

POPULATIONS AT RISK ACROSS THE LIFESPAN: CASE STUDIES

Nurse Home Visitors' Perspectives of Mandatory Reporting of Children's Exposure to Intimate Partner Violence to Child Protection Agencies

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ABSTRACT Objectives: To examine nurse home visitors' perspectives of and intentions to report children's exposure to intimate partner violence (IPV) in the context of the home visitation setting. **Design and Sample:** Cross-sectional study of 532 nurse home visitors in the Nurse-Family Partnership home visitation program. **Measures:** A web-based questionnaire assessing nurse home visitors' support for and attitudes toward mandatory reporting of children's exposure to IPV. Nurses' considerations of what levels of exposure constitute maltreatment and their intended reporting behaviors were also examined. **Results:** Variability and uncertainty were observed in participants' attitudes as well as in their determinations as to which situations constitute child maltreatment. Most of the sample believed reporting exposure to IPV can help the battered woman (67%) and can protect children (92%), while 56% indicated that reporting can negatively affect the nurse-client relationship. Nurses were more likely to endorse reporting children's exposure to IPV when the child was at greatest risk for being physically injured as a result of IPV. **Conclusions:** Training about maltreatment reporting procedures in home visitation programs should focus on the interpretation of child maltreatment laws as well as collaborations with local child protection service agencies to determine if children's exposure to IPV is reportable.

Key words: child maltreatment, exposure to violence, home visitation, intimate partner violence, mandatory reporting, survey research.

Background

Nurses often deliver services to disadvantaged pregnant women and first-time mothers and their children through home visitation programs. Nurse home visitors are responsible for assessing and intervening with families, and provide support, information, and training about maternal and child health in an attempt to improve parenting practices

and prevent an array of developmental and societal issues, ranging from youth behavior problems to child maltreatment (Bilukha et al., 2005). Coupled with home visitors' supportive roles is a legal mandate to report instances of child maltreatment to child protection service (CPS) agencies. As health care professionals, nurses are trained to identify children who might be experiencing child abuse or

neglect, and local legislation dictates the appropriate reporting procedures for suspected instances of child maltreatment (Zink et al., 2005).

Several jurisdictions in Canada and Australia require cases of children exposed to intimate partner violence (IPV) between adults to be reported to CPS agencies. Although the United States has recently moved toward enacting similar legislation, current definitions of maltreatment vary widely between states, and very few states include language specific to children's exposure to IPV (Kantor & Little, 2003; Zink et al., 2004). However, the vague language used in many states' child maltreatment definitions could possibly extend to consequences of or situations involving children exposed to IPV (Mathews & Kenny, 2008). For example, most states consider psychological or emotional abuse of children to be a reportable offense, and it could be argued that exposing children to IPV is a form of such abuse.

Depending on how child maltreatment is defined and subsequently interpreted, equating children's exposure with maltreatment may require all suspected and verified instances of IPV in homes where children are present to be reported to CPS. Given that an estimated 10–20% of children are exposed to IPV annually in the United States (Wolak & Finkelhor, 1998) and anywhere from 25% to one third of children are exposed at some point during childhood (Carlson, 2000), expanding the definition of child maltreatment to include cases of children's exposure to IPV has significant implications for health care providers required to report, as well as CPS agencies that receive and respond to the reports (Edleson, 2004; Kantor & Little, 2003). In Canada in 2008, 34% of all substantiated CPS investigations included exposure to IPV as the primary category of maltreatment (Trocmé et al., 2010).

A growing body of research suggests that similar psychopathology manifests between children who have been exposed to IPV and those who have been victims of physical abuse (Osofsky, 1999). Just as children who have been victims of child maltreatment, children exposed to IPV between adults experience subsequent negative emotional, psychological, and physical health outcomes. For example, children exposed to IPV are at a significantly higher risk for developing aggressive behaviors and conduct disorder, and have been found to exhibit

higher rates of depression, anxiety, and low self-esteem than children not exposed to IPV (Sox, 2004). Moreover, children living in homes where IPV is perpetrated are at risk for being physically injured (Carlson, 2000; Christian, Seidl, & Pinto-Martin, 1997). Christian and colleagues (1997) reviewed 139 emergency department records of children with injuries as a result of IPV and found that children 2 years and under were often injured while in the arms of the abused parent and 39% of the children were injured while trying to intervene in the violent episode. Furthermore, childhood exposure to IPV is linked to negative health outcomes later in life, as children exposed to IPV are at greater risk for unintended pregnancy (Anda et al., 2001), sexually transmitted infections (Hillis et al., 2004), smoking (Anda et al., 1999), and suicide (Dube et al., 2001). Studies have also shown that sons who observe IPV between adults in childhood have an increased risk for perpetrating IPV in adulthood (Fantuzzo & Lindquist, 1989; Strauss & Gelles, 1990), with a recent study estimating an increased risk of 56–63%, depending on the severity of abuse witnessed during childhood (Roberts, Gilman, Fitzmaurice, Decker, & Koenen, 2010).

Even after taking into account the deleterious effects that exposure to IPV can potentially have on children, some experts have recommended against including exposure to IPV in child maltreatment definitions, calling reporting in these instances a "blunt" (Humphreys, 2008, p. 229) or "not appropriate" (Verhoek-Oftedahl & Devine, 2003, p. 379) response. This perspective is driven by the norm that many CPS agencies are usually overwhelmed, underfunded, and understaffed (Weithorn, 2001; Zink et al., 2004, 2005) and are therefore not equipped to handle the increase in number of children that would be reported if children's exposure would require a maltreatment report and subsequent investigation (see Edleson, Gassman-Pines, & Hill, 2006). Furthermore, not all children exposed to IPV experience subsequent negative effects; thus, in these cases, reporting exposure to IPV might be inappropriate, unnecessary, and potentially damaging to families (Christian, 2002).

Although only a few U.S. states explicitly define children's exposure to IPV as maltreatment, health care providers may believe that they have an obligation to report because involving CPS in instances of children's exposure to IPV depends on the local

interpretation of a state's child maltreatment statute (Zink et al., 2004, 2005). Uncertainty regarding providers' obligations to report children's exposure may emerge because the boundary between children's exposure to IPV and child maltreatment is often considered a gray area (Kantor & Little, 2003; Verhoek-Oftedahl & Devine, 2003) and no thresholds or criteria have been established to determine what types of exposure should constitute maltreatment (Edleson, 2004; Kantor & Little, 2003). This lack of clarity may result in serious ethical and legal implications for mandated reporters (Freed & Drake, 1999), yet little is known about how health care providers address reporting children's exposure to IPV.

Issues surrounding mandated reporting of children's exposure to IPV are especially pertinent to nurses working in home visitation settings. Nurses generally visit pregnant women or mothers with young children. Women enrolled in home visiting programs targeted to socially disadvantaged populations may also be at higher risk for exposure to IPV due to demographic factors, such as young age or being unmarried or separated (Coker, Smith, McKeown, & King, 2000). A study of mothers in one home visitation program revealed that 48% of the sample reported experiencing IPV since the birth of their child (Eckenrode et al., 2000)—a rate twice as high as in the general population (Tjaden & Thoennes, 2000). Furthermore, research has demonstrated that professionals involved in home visitation are significantly more likely to report incidents of maltreatment to CPS than those in clinical settings, resulting in a surveillance bias between home visited families where maltreatment is present and those families with maltreatment that do not receive home visitation services (Chaffin & Bard, 2006; Nygren, Nelson, & Klein, 2004; Olds, Henderson, Kitzman, & Cole, 1995).

As a result of working with women at significant risk for experiencing IPV who are pregnant or have young children, nurse home visitors may often be faced with the decision whether or not to report a child's exposure to IPV to CPS. The vague definitions of child maltreatment that currently exist in many U.S. states can further complicate the decision-making process, leaving nurses vulnerable to significant legal, practical, moral, and ethical consequences. For example, if a nurse files a report with CPS in a state where it is not legally justified, this

may not only harm her relationship with the client, but also inappropriately breaks confidentiality. However, if a nurse does not contact CPS after an instance of child maltreatment that is reportable, she may face legal ramifications for failure to report (Edleson et al., 2006).

Focus groups with nurse home visitors in a large home visitation program revealed that nurses were aware of their reporting duties when it came to abuse and neglect perpetrated against children; however, they expressed uncertainty about the circumstances under which more indirect forms of maltreatment, such as children's exposure to IPV should be reported (Davidov, Jack, Frost, & Coben, in press). As federal funding continues to promote the creation and expansion of evidence-based home visitation programs in the United States (U.S. Department of Health & Human Services, 2010), further research is needed to investigate the specific strategies that home visitation providers utilize to maintain trusting relationships with clients while simultaneously serving as mandated reporters of child maltreatment. To date, there is a paucity of research on mandated reporters' perspectives and practices regarding children's exposure to IPV and no quantitative studies have examined this issue within the framework of public health home visiting nurses. Therefore, the purpose of the current research was to examine home visiting nurses' attitudes toward and intentions to report children's exposure to IPV in the context of the home visitation setting.

Research Questions

This study was designed to address the following research questions: (1) Do nurse home visitors support mandatory reporting of children's exposure to IPV? (2) What are the attitudes of nurse home visitors regarding children's exposure to IPV? (3) Which levels of children's exposure to IPV do nurse home visitors believe constitute child maltreatment? and (4) What are nurse home visitors' intended reporting behaviors regarding children exposed to IPV?

Methods

Design and sample

The sample for the current study was recruited from the entire population of home visiting nurses

working in the Nurse-Family Partnership (NFP) program, the largest and most rigorously tested (Macmillan et al., 2009; Mercy & Saul, 2009) home visitation program in the United States (see Olds, 2006 for an overview). E-mails with information about the study and a link to a web-based questionnaire were sent to 1,119 nurse home visitors in the 32 states where the NFP is implemented. Of these, 1,093 reached valid e-mail addresses and 534 questionnaires were returned (response rate = 49%). Two returned questionnaires were not included in the analysis due to large amounts of missing data. This study was approved by our institution's IRB and the NFP Research and Publication Communication Committee.

Measures

The web-based questionnaire was pilot-tested for readability and clarity in a small sample of nurses and social workers working in a different home visitation program. The first section of the ques-

tionnaire focused on support for and attitudes toward reporting exposure to IPV. Nurses' support for mandated reporting of children's exposure to IPV was assessed by asking participants to respond to the statement, "I should be required to report instances of children's exposure to domestic violence" on a Likert scale ranging from 1 (*never*) to 5 (*always*). Nurses were then presented with 16 items assessing attitudes toward reporting exposure to IPV, which focused on the impact that reporting can have on abused women and their children, as well as on home visitors themselves. These items were adapted from questions used in previous studies of mandatory reporting of child abuse (Mathews et al., 2008; Steen, 2008) and IPV reporting (Gielen et al., 2000; Malecha et al., 2000; Sachs, Koziol-McLain, Glass, Webster, & Campbell, 2002). The wording of the attitude items and response choices can be found in Table 1. Because this population of nurses expressed less familiarity with the term "IPV" in a previous study, the term

TABLE 1. Nurse Home Visitors' Attitudes toward Mandatory Reporting of Children's Exposure to IPV (N = 532)

	Strongly agree or agree (%)	Strongly disagree or disagree (%)	Undecided (%)
Impact on abused women and children			
"I feel that the mandatory reporting of children's exposure to domestic violence ..."			
Can damage the relationship between nurse and client	56	25	19
Can disempower the battered woman	22	50	27
Can prevent battered women from seeking further help	30	44	26
Can further traumatize the child(ren)	26	54	21
Can protect the child(ren)	92	3	6
Can cause more disruption to the family	54	22	24
Can damage the battered woman's chances of custody	13	69	18
Would make it easier for battered women to get help	67	8	25
Would put women at greater risk for being abused or hurt	51	14	35
Would make it less likely that a client would tell me about the abuse	62	18	20
Would make my clients resent me for having to report	45	24	31
Would help my clients because they would like for someone else to report the abuse	45	12	42
Impact on nurse home visitor			
I lack faith in law enforcement to respond appropriately to reports of children's exposure to domestic violence.	28	44	28
I fear reprisals from reporting children's exposure to domestic violence.	10	26	64
I fear litigation and/or legal liability from reporting children's exposure to domestic violence.	8	20	72
Workload pressures are likely to deter me from reporting children's exposure to domestic violence.	2	6	92

Note. Percentages may not add to 100 due to rounding.

“domestic violence” was used throughout the questionnaire.

The second portion of the questionnaire consisted of four different scenarios that nurses might encounter during home visitation sessions, each involving a client who discloses IPV to her home visitor (see Appendix). The four scenarios describe IPV that has occurred between the client and her partner when (1) she is pregnant, (2) she is holding her child in her arms, (3) her child is in the other room and hears but does not visually witness the abuse, and (4) her child is not at home during the violent episode. After reading each scenario, participants were asked whether they believed that the scenario indicated child maltreatment and if they would report the case. Response choices for these questions were yes, no, or I don't know. For the first (abuse of a pregnant woman) and second (abuse of a woman with her child in her arms) scenarios, if participants indicated that they would report these cases they were subsequently directed to a question asking which agency they would report to, and were asked to choose from the following options: law enforcement, child protective services, adult protective services, supervisor, or other. For this question, participants could select all options that applied and could write in options if they selected “other”.

At the end of the questionnaire, nurses were asked to provide demographic information including age, number of years in nursing practice, number of years working in the NFP home visitation program, and number of children. Nurses were also asked to list the state in which they practiced home visitation.

Analytic strategy

Means and standard deviations were used to describe all demographic variables and frequencies and percentages were used to describe nurses' responses to each home visitation scenario. To determine the representativeness of our sample ($N = 532$), we obtained similar demographic information from the entire population of NFP nurses from the NFP National Service Office. *T*-tests were used to test for differences between our sample of home visiting nurses and the entire population of NFP nurses and statistical significance was set to $\alpha < .05$. These comparisons revealed no significant differences and thus data are not presented. All sub-

sequent analyses were conducted using STATA 10.0 software (StataCorp LP, College Station, TX, USA).

Results

Demographic characteristics

Currently, there are no male nurse home visitors working within the NFP program, and therefore our sample was comprised entirely of female participants. Their reported mean age was 44 years ($SD = 10.30$). They reported having an average of two children ($SD = 1.17$) and working in the NFP home visitation services for an average of 4 years ($SD = 3.13$) and in nursing practice for a mean of 18 years ($SD = 10.86$). Nurses participating in the study represented 30 of the 32 states where the NFP program is currently implemented.

Support for and attitudes toward mandatory reporting of children's exposure to IPV

Approximately 55% of the nurses indicated that they should “always” be required to report instances of children's exposure to IPV and 20% thought they should be required to report “often.” An additional 20% indicated that they should report “some of the time,” and almost 5% of the sample felt they should be required to report children's exposure to IPV “rarely” or “never.” Participants' attitudes toward mandated reporting of children's exposure to IPV are found in Table 1. Over half of the sample agreed or strongly agreed that reporting children's exposure to IPV can damage the relationship between the nurse and client and 62% felt that reporting can limit a woman's disclosure of abuse to her nurse. In comparison, two thirds of nurse home visitors identified that reporting children's exposure to IPV can make it easier for battered women to get help and the vast majority (92%) agreed or strongly agreed that reporting can protect children exposed to IPV. Furthermore, most nurses disagreed that reporting children's exposure to IPV can damage the battered woman's chances of custody or further traumatize the children. A substantial portion of participants were undecided about their attitudes toward reporting children's exposure to IPV. Additionally, 35% of nurses were undecided as to whether mandatory reporting of children's exposure to IPV could put women at greater risk for being abused or hurt.

TABLE 2. Nurse Home Visitors' Opinions of Whether Child's Exposure to IPV Indicates Child Maltreatment and Intended Reporting Behavior after Reading Four Scenarios (N = 532)

Questionnaire item	Scenario ^a			
	Client is pregnant n (%)	Child is in mother's arms n (%)	Child in other room n (%)	Child not at home n (%)
Scenario indicates child maltreatment ^b				
Yes	288 (54)	450 (85)	268 (50)	75 (14)
No	142 (27)	33 (6)	151 (28)	399 (75)
I don't know	102 (19)	34 (6)	113 (21)	58 (11)
Missing	0	15 (3)	0	0
Nurse would report case described in scenario ^c				
Yes	236 (44)	403 (76)	241 (45)	145 (27)
No	132 (25)	33 (6)	131 (25)	256 (48)
I don't know	153 (29)	82 (15)	144 (27)	108 (20)
Missing	11 (2)	14 (3)	16 (3)	23 (4)

Notes. Percentages may not add to 100 due to rounding.

^aSee Appendix for scenarios.

^bAfter reading each scenario, participants were asked, "In your opinion, do these incidents and facts indicate child maltreatment?"

^cAfter reading each scenario, participants were asked, "Would you report this case (i.e., to law enforcement, to child protective services)?"

Home visitation scenarios

Nurse home visitors' opinions about whether or not the cases described in the four scenarios were indicative of child maltreatment and their intended reporting behaviors after reading each scenario are shown in Table 2. The majority of the sample (85%) considered the abuse of a woman while her child was in her arms to be a form of child maltreatment and 76% would report this case. Only 6% of nurses responded that they would not consider this scenario to indicate child maltreatment or report this case. Approximately half of the sample considered the abuse of a woman who is pregnant and a child overhearing the abuse of their mother to be forms of child maltreatment and almost half of the sample indicated that they would report those cases. A smaller percentage of nurses (14%) considered abuse of a woman when her child was not in the home to be maltreatment, yet 27% of the sample indicated that they would report this case. Approximately 20% of participants were unsure if the abuse of a pregnant woman or a child overhearing but not witnessing IPV should constitute child maltreatment, and close to 30% did not know if they would report these cases.

Table 3 shows the agencies to which participants would report the abuse of a client when she

TABLE 3. Responses to Question "If Yes, to Whom?" After Nurse Home Visitors Endorsed Reporting the Cases Described in Scenarios 1 and 2

	Scenario	
	Client is pregnant ^a n (%)	Child in mother's arms ^b n (%)
Law enforcement	115 (49)	128 (32)
Child protective services	131 (56)	382 (95)
Adult protective services	48 (20)	44 (11)
Supervisor	211 (89)	340 (84)
Other	18 (8)	10 (2)

Notes. Totals equal more than 100% because participants were asked to select all that apply.

^aOf 236 participants who endorsed reporting the case described in the Scenario 1.

^bOf 403 participants who endorsed reporting the case described in the Scenario 2.

was pregnant and when she was holding her child. Of the 236 participants who endorsed reporting the abuse of a pregnant woman, 56% further indicated they would report to CPS. Approximately half would report to police, and 20% would report the case to adult protective services. Of the 403 nurses who indicated that they would report the case of abuse that occurred when the client's child was in

her arms, the vast majority (95%) would report to CPS, whereas almost one third would report to the police, and 11% would report to adult protective services. Most respondents that answered this question also indicated that they would report to their supervisor in the home visitation program. Additionally, participants that wrote in "other" answers specified they would report to the abused woman's health care provider, domestic violence shelters and hotlines, and state health department officials.

Discussion

The majority of our sample of nurse home visitors believed that they should report instances of children's exposure to IPV. Overall, nurse home visitors' attitudes and beliefs about the impacts of reporting were varied. Most participants agreed that reporting children's exposure to IPV can help abused women and protect children, but nurses also recognized that reporting may have negative consequences on home visitation practice (e.g., damaging the relationship between the nurse and client, limiting the client's disclosure of abuse to her nurse). Establishing and maintaining therapeutic relationships with clients is essential to promoting program engagement; yet nurse home visitors' roles as mandated reporters of child maltreatment can hinder the ability to gain trust when working with disadvantaged families (Marcellus, 2005). These issues have been reported in previous qualitative work with this population (e.g., Jack, DiCenso, & Lohfeld, 2005). Focus groups with NFP nurses revealed that nurses' reporting duties often result in a lack of trust from clients and can strain the nurse-client relationship either temporarily or permanently (Davidov et al., in press). Although the view of home visiting nurses as "health police" (p. 416) may be inherent to public health nursing practice, utilizing a framework of relational ethics, which focuses on creating an environment of freedom and choice, mutual respect, engaged interaction, and embodiment, can assist nurses in discussing reporting duties and responsibilities with families (Marcellus, 2005).

Nurse home visitors' opinions of whether the four different scenarios of children's exposure to IPV were indicative of child maltreatment appeared to depend on the proximity of the child to the violent episode. Most participants considered it to be

child maltreatment when abuse was perpetrated toward a mother while she was holding her child in her arms, yet only 14% of the sample considered it child maltreatment when the child was not in the home during the abuse of the mother. The percentage of nurses that would report the four scenarios also decreased the further the child was from the abuse in the scenario. The majority of participants indicated that they would report the scenario where the child was being held during the violent episode, suggesting that nurses may be more likely to report cases of children's exposure to IPV when the child is at risk of physical harm.

These findings are similar to the results from a study of physician management of children's exposure to IPV that found that physicians are more likely to report to CPS when children visually witness the IPV as opposed to only hearing the abuse (Zink et al., 2005). The results of the current study indicate that 45% of nurse home visitors would also report a child who overhears the violence between adults; however, we do not have data on which agency nurses think should receive the report.

Even though very few states explicitly include children's exposure to IPV in their definition of child maltreatment (Mathews & Kenny, 2008), many nurses indicated that they would report children's exposure to CPS. One explanation for this finding is that nurses may judge children's exposure to IPV to constitute emotional or psychological harm, which is considered to be a reportable offense in most states. Similarly, many states' child maltreatment statutes include language such as "substantial risk of harm" or "imminent danger" in their definitions of child maltreatment (Zink et al., 2004, p. 451) and it is possible that our sample of nurses consider abuse of a mother when her child is in her arms to pose a substantial risk to the child for being physically injured, as over 90% of those participants that would report this case indicated that they would report to CPS. A review of emergency department records by Christian et al. (1997) provides support for this line of reasoning, as the authors found that children under 2 years of age were often physically injured while in the arms of the abused parent. Furthermore, for this scenario as well as the other three situations, participants that indicated they would report may have been referencing the fact that they would report to their supervisors as part of the protocol within the home

visitation program. However, focus groups with this population have suggested that home visiting nurses are under the impression that children's exposure to IPV required a report to both their supervisor and CPS (Davidov et al., in press).

Another important outcome of the current study was that almost half of the sample indicated that they would report the abuse of a pregnant woman, and over half of these participants stated that they would report to CPS, indicating that they consider abuse of a pregnant woman to be child maltreatment. Our previous research with community stakeholders, many of whom were CPS case workers, revealed that most CPS agencies require that a child be born before maltreatment can be reported to the agency. The issue of CPS reporting when an abused woman is pregnant also emerged in previous qualitative work with NFP home visiting nurses, as they highlighted the uncertainty that they face with regard to their reporting duties when a client is pregnant as well as when her child is exposed to IPV after birth. The current findings also reveal this indecision, as a substantial proportion of nurses did not know whether the different levels of children's exposure to IPV indicated child maltreatment and if they would report the cases.

Implications for nursing practice

Given that the prevention of child maltreatment and early assessment and intervention for women with children exposed to IPV have been identified as public health priorities (Whitaker, Lutzker, & Shelley, 2005), the views of nurses working within home visiting programs are especially informative. The fundamental problem confirmed by the current research is the substantial variability in whether or not nurses would report children's exposure to IPV, most likely stemming from uncertainty about reporting duties. This variability can be addressed through professional development and nurse education for home visitation providers, including collaborations and consultations with CPS agencies about how to accurately interpret local legislation. In addition, the findings from this study suggest that nurse home visitors may be well positioned to consult on changes and improvements to existing CPS programs and policies for women and children exposed to IPV that also allow for the maintenance of established therapeutic alliances. There is a need

for collaboration between CPS and home visitation programs to evaluate the safety of children and risk for harm in homes where violence is ongoing. Nurse home visitors should also be trained to assess for and evaluate outcomes related to children's exposure to IPV. If reporting is necessary, it is recommended that nurses contact CPS after first discussing their intentions to make the report with the family, or by allowing a family member to make the report in the presence of the nurse, if circumstances permit. This approach may help maintain the trust between nurse and client and prepare the family for a potential CPS investigation (Laughon, Amar, Sheridan, & Anderson, 2011).

Implications for nursing education

The findings of the current study highlight nurse home visitors' responsibilities to be well informed of child maltreatment legislation at the state level, to understand interpretations of the law and to be familiar with local reporting practice within the home visitation setting. Ongoing education to about the types of child maltreatment, with an emphasis on understanding the impact of exposure to IPV on child health, behavior, and development is paramount. Nurse home visitors should be given opportunities to improve their assessment skills to be able to identify children at risk for or experiencing emotional and physical harm as a result of IPV occurring in the home.

Implications for nursing research

Although the NFP is a large home visitation program that exists in many U.S. states, the perspectives of providers in other home visiting programs should be examined to determine if the same variability and uncertainty regarding reporting children's exposure to IPV is present. In addition, future research on home visitors' actual experiences with and responses to disclosures of children's exposure to IPV is warranted in the U.S., as national rates of child maltreatment allegations that include children's exposure to IPV are still unknown (Kantor & Little, 2003).

The data in the current study reflect intended reporting behavior and not actual rates of reporting children's exposure to IPV. In a study of child maltreatment reporting patterns in Canada, where children's exposure to IPV is reportable to CPS in most jurisdictions, investigators found that health care

professionals rarely report instances of children's exposure to IPV and that exposure to IPV is reported significantly less than other types of maltreatment (Tonmyr, Li, Williams, Scott, & Jack, 2010). In addition, we did not include a scenario where a child visually witnesses the incident, but is not being held (as described in Zink et al., 2005) and the perspectives of our sample with regard to this type of scenario would have been useful. Lastly, the current study focuses on home visitors' intentions to report children's exposure to *physical* IPV between adults. Research has demonstrated significant associations between psychological and emotional IPV and long-term negative consequences to women's physical and psychological health (Coker, Smith, Bethea, King, & McKeown, 2000). However, this study does not shed light on nurse home visitors' intended reporting behaviors regarding children's exposure to emotional IPV between adults.

The results of the current study quantify themes that emerged in previous qualitative work with this population (Davidov et al., in press); most notably, that this sample of home visitors exhibits variability and uncertainty with regard to their attitudes about reporting children's exposure to IPV as well as which situations they believe constitute child maltreatment and require a report to CPS agencies. These findings are not unexpected, as research has not yet determined an objective threshold for the severity of exposure to IPV needed for intervention (Edleson, 2004; Kantor & Little, 2003). Even so, it is important that health care providers in home visitation programs are informed of not only of their states' child maltreatment statutes, but also of the ways in which the language of the statute is interpreted under the law as well as within CPS agencies. We recommend that home visitation programs collaborate with legal agencies and local CPS agencies in order to establish which circumstances are reportable to CPS and which types of exposure to IPV are not appropriate for referrals. As nurse home visitors are dually responsible for reporting of child maltreatment and maintaining trusting, therapeutic relationships with their clients, training about reporting duties, support groups, and consultation for professionals mandated to report in order to manage the complexities inherent to home visitation practice with disadvantaged families is recommended (Marcellus, 2005).

In addition, although children exposed to IPV are encountered in a wide variety of health care settings, there is a great deal of untapped potential in examining the public health nurse home visitor's role in responding and intervening with women and children exposed to IPV. Carlson (2000) asserts that education on effective parenting can benefit mothers of children exposed to IPV, and as home visitors are already providing this type of information to clients, they have a unique opportunity to dialog with clients and provide education about the effects of exposure to IPV. Public health nurses working in home visitation settings are also appropriate individuals to help link abused women and their children with CPS agencies, local domestic violence service centers, and mental health services.

Appendix: Home Visitation Scenarios

Scenario #1: You walk into your client's apartment for a home visit and notice that she has a black eye and bruises on her arms. She is 28 weeks pregnant. You talk with your client about how she got the injuries. Your client tells you that she is used to her boyfriend pushing and shoving her, but he has become much more physically violent since the pregnancy. Your client assures you that the situation is "not that bad" and that her boyfriend promised never to hurt her again. She has not revealed to you that her boyfriend was physically abusive prior to this home visit.

Scenario #2: You walk into your client's apartment for a home visit and notice that she has a black eye and bruises on her arms. Her daughter is 6 months old. You talk with your client about how she got the injuries. Your client tells you that she is used to her boyfriend pushing and shoving her, but he has become much more physically violent since the birth of their daughter. You talk with your client to get details of the incident and learn that the child was in the mother's arms during the violent episode. Your client assures you that her boyfriend has never been physically violent toward her in front of their daughter until now and has never hurt their daughter. She tells you that the situation is "not that bad" and that her boyfriend promised never to hurt her again. She has not revealed to you that her boyfriend was physically abusive prior to this home visit.

Scenario #3: Now imagine a scenario identical to Scenario #2, except when you talk with your client to get details of the incident you learn that the child was in the next room during the violent episode. Your client assures you that her son only heard the incident, but did not witness the violence.

Scenario #4: In another situation identical to Scenario #2, imagine when you ask your client for details of the violent episode, she tells you the child was at his grandmother's house.

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