators, victims, siblings, or boyfriends), depression or other mental illness of a family member at home, incarceration of a parent, and suicide attempts from a sibling or the perpetrator.

> *Well, my mother, she had really big problems, well problems with alcohol, meaning that we'd come home from school and she'd be laying on the couch with her bottle, completely drunk.* (*P10-F24/16)*

Moreover, while neither an extramarital affair nor a serious chronic disease in the family feature among the American Centers for Disease Control and Prevention's cited examples of ACEs, four participants mentioned one of these experiences as something that had greatly affected them.

> *As a child, I have the impression that with everything that happened, I was a bit more mature. I saw life a little ahead of time, I think. (…) The disease in particular and the divorce (…) It's quite a lot for someone who's only… 8 years old, well, 7–8 years old. (P05-F16/12)*

Together with the experience of other victimizations and ACEs, this type of adversity is not insignificant in terms of impact, as identified in Hughes et al.'s (2017) systematic review and *meta*-analysis. Their study found that four or more ACEs increases health risks in all outcomes

measured in adult populations. The risk is particularly high in regard to mental health, substance abuse, sexual risk taking and interpersonal and self-directed violence.

4. Discussion

This study is the first of this kind in Switzerland. It covers the major life domains of the participants since birth, and reports on other types of victimization and ACEs. It benefits from the approach taken to recruitment. Indeed, the fact that the participants are the children of former patients of a medicolegal consultation where they reported IPV a few years before the study took place, probably made the situations encountered in the study more diverse than those in studies that recruit youth directly from IPV-related services. It also gave participants a few years' hindsight on their experiences.

In addition to physical violence, participants were able to identify other forms that IPV can take, as well as distinguish IPV victims from the IPV perpetrators. The experience of IPV was often lengthy for these children and did not always end with the separation. They showed agency in IPV prevention, intervention and solution seeking. IPV often co-occurred with direct victimization of children from the IPV perpetrator, as well as other types of victimization and other ACEs. Based on these various factors, the findings show that the experience can be quite different from one child to another, despite underlying similarities.

First, this study shows commonalities and disparities in terms of the combinations of different types of violence, duration and frequency. While we know that there is a heightened risk of negative outcomes attached to both early age of exposure and long experience of IPV (Graham-Bermann & Perkins, 2010; Stanley, 2011), the testimonies in our study show that any form and degree of IPV are distressing enough for insitutions and professionals to do everything in their power in terms of prevention and care. Some perpetrators, victims and professionals alike may think that when children are not in the room where acute IPV events occur they are insulated and protected from these experiences. Our findings provide yet another proof that this is far from being the case (Överlien & Hydén, 2009). Moreover, anxious anticipation, and the unpredictability of violence, hearing insults, blows or the breaking of objects show it is not just *seeing* the violence that is remembered and that is impactful. As Överlien & Hydén (2009) summarize: *"Children who experience violence in their homes experience it with all their senses"*.

This study unveils another important aspect of the experience of children living with IPV that is seldom documented in the literature: the triggers of the acute IPV events are often reported to be related to them, to something they have said or to something they have done. Such interpretations could at least in part explain feelings of self-blame, which can in turn put young people at higher risk for behavioral difficulties (Fong et al., 2019).

The intense involvement of children during and around acute IPV events is another finding consistent with other studies (De Puy et al., 2019; McGee, 2000; Mullender et al., 2002; Överlien, 2017; Överlien & Hydén, 2009). Although many expressed a sense of powerlessness and a lack of understanding in the face of IPV, their actions indicated that from very early on children had ideas about what they could and could not do to prevent IPV, to achieve some control over it, and protect the victimized parents, themselves and/or siblings from it (McGee, 2000; Mullender et al., 2002; Överlien, 2017; Överlien & Hydén, 2009).

Description of male perpetrators' traits and behaviors matched accounts of other studies (Hui & Maddern, 2021), notably being hot-tempered and neglectful towards children. But in addition, a contrast in demeanors was reported, with negative traits often disappearing outside of the privacy of home, in order to present the outside world with a friendly and caring image. Interestingly, this connects with findings from a study with IPV-victimized mothers who explained that the perpetrator's double-faced personality impacted their credibility as a victim and custody decisions (Cattagni Kleiner & Romain-Glassey, 2024).

The abuse experiences of children living with IPV can be very complex, with the co-occurrence of multiple victimizations and other ACEs as found in the present study (Hamby et al., 2010). Chan et al.'s (2021) *meta*-analysis using studies measuring co-occurrence of at least two types of family victimization (for the most part IPV and child neglect and abuse) showed that the co-occurrence of any other type of family victimization could be six times higher when one type is already present than when not present. The accounts in our study point to the perpetrator of IPV also abusing, and sometimes also neglecting, the children and echoes Romito's (2011) review finding that about half of violent partners are also violent with their children. Single perpetrator for physical IPV and physical abuse on children is also the configuration most often found (50 %) in adolescents reporting both types of violence in a survey of a United States national sample of adolescents (Jobe-Shields et al, 2018). The co-occurrence of other ACEs also appears to be more likely in families that experience violence (Berg et al., 2022).

4.1. Implications for practice

Detection of children living with parental IPV rarely happens through direct communication with children, at least in Switzerland. It is therefore important that health professionals follow WHO's recommendations to ask women about IPV *"when assessing conditions that may be caused or complicated by IPV"* (WHO, 2013). Then, once IPV is detected, children should systematically be taken into consideration. Similarly, it is essential that professionals in contact with children know how to recognize signs of trauma and consider IPV as a possibility when such signs are identified, since experiencing IPV is not symptom-specific (Dessimoz Kunzle et al., 2022; McTavish et al., 2016). Moreover, as occurred during the interviews, the term *"violence"* may be used infrequently, by children and adolescents in favor of "rows," "arguments," or "accidents," and professionals need to find out what is meant when these terms are used. They should take into account children's experience and consider them as full victims of IPV. However, it is also essential not to view children solely as victims and we agree with Överlien's (2017) warning that viewing children only as non-adults and as victims may prevent professionals from listening to them about their experiences and from recognizing their agency.

The presence of other victimizations and other ACEs requires a global approach to known situations of children living with IPV or child abuse. Thus, in the presence of one form of victimization, we recommend that professionals screen for others, as well as for other ACEs, especially those that may contribute to IPV, such as a perpetrator's mental disorder or addiction.

Arai et al.'s (2021) recommendation that the needs of children living or having lived with IPV should be assessed individually given the diversity of situations, is even more relevant when also considering that, for many, it means experiencing other victimizations and perhaps more ACEs than average (Holt et al., 2008; Marshall et al., 2019; Noble-Carr et al., 2019). This, and the fact that IPV does not always end with separation, calls for long-term follow-up by professionals (Stanley et al., 2012). Finally, although evident to most professionals and therefore, at-risk of being overlooked, this study identified an important message that needs to be communicated to children and youth through prevention and services: they are not in any way responsible for IPV.

4.2. Limitations

The study does not reflect situations where IPV was never disclosed. However, by the time victimized parents come to the medico-legal service, IPV has usually been going on for years without professional involvement. It also does not represent IPV situations where physical violence was not present, because virtually all medico-legal consultations for IPV follow a recent event of physical violence.

4.3. Conclusion

Living with IPV as a child is an experience that can last many years. Children can show agency in this context. The co-occurrence of other victimizations and ACEs makes each situation different and complex. We recommend that professionals see children living with IPV as victims, screen for other victimizations and ACEs, and consider children's agency when addressing IPV situations. This should improve responses to them and contribute to enforcing the Istanbul Convention which states that children experiencing IPV should have the same rights to protection and support services as victims of IPV (Council of Europe, 2014). To go a step further in this endeavor, qualitative research should gather their views on the impact this experience had on their health and well-being as well as their needs in relation to services and professionals. Studies that explore the nature of the links between different forms of victimization can assist in informing prevention strategies.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Data availability

The data that has been used is confidential.

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