HHS Public Access

Author manuscript

J Fam Violence. Author manuscript; available in PMC 2024 October 23.

Published in final edited form as:

J Fam Violence. 2024 August ; 39(6): 1145–1163. doi:10.1007/s10896-023-00597-5.

Child-Focused and Economic Stability Service Requests and Barriers to Service Access Among Intimate Partner Violence Survivors With and Without Children, 2017–2021

Kayla N. Anderson[1], **May S. Chen**[1], **Elizabeth A. Swedo**[1], **Ruth W. Leemis**[1], **Lianne Fuino Estefan**[1], **Leah K. Gilbert**[2]

[1]National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, MS S106-10, Atlanta, GA 30341, USA

[2]Office of Safety, Security, and Asset Management, CDC, Atlanta, GA, USA

Abstract

Purpose—Intimate partner violence (IPV) exposure in childhood is common, with impacts on lifespan well-being. However, there are knowledge gaps about needs and barriers to services for IPV survivors with children.

Method—We analyzed data from adults aged ≥ 19 years who resided in the U.S., were experiencing IPV, and who contacted the National Domestic Violence Hotline from 1/1/2017–12/31/2021 (*N* = 599,207). Adjusted prevalence ratios (aPRs) and 95% CIs were calculated to compare differences in IPV exposure, service requests, and service access barriers for IPV survivors with and without children at home, adjusting for age, gender, and race/ethnicity. We examined time trends (2017–2021), with comparisons before and during the COVID-19 pandemic.

Results—Many adult IPV survivors (42.6%) reported having a child at home; survivors with children reported greater polyvictimization (mean IPV types: 2.27, *SD*: 1.03) than those without children (*M*: 2.06, *SD*: 1.04). A small proportion of those with children requested support identifying child-focused services (4.1%); a greater proportion of those with children (30.8%) requested economic stability services compared to those without children (25.2%) (aPR: 1.16, 95% CI: 1.15–1.17). Additionally, 33.1% of survivors with children at home reported having any service access barrier; this was 16% higher than adult IPV survivors without children (28.7%) (aPR: 1.16, 95% CI: 1.15–1.17). There were changes over time, including during the COVID-19 pandemic.

Conclusions—IPV survivors with children need additional supports; organizations serving IPV survivors with children may consider the unique needs and victimization profile of this population when designing interventions and services.

✉ Kayla N. Anderson, KAnderson5@cdc.gov.

Disclaimer The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Conflict of Interest The authors have no conflicts of interest or financial disclosures to report.

Keywords

Intimate partner violence; Adverse childhood experiences; Intervention; Service support; COVID-19

Introduction

Adverse childhood experiences (ACEs) are preventable, potentially traumatic events that occur in childhood (0–17 years old) that can undermine a child's sense of safety, stability, and bonding (CDC, 2021). Exposure to intimate partner violence (IPV) within the home is one such ACE that has been linked to a range of negative health consequences across the lifespan. Exposure to IPV in childhood is associated with increased risk of poor mental health, including depression, anxiety, trauma symptoms, and low self-esteem (Artz et al., 2014; Evans et al., 2008; Vu et al., 2016); aggressive behavior and conduct problems (Evans et al., 2008; Lee et al., 2022; Vu et al., 2016); poor academic performance (Cage et al., 2021; Font & Maguire-Jack, 2016; Kiesel et al., 2017); and poorer general health (Cannon et al., 2010; Holmes et al., 2022). Furthermore, exposure to IPV during childhood increases the likelihood of perpetrating or experiencing IPV in adolescence (Choi & Temple, 2016; Reyes et al., 2015; Evans et al., 2021) and adulthood (Kimber et al., 2018), contributing to a potential intergenerational cycle of violence. Beyond the individual consequences of childhood exposure to IPV, the societal burden is substantial. One study estimated that the average lifetime cost of childhood exposure to IPV is over $50,000 per victim due to increased healthcare costs, crime costs, and lost productivity; this is estimated to cost the U.S. approximately $55 billion annually (Holmes et al., 2018).

A significant number of children in the United States live in homes where IPV occurs. Data from the 2016–2017 National Intimate Partner and Sexual Violence Survey indicated that, among adult female respondents with children in their home, 15.6% reported that their child had ever witnessed emotional IPV and 10.7% reported their child had ever witnessed physical IPV. In this same survey, among male respondents with children in their home, estimates were 7.3% (emotional IPV) and 5.3% (physical IPV), respectively (Leemis et al., 2022). In national estimates from the 2011–2020 Behavioral Risk Factor Surveillance System, 16.9% of young adults aged 18–24 years reported witnessing physical IPV during their childhood (aged < 18 years) (Swedo et al., 2023). This illustrates that the national burden of witnessing IPV on U.S. children is substantial; moreover, children may also be aware of, exposed to, and negatively impacted by IPV in the home beyond witnessing its acute occurrence(s).

Despite evidence that children frequently reside in homes where IPV occurs, and that exposure to IPV has a substantial impact on children's long-term health and well-being, there are critical gaps in understanding prevention and intervention needs as well as barriers to service access for adult IPV survivors with children in their home. Moreover, the social and economic consequences of the COVID-19 pandemic have raised concern about increases in IPV and its impacts on children (Humphreys et al., 2020; McNeil et al., 2022). For example, one study released by the American Academy of Pediatrics indicated

that up to 21% of U.S. children witnessed IPV early in the COVID-19 pandemic (AAP, 2021). In addition, due to needed early COVID-19 mitigation measures, scientists and service practitioners have reported concerns about reductions in service access and increases in service barriers (Risser et al., 2022; Roesch et al., 2020). However, there is limited information quantifying service needs and barriers for IPV survivors, and how these may differ among IPV survivors with and without children at home.

To fill these gaps, this analysis addresses multiple research objectives including examining if there are differences in the type of IPV exposure, requests for economic stability services, and barriers to service access among IPV survivors with and without children from January 1, 2017 to December 31, 2021 using data from the National Domestic Violence Hotline. As part of our objectives, we also describe the proportion of IPV survivors with children at home who requested child-focused services during this time frame. Finally, we examine changes before and during the COVID-19 pandemic for service requests and barriers to access for IPV survivors with and without children at home.

Methods

Participants and Procedures

The National Domestic Violence Hotline (“The Hotline”) provides essential tools and support to help survivors of IPV so they can live their lives free of abuse. While the majority of contacts to The Hotline are IPV survivors, The Hotline also receives inquiries from non-survivors, such as those seeking information on behalf of a loved one experiencing IPV or those seeking resources on healthy relationships. Free, confidential, and compassionate support, crisis intervention, education, and referral to services are available from trained IPV advocates 24 hours a day, seven days a week, 365 days per year (The Hotline, 2022). The Hotline was authorized by the U.S. Congress as part of the Violence Against Women Act in 1994, and has been the national hotline for crisis, educational, and service support for individuals experiencing IPV since the first call was answered in 1996 (The Hotline, 2022). In the past five years, The Hotline has responded to between 250,000 and 409,000 contacts annually (The Hotline, 2021).

In 2020, the U.S. Centers for Disease Control and Prevention formalized a partnership with The Hotline to share data with the goal of improving near real-time public health surveillance of IPV, and ultimately informing prevention and intervention efforts. As part of their internal processes, The Hotline obtains data about the IPV survivors’ or other contacts’ demographic characteristics, needs, and circumstances during each interaction. However, data are only collected if volunteered by the individual contacting The Hotline as part of their interaction; data are not collected via systematic interview or questionnaire, as the purpose of the interaction is to support the needs of the person contacting The Hotline. IPV advocates enter the data that have been volunteered by the person contacting the Hotline at the time of the interaction using a structured database that captures information on each characteristic, service need, and barrier of interest, if known; data are de-identified. New advocates receive an extensive 4-week training on handling contacts to The Hotline, which includes > 20 hours of training on use of the database with review by tenured advocates.

Analysis of these data are considered public health surveillance and practice by CDC; no institutional review board approval is required.

Statistical Analysis

We restricted our analytic dataset to adults aged ≥ 19 years who resided in the United States, who reported experiencing IPV, and who contacted The Hotline from January 1, 2017–December 31, 2021. We examined the proportion of U.S. adult IPV survivors who contacted The Hotline and reported having a child at home; demographics (gender, age, race/ethnicity) for those with and without children at home are described. For IPV survivors with and without children at home, we describe the proportion of each specific type of IPV experienced, if known (digital; economic or financial; emotional; physical; sexual; see Appendix Table 4 for The Hotlines' definitions), if economic stability services were requested, and if any barriers to service access were reported. Given co-occurrence of emotional IPV with other IPV types, when digital, economic or financial, physical, or sexual IPV are disclosed during a hotline contact, The Hotline codes these contacts as inclusive of emotional IPV (i.e., a contact who discloses physical IPV, for example, would be coded as experiencing emotional *and* physical IPV). Emotional IPV can also be reported and coded as the sole form of IPV experienced. Economic stability services included emergency financial aid, emergency transportation, food or household goods, shelter, and transitional housing. Barriers to service access may have been reported for the following reasons: due to inaccessibility (e.g., contact is denied services due to disability or physical health condition), the COVID-19 pandemic, culture, finance, gender, immigration status, language, mental health, being a minor, not having a phone, not having a police report, having older children at home, having pets needing shelter, sexual orientation, needing services that do not exist, transportation issues, capacity issues, or other unknown barriers. For IPV survivors with children at home, we describe the proportion of survivors who requested support identifying child-focused services, including childcare or child counseling services, and if barriers to service access were reported specifically due to having older children in the home that a service provider would not accommodate. We calculated adjusted prevalence ratios (aPRs) and 95% confidence intervals (CIs) to compare differences in IPV types experienced, economic support services requested, and if any barriers to accessing needed services were reported for IPV survivors with and without children. Models used data from 2017 to 2021, and adjusted for gender, age, and race/ethnicity. Finally, to examine polyvictimization across IPV types, we summed the total number of known IPV types experienced (digital, economic or financial, emotional, physical, sexual) and calculated descriptive statistics for IPV survivors with and without children at home.

We examined time trends in the proportion of adult U.S. IPV survivors with children at home who contacted The Hotline using month and year data from January 1, 2017–December 31, 2021. All other trend analyses were stratified by those with and without children at home. We examined time trends for the proportion of survivors who requested support identifying child-focused services (with children only), economic stability services, and who reported any barriers to service access. Due to the impact of the COVID-19 pandemic on social support services and IPV (Piquero et al., 2021), we examined differences in requests for child-focused service support (with children only), economic stability

services, and reporting any barriers to services before and during the COVID-19 pandemic. As the data showed seasonal trends in contact volume to The Hotline, we examined differences by comparing seasons in the first year of the pandemic (March–May 2020, June–Aug. 2020, Sept.–Nov. 2020, Dec. 2020–Feb. 2021) to the corresponding period pre-pandemic. As differences in pandemic mitigation measures, service delivery, and behavioral patterns may have changed as the pandemic progressed, we also compared differences in the second pandemic year (March–May 2021, June–Aug. 2021, Sept.–Nov. 2021) to the corresponding period in pandemic year one. APRs were calculated to examine differences before and during the pandemic; there were separate models for adult IPV survivors with and without children. Models were adjusted for gender, age, and race/ethnicity. Analyses were conducted in SAS version 9.4 (SAS Institute).

Results

A total of 599,207 adult IPV survivors [annual mean: 119,841; range: 79,620 (2017)–131,889 (2021)] who contacted the Hotline between 2017 and 2021 and reported living in the U.S. were included in this analysis. Regardless of whether there was a child at home, the majority of adult IPV survivors contacting the Hotline from 2017 to 2021 were female, aged 25–45 years, and White, Black, or Hispanic or Latino(a) (Table 1). Among adult IPV survivors who contacted The Hotline from 2017 to 2021, 42.6% (255,210) reported having a child at home [annual mean: 51,042; range: 35,555 (2017)–56,623 (2018)]. Adult female IPV survivors had a greater than average proportion of children at home (43.6%), although there were notable proportions of children in homes with male IPV survivors (35.9%) and IPV survivors who identified as transgender, non-binary, or another identity (15.9%) (Table 1). IPV survivors aged 25–33 years (49.4%) and 34–45 years (53.8%) had higher than average proportions of children at home. IPV survivors who identified as Hispanic or Latino(a) (52.0%), Black (46.7%), and Native Hawaiian or other Pacific Islander (43.7%) had higher proportions of children at home compared to the average across racial and ethnic groups.

The proportion of U.S. adult IPV survivors contacting The Hotline with children at home declined slightly over time, from 44.7% to 2017 to 39.8% in 2021, although this trend shows initial signs of reversing in the latter half of 2021 (Appendix Fig. 3). Demographic characteristics were largely stable over time; annual demographic estimates for U.S. adult IPV survivors with and without children at home who contacted The Hotline from 2017 to 2021 are in Appendix Table 5.

Types of IPV Experienced

Regardless of whether there was a child at home, the most commonly reported type of IPV was emotional violence, followed by physical, economic or financial, digital, and sexual violence (Fig. 1). Adult IPV survivors with children at home reported more polyvictimization (mean types of IPV experienced: 2.27, *SD*: 1.03) than those without children at home (*M*: 2.06, *SD*: 1.04). Compared to adult IPV survivors without children at home, those with children at home were more likely to report experiencing economic or financial (aPR: 1.42, 95% CI: 1.41–1.43), physical (aPR: 1.09, 95% CI: 1.09–1.10),

emotional (aPR: 1.05, 95% CI: 1.05–1.05), and digital violence (aPR: 1.05, 95% CI: 1.04–1.06) (Fig. 1).

However, IPV survivors with children at home were less likely to report experiencing sexual violence compared to IPV survivors without children at home (aPR: 0.92, 95% CI: 0.91–0.94) (Fig. 1). There was relative annual stability in the IPV types reported for adult IPV survivors with and without children at home who contacted The Hotline from 2017 to 2021 (Appendix Figs. 4 and 5).

Support for Identifying Child-Focused and Economic Stability Services

Among U.S. adult IPV survivors with children at home who contacted The Hotline from 2017 to 2021, a small proportion requested support identifying child-focused services (4.1%), including childcare help (1.1%) or child counseling (3.2%). Regardless of whether there was a child at home, the most common type of economic stability service requested was accessing shelter (Table 2). Proportions of adult IPV victims requesting support identifying other economic stability services were low for those with and without children (< 5%) (Table 2).

There were differences in requests for support identifying economic stability services for adult IPV survivors with and without children. A greater proportion of adult IPV survivors with children (30.8%) requested any economic stability service compared to adult IPV survivors without children at home (25.2%) (aPR: 1.16, 1.15–1.17). Although the proportion of survivors requesting support identifying specific economic stability services was generally low, adult IPV survivors with children requested support at higher levels than those without children at home (Table 2). For example, adult IPV survivors with children at home had 71% more requests for transitional housing (aPR: 1.71, 95% CI: 1.66–1.76), 68% more requests for food or household goods (aPR: 1.68, 95% CI: 1.59–1.78), and 53% more requests for emergency financial aid (aPR: 1.53, 95% CI: 1.49–1.58) than those without children at home (Table 2).

Barriers to Accessing Needed Services

Across all included years, one-third (33.1%) of U.S. adult IPV survivors with children at home reported experiencing any barrier to service access; this was 16% higher than adult IPV survivors without children at home (28.7%) (aPR: 1.16, 95% CI: 1.15–1.17). We also examined two specific barriers that were particularly relevant to IPV survivors with children and the years analyzed. Only a small percentage of adult IPV survivors with children at home reported barriers were due to having an older child in the home that a service provider would not accommodate (1.4%) (Table 2). The COVID-19 pandemic, which was widespread in the U.S. beginning in March 2020, may also have contributed to barriers in accessing needed services in affected years. Barriers to service access that were reported and were specifically related to the COVID-19 pandemic occurred among 8.4% of adult IPV survivors with children and 4.2% of those without children at home during March–December 2020; this was reduced to 4.2% and 3.5% in 2021 among those with and without children at home, respectively. From March 2020–December 2021, more adult IPV survivors with children

reported having any barriers to service access compared to those without children at home (aPR: 1.16, 95% CI: 1.12–1.20) (Table 2).

Time Trends in Child-Focused and Economic Stability Requests and Service Barriers

Among adult IPV survivors with children at home, requests for support for any child-focused services were generally low with some seasonal variation (Fig. 2, Panel A). There were changes in the proportion of adult IPV survivors with children at home who requested child-focused services before and during the COVID-19 pandemic (Table 3). Fewer adult IPV survivors with children requested child-focused services in March–May 2020 (aPR: 0.73, 95% CI: 0.64–0.81), but a greater proportion of IPV survivors with children requested these services in Sept.–Nov. 2020 (aPR: 1.19, 95% CI: 1.07–1.34), compared to the corresponding periods pre-pandemic in 2019. In 2021, a generally smaller proportion of adult IPV survivors with children requested child-focused services compared to 2020, particularly in June–Nov. 2021 (Table 3).

There was clear seasonal variation in requests for economic stability service support among IPV survivors with children at home, with increases occurring in the summer each year (Fig. 2, Panel B). Taking into account this seasonal variation, there was a slight declining trend from 2017 to 2020 in requests for support identifying economic stability services among adult IPV survivors with children. This is further supported in that a smaller proportion of adult IPV survivors with children at home requested economic stability service support throughout all periods of the first pandemic year (March 2020–February 2021) compared to pre-pandemic (Table 3). Following a seasonal decline in early 2021, there was an increase in economic stability service support requested among adult IPV survivors with children in 2021 (Fig. 2, Panel B), with higher proportions of economic stability service support requested in Sept.–Nov. 2021 compared to the corresponding periods in 2020 (aPR: 1.06, 95% CI: 1.02–1.09; Table 3). There was a decreasing trend in requests for economic stability service support for IPV survivors without children from 2017 to 2020, although requests increased after early 2021. While some seasonal variation was present among IPV survivors without children, this was less pronounced than among those with children (Appendix Fig. 6). Comparisons before and during the COVID-19 pandemic for adult IPV survivors without children at home are in Appendix Table 6.

There were declines in the proportion of adult IPV survivors with children who reported any barriers to accessing needed services over time. Among adult IPV survivors with children at home, 44.6% reported at least one barrier to service access when contacting The Hotline in 2017; this was reduced to 26.0% by 2021 (Fig. 2, Panel C). Despite this overall decline, there was a spike in having any barrier to service access in March 2020, coinciding with the onset of the COVID-19 pandemic in the U.S.; this spike began to decline in June 2020 through June 2021, and increase thereafter (Fig. 2, Panel C). Since July 2021, there was an increasing proportion of IPV survivors with children who reported at least one barrier to accessing services (Fig. 2, Panel C), although the proportion requesting services did not rise above the corresponding period in 2020 (Table 3). The time trend patterns for barriers to service access were similar among those without children at home (2017: 40.9%; 2021:

20.7%; Appendix Fig. 7); comparisons before and during the COVID-19 pandemic for those without children at home are in Appendix Table 6.

Discussion

Findings from this analysis indicate that IPV survivors with children at home have distinct experiences and needs compared to survivors without children at home. Survivors with children at home were more likely to experience economic or financial, physical, emotional, and digital IPV—as well as multiple forms of IPV—compared to survivors without children at home. IPV survivors with children at home also requested economic stability services more often than survivors without children at home. Moreover, over one-third of survivors with children at home reported economic or financial violence, affecting financial stability of IPV survivors and their children. Taken together, our findings suggest that IPV survivors with children at home need additional supports; organizations serving IPV survivors with children may consider the unique needs and victimization profile of this population when designing interventions and services.

Our findings highlight the experiences, needs, and barriers to service access for IPV survivors; however, they also provide more context to the environment in which millions of U.S. children grow up (McDonald et al., 2006; Finkelhor et al., 2015). The majority of research in this area focuses on the negative impact witnessing physical IPV has on children (Artz et al., 2014); our findings shed light on the gamut of IPV types to which children may be exposed. While the negative impacts of childhood exposure to physical IPV are well-documented (Artz et al., 2014), less is known about the impact of exposure to economic or financial, emotional, and digital types of IPV on children's short- and long-term health and behavioral outcomes (Fox et al., 2014; Smith et al., 1996). Given how common these types of IPV were for survivors with children at home in our analysis of national data from The Hotline, this is an important area for future research efforts. Surveillance, research, and violence exposure screening efforts may consider expanding the types of IPV included in assessments of IPV exposure for children and families.

The high proportion of adult IPV survivors contacting The Hotline with children at home has important implications for primary, secondary, and tertiary prevention efforts. Interactions with hotlines represent a critical intervention period—an opportunity to not only provide services to the survivor but also intervene on behalf of exposed children. A large proportion of adult IPV survivors who contacted The Hotline (42.6%) in our analysis reported children at home. These survivors also requested higher proportions of economic stability services than those without children, including those related to housing. Significant research demonstrates that relationships between IPV and economic stability are complex. For example, programs and policies providing services to strengthen economic supports and household financial security are critical to preventing IPV as well as providing survivors and their children with resources needed to safely leave abusive relationships (Matjasko et al., 2013; Niolon et al., 2017). However, the effects of economic instability can be compounding: IPV is a significant contributor to housing instability and home-lessness among survivors and children (Pavao et al., 2007; O'Campo et al., 2016), which can have serious implications for children's sense of safety and stability. Thus, evidence-based

strategies that are survivor-and family-centered and that support economic stability to prevent and mitigate the harms of IPV are critical. While hotline contacts more often request short-term emergency assistance, such as shelter, there are also other promising intervention strategies—such as rapid rehousing and flexible funding (Klein et al., 2021)—that may provide greater benefits over time. Benefits of these services include decreased revictimization, improved economic stability, increased safety, and more optimum health (Decker et al., 2022). Taken together, our findings demonstrate the importance of access to appropriate shelter and other housing services for IPV survivors and their children and support the need for more research into promising housing and economic intervention strategies that support family stability. Research has also demonstrated a potential link between access to shelter services and increased use of other services, leading to better health and safety outcomes (Klein et al., 2021). This is particularly salient given that our analysis found that over one-third of IPV survivors with children at home reported barriers to accessing services. More research is needed to understand these barriers, and cross-sector strategies that provide tailored prevention and intervention services that meet the unique needs of IPV survivors and their children.

Despite the large proportion of adult IPV survivors with children at home and greater requests for economic stability services among these survivors, only 4.1% requested support identifying child-focused services. While this low percentage of child-focused service requests likely reflects the emergency nature of calls to hotlines, it represents a critical opportunity for additional intervention support for these families. Our analysis also suggested seasonal variation in economic stability service requests for IPV survivors with children—with spikes in requests in the summer months annually. As IPV rates tend to be highest in the summer (Lauritsen & White, 2014), this may reflect expected seasonal variation; however, our analysis indicated that seasonal variation in these requests was much less pronounced among IPV survivors without children at home. Taken together, this may suggest that IPV survivors with children are particularly in need of support when children are more frequently at home and out of school (e.g., during summer months and other breaks throughout the academic calendar). Given childhood violence exposure is associated with long-term emotional and behavioral health consequences (Holmes et al., 2022), it is critical to attend to the needs of exposed children in the context of both the immediate IPV response and the promotion of family stability, recovery, and resilience. While it remains essential for emergency services to address the most urgent needs of IPV survivors, it is also important to consider how to bolster emergency service provision to facilitate resources for survivors with children. Although child-focused services may be limited in typical IPV service support contexts, cross-sector, trauma-informed service coordination can reach children in multiple settings to facilitate positive outcomes (Holmes et al., 2022). Emergency service providers, such as hotlines, may wish to consider how to expand IPV survivor linkage with cross-sector community resources for children, with particular focus on the summer months.

The COVID-19 pandemic has had an impact on social support services and IPV rates (Bhuptani et al., 2022; Kourti et al., 2023; Piquero et al., 2021), with a substantial number of children exposed to IPV (AAP, 2021). This analysis provides evidence of variation in child-focused and economic stability service requests by season and time period of the COVID-19 pandemic from March 2020–December 2021. For example, we found that IPV

survivors with children requested fewer economic stability services in the first pandemic year compared to pre-pandemic, but that a greater proportion of IPV survivors requested these types of services in Fall 2021 (second pandemic year) compared to Fall 2020 (first pandemic year). Differences in shelter-in-place orders and other pandemic mitigation efforts, perceived or actual disruptions in healthcare and social service provision, concerns about safety in requesting aide while at home with IPV perpetrators, economic disruptions due to the COVID-19 pandemic (i.e., job loss) —as well as policies that mitigated the economic impact on families (i.e., expansion of child tax credits; economic stimulus supports to eligible adults)—and differences in social isolation at various time periods of the pandemic may all be contributing to these findings. Moreover, this analysis further documented an increase in barriers to service access at the beginning of the COVID-19 pandemic—which were more common among IPV survivors with children than without—with reductions in barriers after the initial U.S. shelter-in-place orders through mid-2021. Research with U.S.-based IPV advocates in 2020 indicated that IPV survivors reported disruptions in access to basic needs via diminished access to safe and affordable housing, child-care, technology (e.g., lack of reliable or private internet access), transportation, and employment (Ragavan et al., 2020). Future disaster and pandemic preparedness efforts at national, state, and local levels may include collaborations with IPV emergency service providers and other cross-sector community and governmental partners to integrate continuous-operations planning for IPV-related services, as well as novel preparedness measures that facilitate support for survivors who may be isolated at home with abusive partners (see potential strategies and concerns in Ragavan et al., 2020; Emezue, 2020). Our analysis suggests that the proportion of IPV survivors with children who reported any barrier to service access began increasing in mid-2021 following earlier declines; monitoring of trends in barriers to service access is warranted in additional research to see if this trend continues into 2022 and beyond.

This analysis has a number of strengths, including the ability to examine national estimates and trends in IPV survivor service support requests and barriers to services before and during the COVID-19 pandemic. There are also limitations to consider. First and foremost, the primary purpose of The Hotline is to provide resources and other support to IPV survivors; data were not collected via a systematic survey nor intended for surveillance purposes. Data on each contact with The Hotline are collected and entered into a structured database at the time of interaction; however, information is only collected if the IPV survivor mentions a characteristic, service need, or barrier during the duration of the contact as part of the conversation with the advocate. Therefore, there may be misclassification in some responses, with false negative classification of characteristics (including the IPV type experienced or whether a child is in the home), service needs, or barriers, which may have an impact on the analysis findings. Moreover, we only included contacts that specified residing in the United States; as providing location is not required, some contacts who reside in the U.S. may have been inadvertently excluded from analysis. Second, because of the co-occurrence of emotional IPV with other forms of IPV, The Hotline codes all *known* reported forms of IPV (i.e., digital, economic or financial, physical, or sexual) as also including emotional IPV. This results in nearly all IPV survivors having reported emotional IPV [with the exception of those with an unknown type of IPV experienced], which may

inflate findings for polyvictimization. Third, although The Hotline is a national U.S.-based resource, some jurisdictions have localized hotlines and resources available; this may result in underrepresentation of call volume, needs, and service barriers for IPV survivors in those areas. Fourth, data only represent information about IPV survivors who contact The Hotline for service or other support, they are not reflective of all IPV survivors in the United States or all those who need services. Fifth, there may be additional child-focused and economic stability services, or barriers to service access, which are critical for IPV survivors but may not be systematically captured in the data. Sixth, these data are unable to be used to describe the frequency and severity of IPV reported, which has implications for survivor and child health.

Exposure to IPV at home is a common ACE that contributes to a host of long-term negative health and social consequences for children, including risk for perpetuating and experiencing intergenerational violence. This analysis underscores the importance of providing survivor- and family-oriented supports to IPV survivors with children at home, including readily accessible housing, financial resources, and child-focused services. These findings align with CDC's technical package summarizing the best available evidence to prevent IPV and lessen the short and long-term consequences for survivors and their families through strengthening economic supports for families and providing survivor-centered services (Niolon et al., 2017). Hotlines and other emergency service providers may help provide support to IPV survivors and their families by proactively referring to resources that can specifically benefit families and children, especially during the summer months and when more service barriers are reported. Cross-sector, comprehensive efforts that emphasize primary prevention and trauma-informed intervention strategies may help communities prevent IPV, including childhood exposure to IPV, and prevent or lesson the short- and long-term harms of IPV for survivors and their children (Niolon et al., 2017; CDC, 2019).

Data Availability

The data are not publicly available.

Appendix 1

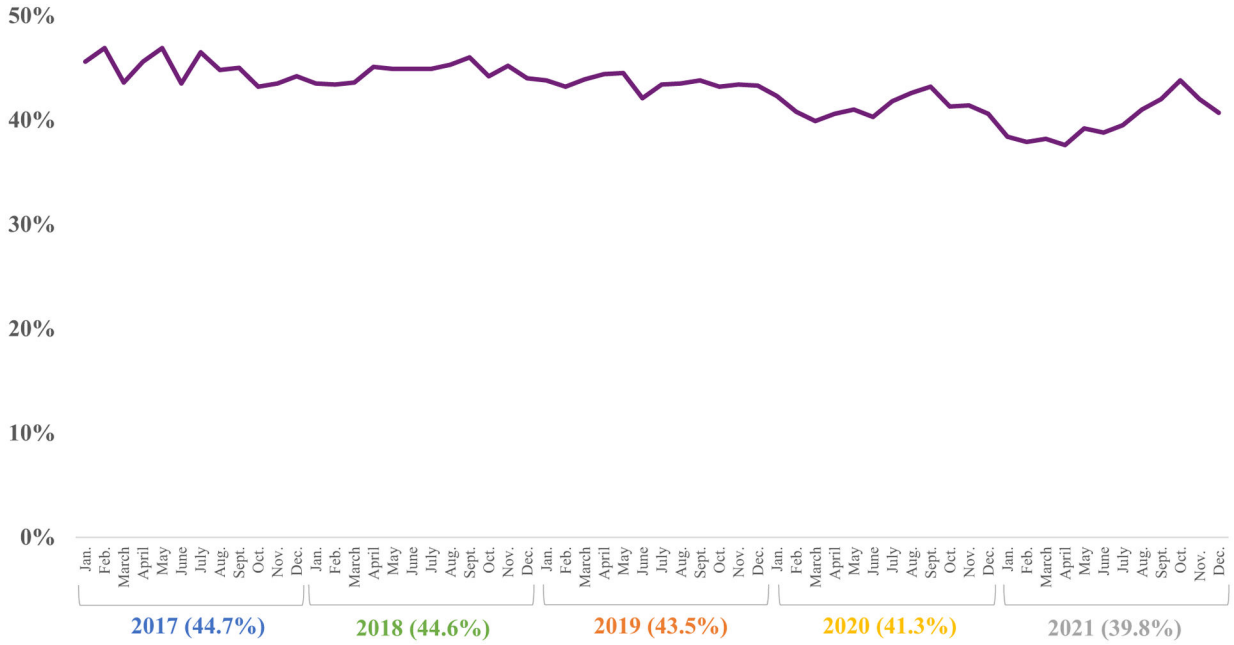

Fig. 3. Trends in the proportion of adult intimate partner violence survivors contacting The Hotline* with children at home, January 1, 2017–December 31, 2021.

IPV = intimate partner violence; *The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of intimate partner violence so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing intimate partner violence and who contacted The Hotline from January 1, 2017–December 31, 2021

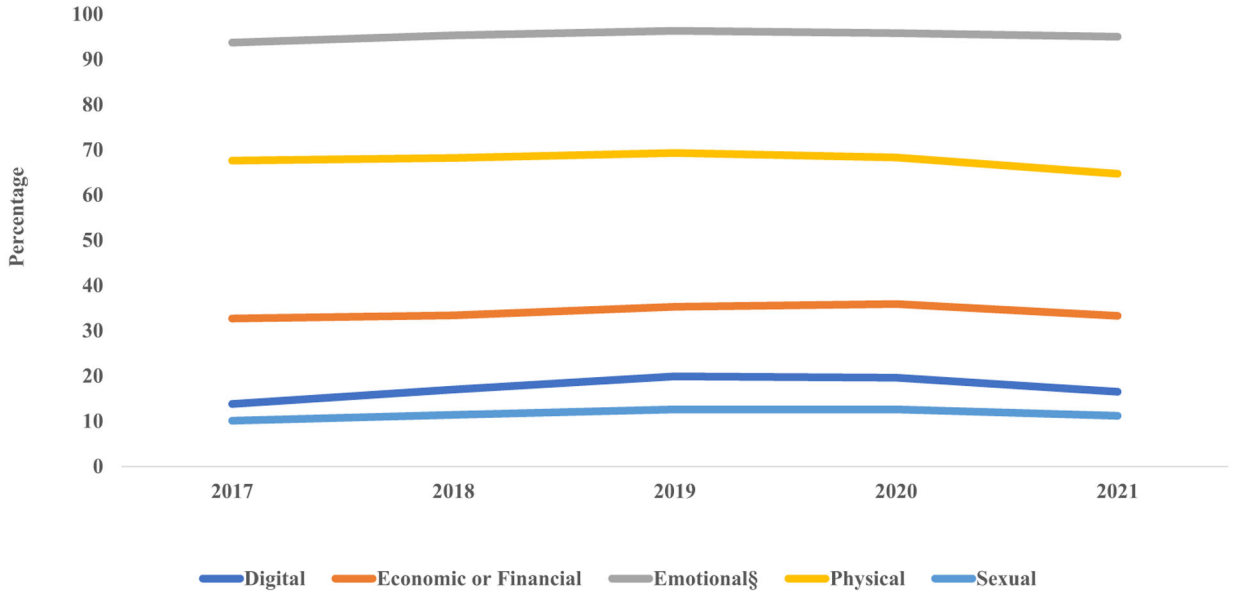

Fig. 4. Trends in reported intimate partner violence types experienced by adult survivors contacting The Hotline* with children at home, January 1, 2017– December 31, 2021.

*The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of intimate partner violence so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing intimate partner violence, reported having children at home, and who contacted The Hotline from January 1, 2017–December 31, 2021. §Given co-occurrence of emotional IPV with other IPV types, when digital, economic or financial, physical, or sexual IPV are disclosed during a hotline contact, The Hotline codes these contacts as inclusive of emotional IPV (i.e., a contact who discloses physical IPV, for example, would be coded as experiencing emotional *and* physical IPV). Emotional IPV can also be reported and coded as the sole form of IPV experienced. This results in the majority of IPV survivors with known IPV types coded as having experienced emotional violence; there are a small proportion of IPV survivors with an unknown type of IPV that are not coded to have experienced emotional violence

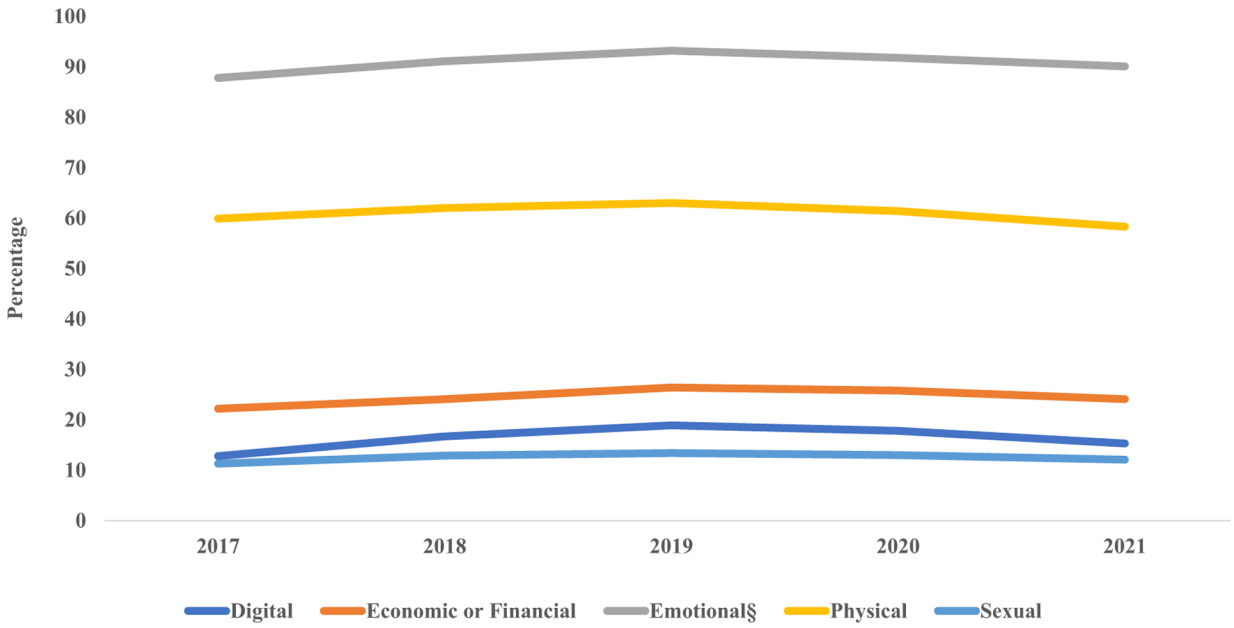

Fig. 5. Trends in reported intimate partner violence types experienced by adult survivors contacting The Hotline* without children at home, January 1, 2017–December 31, 2021.

*The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of intimate partner violence so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing intimate partner violence, did not report having children at home, and who contacted The Hotline from January 1, 2017–December 31, 2021. §Given co-occurrence of emotional IPV with other IPV types, when digital, economic or financial, physical, or sexual IPV are disclosed during a hotline contact, The Hotline codes these contacts as inclusive of emotional IPV (i.e., a contact who discloses physical IPV, for example, would be coded as experiencing emotional *and* physical IPV). Emotional IPV can also be reported and coded as the sole form of IPV experienced. This results in the majority of IPV survivors with known IPV types coded as having experienced emotional violence; there are a small proportion

of IPV survivors with an unknown type of IPV that are not coded to have experienced emotional violence

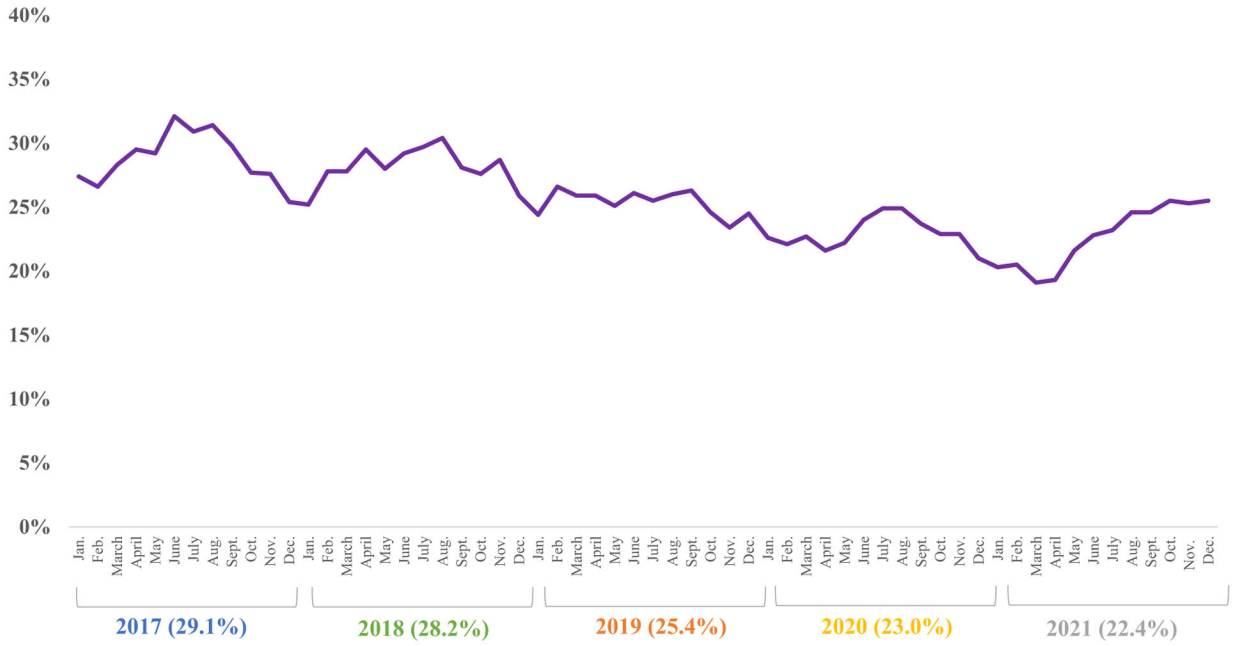

Fig. 6. Trends in the proportion of adult intimate partner violence survivors without children at home who requested support from The Hotline* to identify economic stability services, January 1, 2017–December 31, 2021.

*The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of intimate partner violence so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing intimate partner violence, did not report having children at home, and who contacted The Hotline from January 1, 2017–December 31, 2021

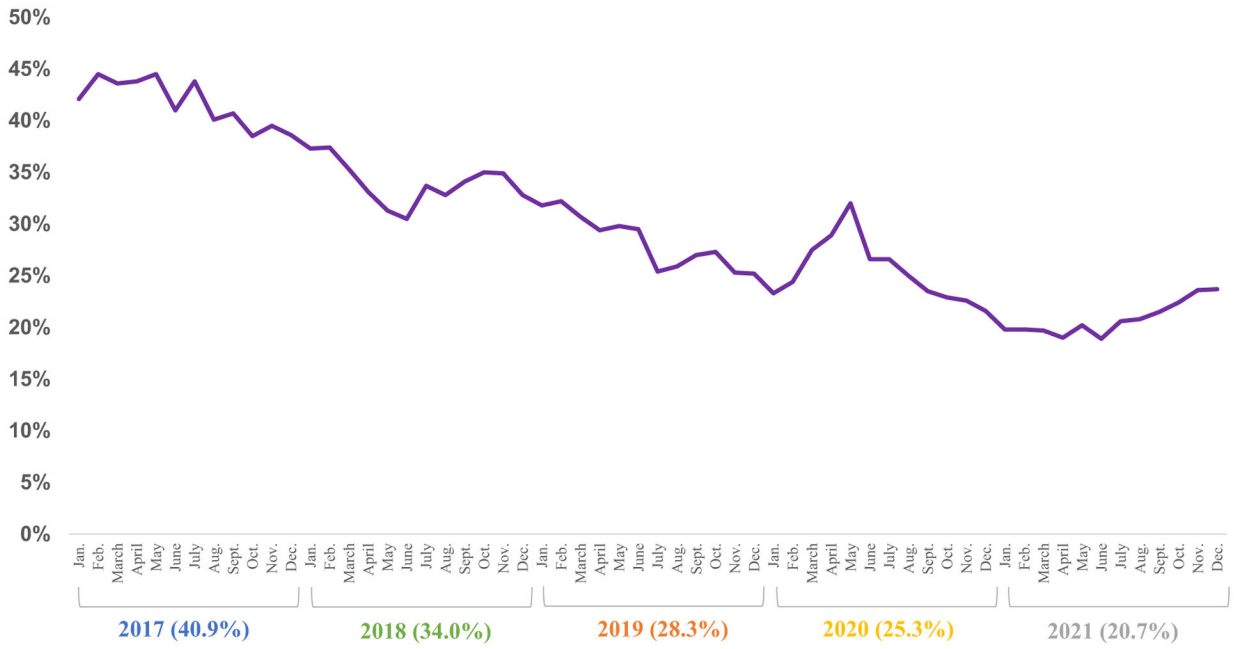

Fig. 7. Trends in the proportion of adult intimate partner violence survivors without children at home who reported having any barriers to service access, The Hotline*, January 1, 2017–December 31, 2021.

*The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of intimate partner violence so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing intimate partner violence, did not report having children at home, and who contacted The Hotline from January 1, 2017–December 31, 2021

Table 4

Definitions of types of intimate partner violence as used by The Hotline* during interactions with survivors

Digital	The survivor has at any point been subjected to control, harassment, intimidation, or threats via technological means. Examples include, but are not limited to: cyberstalking; non-consensual sexting; electronic surveillance; unwanted dissemination of nude/sexual images, audio, or video; online impersonation; online harassment; GPS monitoring; hacking, or online banking or credit fraud.
Economic or Financial	The survivor has at any point been subjected to tactics limiting access to financial information, resources, or ability to achieve financial independence or stability. Examples include, but are not limited to: controlling or withholding funds; not allowing survivors access to accounts; forbidding or sabotaging employment; focusing the survivor to take on debt; opening accounts in the survivor or children's names without consent.
Emotional	The survivor has at any point been subjected to tactics that cause psychological, mental, and/or spiritual harm. Examples include, but are not limited to: isolation from support systems or means of seeking support; stated or implied threats to the survivors' safety or wellbeing; verbal abuse, humiliation, or infantilization; behavior that diminishes the survivors' sense of identity, dignity, self-esteem, and/or self-worth.
Physical	The survivor has at any point been subjected to control, harassment, intimidation, or threats via physical means, and/or tactics that cause, or have the intention of causing, bodily injury/harm, disability, and/or death. Examples include, but are not limited to: hitting, grabbing, punching, burning, kicking, shoving, biting, or slapping; throwing objects; use of restraints, body or strength; strangling or smothering; driving recklessly; using weapons; forced use of drugs or alcohol; prolonged sleep deprivation; denying necessary medical treatment.

Sexual	The survivor has at any point been subjected to non-consensual (by coercion, pressure, guilt, or force) sexual contact or interaction. Examples include, but are not limited to: sharing or harassing in regard to sexual behavior, orientation, or preferences; sending or demanding sexual images, audio, or video; demanding affection (publicly or privately); refusal to use contraception; deliberately causing unwanted physical pain or humiliation during sex; pressure to engage in sexual activity of any kind; deliberately passing on sexual diseases or infection; using objects, toys, or other items (e.g., lubricants) without consent.
Unknown	The type of abuse was not disclosed during the conversation.

The Hotline* captures all types of abuse that apply to the survivors' experience as disclosed during the interaction. It may be possible for one form of abuse to encompass another. For example, sexting coercion includes digital, sexual, and emotional abuse; online banking fraud including financial, digital, and emotional abuse. Please note that all forms of abuse are inclusive of emotional abuse. However, emotional abuse tactics can exist without the presence of any other type of abuse

Table 5

Annual demographic characteristics for adult intimate partner violence survivors who contacted The Hotline*, stratified by presence of a child at home, January 1, 2017–December 31, 2021

	2017				2018				2019				2020	
	IPV Survivors with Child at Home		IPV Survivors without Child at Home		IPV Survivors with Child at Home		IPV Survivors without Child at Home		IPV Survivors with Child at Home		IPV Survivors without Child at Home		IPV Survivors with Child at Home	
	N	Row %	*N*	Row %	*N*	Row %	*N*	Row %	*N*	Row %	*N*	Row %	*N*	Row %
Gender														
Female	33,011	45.5%	39,495	54.5%	52,188	45.5%	62,576	54.5%	51,554	44.5%	64,202	55.5%	49,398	42.4%
Male	2,331	36.7%	4,013	63.3%	4,117	37.7%	6,793	62.3%	4,119	36.8%	7,080	63.2%	4,428	34.9%
Transgender, non-binary, or another gender identity	43	16.0%	225	84.0%	82	14.0%	503	86.0%	119	14.0%	733	86.0%	203	17.1%
Unknown	170	33.9%	332	66.1%	236	31.9%	504	68.1%	306	29.7%	726	70.4%	457	31.4%
Age (in years)														
19–24	3,960	35.0%	7,355	65.0%	6,005	33.2%	12,095	66.8%	5,815	31.4%	12,726	68.6%	5,444	28.7%
25–33	13,349	53.2%	11,754	46.8%	22,173	52.9%	19,721	47.1%	21,487	50.9%	20,770	49.2%	20,616	47.1%
34–15	13,794	54.6%	11,481	45.4%	22,052	55.3%	17,861	44.8%	22,292	54.5%	18,626	45.5%	22,045	53.2%
46–51	2,885	34.7%	5,422	65.3%	4,216	33.8%	8,242	66.2%	4,311	35.9%	7,715	64.1%	3,987	33.7%
52–63	1,469	17.8%	6,771	82.2%	2,056	16.5%	10,431	83.5%	2,057	16.3%	10,582	83.7%	2,214	17.2%
64+	98	7.1%	1,282	92.9%	121	5.6%	2,026	94.4%	136	5.5%	2,322	94.5%	180	6.0%
Race and ethnicity §														
American Indian or Alaska Native	376	39.8%	568	60.2%	612	42.2%	840	57.8%	632	42.2%	865	57.8%	632	42.3%
Arabic or Middle Eastern	179	41.7%	250	58.3%	350	41.9%	486	58.1%	346	45.6%	413	54.4%	352	39.3%
Asian	1,381	39.9%	2,077	60.1%	2,143	39.4%	3,300	60.6%	2,120	38.0%	3,461	62.0%	2,309	38.2%
Black	8,590	49.3%	8,824	50.7%	13,237	49.0%	13,763	51.0%	13,215	48.1%	14,288	51.9%	11,379	44.6%

	2017				2018				2019				2020	
	IPV Survivors with Child at Home		IPV Survivors without Child at Home		IPV Survivors with Child at Home		IPV Survivors without Child at Home		IPV Survivors with Child at Home		IPV Survivors without Child at Home		IPV Survivors with Child at Home	
	N	Row %	*N*	Row %	*N*	Row %	*N*	Row %	*N*	Row %	*N*	Row %	*N*	Row %
Hispanic or Latino(a)	7,088	55.7%	5,639	44.3%	10,420	53.4%	9,084	46.6%	10,658	52.4%	9,675	47.6%	11,464	51.1%
Native Hawaiian or other Pacific Islander	152	38.7%	241	61.3%	241	46.0%	283	54.0%	292	50.4%	287	49.6%	261	44.5%
White	14,654	40.1%	21,886	59.9%	24,474	41.0%	35,234	59.0%	23,553	40.0%	35,325	60.0%	22,339	37.7%
Multiracial	1,772	42.9%	2,356	57.1%	3,008	43.2%	3,958	56.8%	3,055	41.0%	4,398	59.0%	2,958	38.5%
Another race or ethnicity	383	38.9%	602	61.1%	845	41.3%	1,199	58.7%	894	37.4%	1,497	62.6%	916	36.3%
Unknown	980	37.7%	1,622	62.3%	1,293	36.7%	2,229	63.3%	1,333	34.5%	2,532	65.5%	1,876	34.1%

IPV = intimate partner violence;

*The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of intimate partner violence so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing intimate partner violence and who contacted The Hotline from January 1, 2017–December 31, 2021.

§All racial/ethnic categories are non-Hispanic or Latino, except for this specific racial/ethnic category. Intimate partner violence survivors who are Hispanic or Latino(a) may be included in the multiracial category if they identified as Hispanic or Latino(a) and another racial or ethnic group

Table 6

Trends in the proportion of adult intimate partner violence survivors who contacted The Hotline* without children at home and requested support identifying economic stability services and reported barriers to service access, before and during the COVID-19 pandemic, March 1, 2019–December 31, 2021§

	Trends in calls during the first pandemic year (March 2020-February 2021) compared to the corresponding period pre-pandemic (March 2019-February 2020)								Trends in calls during the second pandemic year (March 2021-November 2021) compared to the first pandemic year (March 2020-November 2020)					
	March–May 2020¶		June–Aug. 2020†		Sept.–Nov. 2020**		Dec. 2020–Feb. 2021§§		March–May 2021¶¶		June–Aug. 2021††		Sept.–Nov. 2021***	
	% Yes	aPR§ (95% CI)	% Yes	aPR§ (95% CI)	% Yes	aPR§ (95% CI)	% Yes	aPR§ (95% CI)	% Yes	aPR§ (95% CI)	% Yes	aPR§ (95% CI)	% Yes	aPR§ (95% CI)
Requested any economic stability service§§§	22.2	0.88 (0.85–0.91)	24.6	0.96 (0.93–0.99)	23.1	0.96 (0.93–0.99)	20.6	0.85 (0.82–0.88)	20.0	0.92 (0.89–0.95)	23.5	0.97 (0.94–1.00)	31.5	1.09 (1.05–1.12)
Reported any barrier to service access¶¶¶	29.5	0.98 (0.95–1.01)	26.1	0.97 (0.94–1.00)	23.0	0.87 (0.84–0.90)	20.4	0.69 (0.67–0.71)	19.6	0.67 (0.65–0.69)	20.0	0.77 (0.74–0.80)	23.6	0.98 (0.95–1.02)

IPV = intimate partner violence; aPR = adjusted prevalence ratio; 95% CI = 95% confidence interval.

*The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of IPV so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were

experiencing IPV, who did not have children at home, and who contacted The Hotline from March 1, 2019–December 31, 2021.

[§] Compares prevalence for adult IPV survivors without children at home for time periods of interest for the variables of interest; all analyses were adjusted for IPV survivor gender, age, and race/ethnicity.

[¶] Comparison period is March–May 2019.

[†] Comparison period is June–August 2019.

[**] Comparison period is September–November 2019.

[§§] Comparison period is December 2019–February 2020.

[¶¶] Comparison period is March–May 2020.

[††] Comparison period is June–August 2020.

[***] Comparison period is September–November 2020.

[§§§] Includes requests for emergency financial aid, emergency transportation, food or household goods, shelter, or transitional housing services;

[¶¶¶] Barriers included those related to accessibility, the COVID-19 pandemic, culture, finance, gender, immigration status, language, mental health, being a minor, not having a phone, not having a police report, having older children at home, having pets needing shelter, sexual orientation, needing services that do not exist, transportation issues, capacity issues, or other unknown barriers

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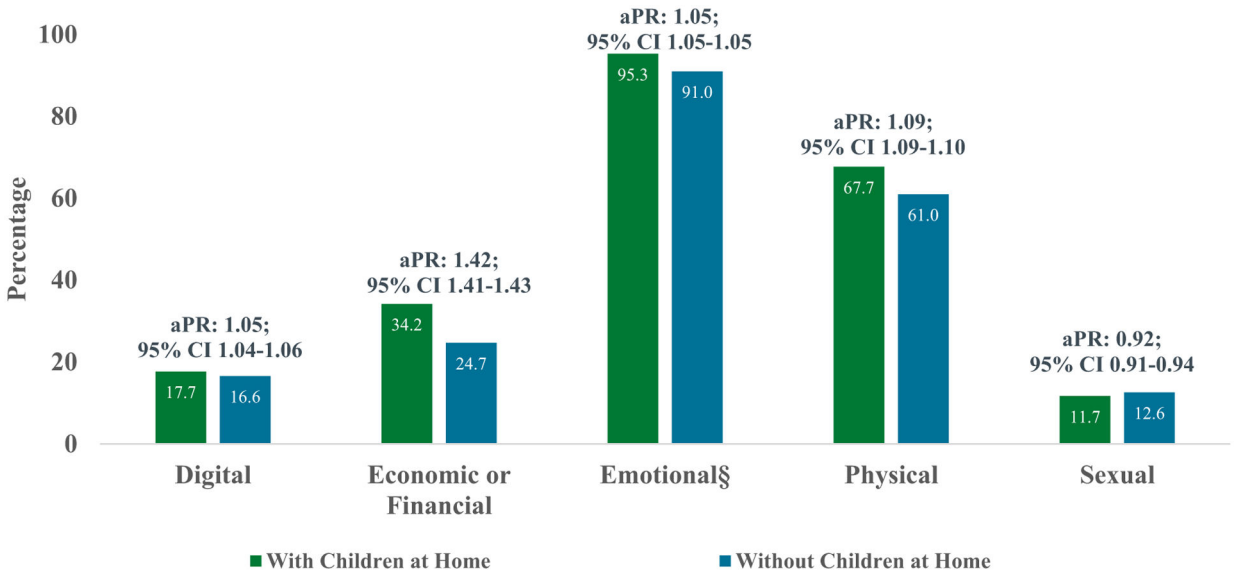

Fig. 1. Types of intimate partner violence reported by adult survivors with and without children at home, The Hotline,* January 1, 2017–December 31, 2021.

aPR = adjusted prevalence ratio; 95% CI = 95% confidence interval. *The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of intimate partner violence so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing intimate partner violence and who contacted The Hotline from January 1, 2017–December 31, 2021. §Given co-occurrence of emotional IPV with other IPV types, when digital, economic or financial, physical, or sexual IPV are disclosed during a hotline contact, The Hotline codes these contacts as inclusive of emotional IPV (i.e., a contact who discloses physical IPV, for example, would be coded as experiencing emotional *and* physical IPV). Emotional IPV can also be reported and coded as the sole form of IPV experienced. This results in the majority of IPV survivors with known IPV types coded as having experienced emotional violence; there are a small proportion of IPV survivors with an unknown type of IPV that are not coded to have experienced emotional violence

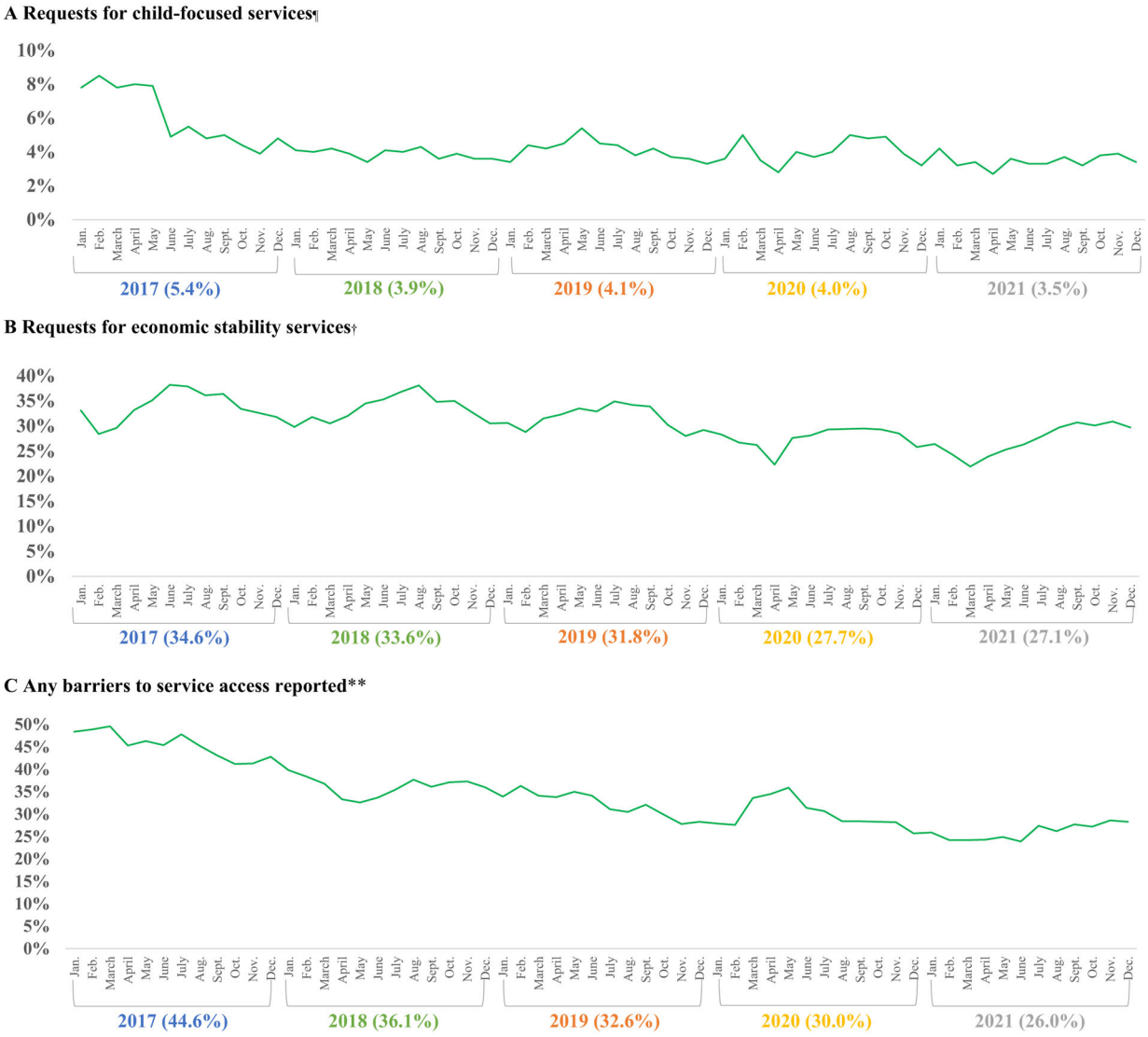

Fig. 2. Trends in the percentage of adult intimate partner survivors with children at home who requested child-focused or economic stability services, as well as reported any barriers to service access, The Hotline,* January 1, 2017–December 31, 2021.

*The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of intimate partner violence so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing intimate partner violence, who reported having children at home, and who contacted The Hotline from January 1, 2017–December 31, 2021. ¶Includes requests for childcare help and child counseling services. †Includes requests for emergency financial aid, emergency transportation, food or household goods, shelter, or transitional housing services. **Barriers included those related to accessibility, the COVID-19 pandemic, culture, finance, gender, immigration status, language, mental health, being a minor, not having a phone, not having a police report, having older children at home, having pets needing shelter, sexual

orientation, needing services that do not exist, transportation issues, capacity issues, or other unknown barriers

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Table 1

Demographic characteristics for U.S. adult intimate partner violence survivors who contacted The Hotline*, with and without a child at home, January 1, 2017–December 31, 2021

	All Included IPV Survivors		IPV Survivors with Children at Home		IPV Survivors without Children at Home	
	N	**Column %**	***N***	**Row %**	***N***	**Row %**
Gender						
Female	534,675	89.2%	233,239	43.6%	301,436	56.4%
Male	54,103	9.0%	19,397	35.9%	34,706	64.2%
Transgender, non-binary, or another gender identity	4,522	0.8%	719	15.9%	3,803	84.1%
Unknown	5,907	1.0%	1,855	31.4%	4,052	68.6%
Age (in years)						
19–24	86,363	14.4%	26,381	30.6%	59,982	69.4%
25–33	196,949	32.9%	97,203	49.4%	99,746	50.6%
34–45	189,362	31.6%	101,808	53.8%	87,554	46.2%
46–51	55,797	9.3%	19,122	34.3%	36,675	65.7%
52–63	58,828	9.8%	9,939	16.9%	48,889	83.1%
64+	11,908	2.0%	757	6.4%	11,151	93.6%
Race/ethnicity§						
American Indian or Alaska Native	6,830	1.1%	2,824	41.4%	4,006	58.7%
Arabic or Middle Eastern	3,781	0.6%	1,556	41.2%	2,225	58.8%
Asian	26,473	4.4%	10,072	38.1%	16,401	61.9%
Black	121,774	20.3%	56,823	46.7%	64,951	53.3%
Hispanic or Latino(a)	96,893	16.2%	50,356	52.0%	46,537	48.0%
Native Hawaiian or other Pacific Islander	2,572	0.4%	1,125	43.7%	1,447	56.3%
White	274,211	45.8%	106,928	39.0%	167,283	61.0%
Multiracial	33,733	5.6%	13,621	40.4%	20,112	59.6%
Another race or ethnicity	10,144	1.7%	3,847	37.9%	6,297	62.1%
Unknown	22,796	3.8%	8,058	35.4%	14,738	64.6%

IPV = intimate partner violence;

* The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of IPV so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing IPV and who contacted The Hotline from January 1, 2017–December 31, 2021.

§ All racial/ethnic categories are non-Hispanic or Latino, except for this specific racial/ethnic category. IPV survivors who are Hispanic or Latino(a) may be included in the multiracial category if they identified as Hispanic or Latino(a) and another racial or ethnic group

Table 2

Requests for child-focused and economic stability services, and reported barriers to service access, among U.S. adult intimate partner violence survivors who contacted The Hotline[*] with and without children at home, January 1, 2017–December 31, 2021

	All Included IPV Survivors		IPV Survivors with Children at Home		IPV Survivors without Children at Home			
	N Yes	% Yes	*N* Yes	% Yes	*N* Yes	% Yes	aPR[§]	95% CI
Requests for Child-Focused Services								
Childcare Help	–	–	2,670	1.1%	–	–	–	–
Child Counseling	–	–	8,186	3.2%	–	–	–	–
≥ 1 Child Services Above	–	–	10,441	4.1%	–	–	–	–
Requests for Economic Stability Services								
Emergency Financial Aid	22,749	3.8%	12,275	4.8%	10,474	3.0%	1.53	1.49–1.58
Emergency Transportation	17,966	3.0%	8,029	3.2%	9,937	2.9%	1.05	1.02–1.08
Food or Household Goods	5,081	0.9%	2,831	1.1%	2,250	0.7%	1.68	1.59–1.78
Shelter	137,396	22.9%	63,872	25.0%	73,524	21.4%	1.11	1.10–1.12
Transitional Housing	21,399	3.6%	12,068	4.7%	9,331	2.7%	1.71	1.66–1.76
≥ 1 Economic Stability Services Above	165,232	27.6%	78,501	30.8%	86,731	25.2%	1.16	1.15–1.17
Barriers to Service Access								
Barrier due to Older Child	–	–	3,637	1.4%	–	–	–	–
Barrier due to COVID-19[¶]	13,111	5.6%	5,723	6.0%	7,388	5.3%	1.16	1.12–1.20
Any (≥ 1) Included Barrier Noted[†]	183,047	30.6%	84,435	33.1%	98,612	28.7%	1.16	1.15–1.17

IPV = intimate partner violence; aPR = adjusted prevalence ratio; 95% CI = 95% confidence interval.

[*] The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of IPV so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing IPV and who contacted The Hotline from January 1, 2017–December 31, 2021.

[§] Compares prevalence for adult IPV survivors with and without children at home for the variable of interest; all analyses were adjusted for IPV survivor gender, age, and race/ethnicity.

[¶] Barriers to service access due to the COVID-19 pandemic were analyzed only for data collected from March 2020–December 31, 2021.

[†] Barriers included those related to accessibility, the COVID-19 pandemic, culture, finance, gender, immigration status, language, mental health, being a minor, not having a phone, not having a police report, having older children at home, having pets needing shelter, sexual orientation, needing services that do not exist, transportation issues, capacity issues, or other unknown barriers

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Table 3

Trends in the proportion of U.S. adult intimate partner violence survivors who contacted The Hotline[*] with children at home who requested child-focused or economic stability services, and reported barriers to service access, before and during the COVID-19 pandemic, March 1, 2019–December 31, 2021[§]

	Trends in calls during the first pandemic year (March 2020-February 2021) compared to the corresponding period pre-pandemic (March 2019-February 2020)								**Trends in calls during the second pandemic year (March 2021-November 2021) compared to the first pandemic year (March 2020-November 2020)**					
	March–May 2020[¶]		**June–Aug.2020[†]**		**Sept.–Nov. 2020[**]**		**Dec.2020–Feb. 2021[§§]**		**March–May 2021[¶¶]**		**June–Aug. 2021[††]**		**Sept.–Nov.2021[***]**	
	% Yes	**aPR[§] (95% CI)**	**% Yes**	**aPR[§] (95% CI)**	**% Yes**	**aPR[§] (95% CI)**	**% Yes**	**aPR[§] (95% CI)**	**% Yes**	**aPR[§] (95% CI)**	**% Yes**	**aPR[§] (95% CI)**	**% Yes**	**aPR[§] (95% CI)**
Requested any child-focused service[§§§]	3.4	0.73(0.64–0.81)	4.2	0.99(0.89–1.11)	4.5	1.19(1.07–1.34)	3.5	0.95(0.84–1.07)	3.2	0.95(0.84–1.09)	3.4	0.81(0.72–0.91)	3.6	0.80(0.71–0.90)
Requested any economic stability service[¶¶¶]	25.4	0.80(0.77–0.83)	28.9	0.88(0.85–0.91)	29.1	0.95(0.92–0.99)	25.6	0.88(0.85–0.92)	23.6	0.94(0.90–0.98)	28.0	0.97(0.94–1.01)	30.6	1.06(1.02–1.09)
Reported any barrier to service access[†††]	34.7	1.01(0.98–1.04)	30.2	0.95(0.92–0.98)	28.3	0.94(0.90–0.97)	25.4	0.77(0.74–0.80)	24.4	0.70(0.68–0.73)	25.9	0.86(0.83–0.89)	27.9	0.98(0.95–1.02)

IPV = intimate partner violence; aPR = adjusted prevalence ratio; 95% CI = 95% confidence interval.

[*]The Hotline refers to the National Domestic Violence Hotline, which provides essential tools and support to help survivors of IPV so that they can live their lives free of abuse. This analysis includes data from U.S. adults aged ≥ 19 years who were experiencing IPV, who had children at home, and who contacted The Hotline from March 1, 2019–December 31, 2021.

[§]Compares prevalence for adult IPV survivors with children in the home for time periods of interest for the variables of interest; all analyses were adjusted for IPV survivor gender, age, and race/ethnicity.

[¶]Comparison period is March–May 2019;

[†]Comparison period is June–August 2019.

[**]Comparison period is September–November 2019.

[§§]Comparison period is December 2019–February 2020.

[¶¶]Comparison period is March–May 2020.

[††]Comparison period is June–August 2020.

***Comparison period is September–November 2020.

§§§Includes requests for childcare help and child counseling services.

¶¶¶Includes requests for emergency financial aid, emergency transportation, food or household goods, shelter, or transitional housing services.

†††Barriers included those related to accessibility, the COVID-19 pandemic, culture, finance, gender, immigration status, language, mental health, being a minor, not having a phone, not having a police report, having older children at home, having pets needing shelter, sexual orientation, needing services that do not exist, transportation issues, capacity issues, or other unknown barriers