Dear Reviewer,

Thank you for reviewing our paper. Please find our responses to your review below. We have included your review and our comments are in red.

This is, in summary, an interesting review manuscript aimed to investigate how ongoing exposure to family violence significantly enhances the development of psychiatric disorders among children. Specifically, this paper provides a general commentary on the misalignment between current knowledge regarding early brain development and the application of this knowledge in key mental health diagnostic texts in determining, or failing to determine, responses to children impacted by familial violence.

The authors may find my main comments/suggestions as follows.

First, when throughout the Introduction section the authors referred to family violence on infants, children and adolescents, they correctly reported that there are many terms to define this complex phenomenon. However, although the difficulties in universally defining the occurrence of this condition, the family violence against infants, children and adolescents needs to be distinguished in terms of risk and precipitating factors, family background and temperamental/personality traits, given the great heterogeneity of this phenomenon on the different ages.

This has been added:

Lines 78 – 82 - Explanations for what causes violence within families remains complex, with societal attitudes, gender and cultural inequalities, economic pressures and intergenerational transmission of interpersonal violence often cited as significant contributors [10, 13, 27, 28]. Homelessness, alcohol and substance abuse issues, as well as mental health difficulties are also identified as serious risk factors associated with the prevalence of family violence [10, 27, 29-34].

Lines 149-154 - Thus, exposure to violence from birth impacts the developing regulatory capacities of the infant, with increasing socioemotional difficulties being displayed by 12 months [91]. Children up to the age of 8 years have been found to have lower cognitive scores than their peers who were not exposed to family violence [40]. In particular, internalising and externalising difficulties become more apparent for children as they approach school age and beyond, evidenced through anxious, avoidant and/or disruptive behaviours [42, 92].
Thus, I suggest to add more information to this regard in order to provide a comprehensive overview of this complex condition for the general readership. In addition, whether children under five are more likely than older children to be exposed to trauma needs to be further clarified.

**This has been added:**

Lines 98 to 102 – This is because younger children, and infants in particular, are more likely to be in the immediate care of, or in close proximity to their mothers during violent episodes perpetrated by partners [136]. The younger the child the less capacity they have to protect themselves, flee the violence or be in other environments such as school, after school care etc.

More ahead, the authors referred to altered child developing and insecure attachment; however, more details are requested to this regard.

**This has been added:**

Lines 128-130 “reported significantly higher trauma symptoms and lower prenatal attachment than those who reported no history of interpersonal trauma” [p. 46].

Lines 133 – 140 - Exposure to family violence creates relational ruptures which can interrupt the healthy formation of safe and reliable bonds between children and their parent/s [78, 79]. This impacts subsequent social relationships, and produces adult attachment behaviours including an oversensitivity to rejection, avoidant and ambivalent patterns of relating and increased risk of replicating violence in intimate relationships [82-84]. Attachment theory pioneer John Bowlby considered family violence a disorder of attachment [85]. He believed enormous psychological damage was done to the child and the family system, and was puzzled as to why “family violence as a causal factor in psychiatry should have been so neglected” [p. 9].

Importantly, when the authors referred to the science of brain development, they correctly reported that research into the impacts of trauma on the developing brain has been significant in the last years. However, they could also, in my opinion, refer to the relevance of hypothalamic-pituitary-adrenal (HPA) dysfunctions throughout the brain development. Recent evidence documented that HPA axis dysfunctions are involved in the pathophysiology of many diseases, in particular neuropsychiatric conditions. Neuropsychiatric conditions and, in particular, mood disturbances may be associated with various HPA axis activity abnormalities, with important pathophysiological implications. Targeting HPA axis dysfunctions might be a novel strategy to improve the outcomes of these conditions. In order to comprehensively
address this topic, I suggest to cite and discuss the recent systematic review/metanalysis of Belvederi Murri and colleagues which was published on Psychoneuro-endocrinology in 2016.

It is not the purpose of this article to target treatment responses specifically, but rather to set the starting point as the need to first acknowledge that family violence happens, and impacts mental health. However, the following has been added:

Lines 164-168. Further, crucial to healthy infant development is the regulatory role played by the hypothalamic-pituitary-adrenal (HPA) axis and the associated neuroendocrine responses to stress [105]. Disturbances in the functioning of the HPA axis have been found to have particular implications for the development of neuropsychiatric conditions [106].

In addition, there are some statements throughout the Discussion section such as: “there is no recognition that violence within families impacts all members of that family, no matter their age” or “there is the need to take action/intervene on the safety needs of the children of adults with mental health disorders who are victims and/or perpetrators of family violence, thus avoiding any action to ensure their safety as well as assess their needs for treatment” that need to be further specified and more adequately supported by adequate references.

Line 393-397 additional references added.

According to the authors’ expertise, what are the main recipients of violence among the family members?

As discussed earlier (introduction) women and children are identified as main victims of family violence

Which type of interventions may be planned to ensure safety and avoid unmet needs in victims and/or perpetrators of family violence?

This has been added:

Lines 484 – 499. Community, community health and justice based services have led the way in developing specific treatment responses for children and women impacted by family violence [41, 155, 170-175]. Similarly, community based men’s behaviour treatment programs, developed to address men’s violence, have existed for decades [176-180]. Interventions focusing on reparative work with children and their fathers after family violence is relatively newer territory [158, 181] as is any concentrated treatment approach for women who perpetrate violence within intimate relationships, or support programs for men who are victims of family violence [21, 22, 136, 182-184]. Considerably fewer treatment programs to address the impacts of family violence have been developed within CAMHS settings, or within mental
health generally, but where they have, there is a strong focus on infants [151, 156-158, 162, 185, 186]. Community based approaches to working with family violence have tended to eschew a recognition of mental health issues or approaches [166, 178, 187]. Given the high correlation between mental health issues and family violence, there would be much to be gained by bringing these differing services together (including the judicial system) to build new, stronger and more efficacious treatment responses to family violence.

Moreover, the three Tables reported throughout the main text are useful and enhance the internal coherence of the paper but, unfortunately, they are too long and need to be reduced in length. I suggest to generally summarize their main contents.

The tables were reduced prior to submission of the article and we are concerned that further summarising of the table will reduce the integrity and transparency of the information provided. However we acknowledge they are not ideal in their current format. When we pasted the tables into the manuscript template we had a lot of trouble with the formatting and despite numerous attempts by two of the authors we were not able to get them looking as good as we would have liked. This can be seen by the remaining problems with the column width (it is not consistent and it is not wide enough to include all the text of words in one line at times eg “trauma/tic” has the “c” on a separate line”. We had also initially thought the tables could be landscape orientation so that the first and final column can be wider and can accommodate the additional text. But we are not sure if that is possible. We also note that Table 3 has the text centered and the text from the other two tables is justified and the text under the table does not seem to be grouped well with the table (it seems to be double spaced and go into the text of the paragraph below). It would be great if we can liaise with the editorial team about what is possible with the formatting of the tables.

Importantly, the authors should insert the most relevant shortcomings/limitations of the present manuscript as they are completely missing in the current version of the paper. This would guarantee a more critical paper for the general readership.

This has been added:

Lines – 500 -515 -  It is impossible to capture every conceivable relational stressor that may contribute to mental health difficulties in infancy, childhood, adolescence and beyond. There are other, high prevalence and significant stressors where it could equally be argued greater recognition and acknowledgement is needed within the pages of the DSM-5 and ICD-10. It cannot be definitively argued that family violence has more impact necessarily than another stressor such as early neglect, and/or sexual abuse, both of which carry monumentally damaging risk factors [188-193]. The high correlation between one form of adversity and others (for example child abuse, homelessness etc., and family violence) also adds additional
complexities not covered in this paper [44, 99, 194]. The sheer size of these classification manuals, the diversity of issues needing to be covered and the complexities in the uniformity of definitions leaves it open to criticism's such as have been covered in this paper [9, 167, 169]. Furthermore, it needs to be noted that the sheer work involved in tabulating the results of the vast number of working groups that contribute to each diagnosis and the lengthy time line between the publication of each version of the DSM hinders its ability to quickly incorporate new research methods such as has “emerged through remarkable advances in new technologies and substantive knowledge in neuroscience” [188].(p. 28).

Kind regards,

Dr Wendy Bunston, Dr Candice Franich-Ray, Ms Sara Tatlow