ABSTRACT

Millions of parents, most of them mothers, are abused by an intimate partner each year in the United States. Intimate partner violence is all too common in homes with children; it’s estimated that 15 million children are exposed each year. The short- and long-term impacts to child health and well-being are profound. Pediatric clinical practice represents an underutilized venue for assessment and intervention in the abuse of parents. This article summarizes the basic elements of an approach in practice. [Pediatr Ann. 2017;46(12):e438-e440.]

Intimate partner violence (IPV), also known as domestic violence, is defined as any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors. IPV is a common occurrence, as more than 27% of women and 11% of men have experienced sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime and experienced an IPV-related health impact as a result. It is estimated that 15 million children in the United States are exposed to IPV each year, which equals approximately 25% of all homes with children. Such exposure results in a variety of negative physical, mental, and emotional impacts both acutely and across the lifespan and detrimentally affects wellness and success. A rapidly growing body of literature describes the mechanisms by which adverse childhood experiences such as IPV exposure result in poor health, and makes imperative the need to address such experiences to enable children to achieve good health and reach their full potential. Co-occurrence of IPV and child maltreatment is high with estimates for the overlap between 30% and 60%. Given the prevalence of childhood exposure and the long-term impacts on the health and well-being of children, it is quite obvious why IPV has been indicated as a pediatric problem.

APPROACH TO IPV IN CHILD HEALTH CARE SETTINGS

The American Academy of Pediatrics (AAP), as well as other professional bodies have strongly recommended addressing IPV in child health care settings. In the AAP policy report of 2010 several areas of pediatric involvement in IPV are encouraged, including assessment and intervention. Approaching IPV in child health care settings can be challenging as the guardian/parent is the primary target of the assessment, not the child patient. There are several specific areas that have been the source of much discussion. An overarching challenge is that many child health care providers are uncomfortable addressing the topic in clinical practice and name a variety of challenges including limited time, lack of education/experience with IPV, and lack of access to resources in the event of a disclosure. Fear of offending the caregiver is another well-documented barrier; however, evidence suggests that parents are welcoming of such assessments and service delivery in a variety of child health care settings including the emergency department and well-child visits.

ASSESSMENT

Screening for caregiver/parent IPV in clinical practice has been approached in one of two ways: (1) universal assessment involves asking all adult care providers and (2) targeted case finding involves only asking those
who have specific risk factors or signs of abuse (i.e., physical injury, anxiety, or depression). The major weakness of targeted screening is that many people who are victims will not be identified, as the most common presentation of IPV is lack of any specific indicators.13 Perhaps ideally, assessment for IPV in the home should be thought of as a routine assessment (not “screening”) of behavioral and emotional health within the well-child visit.14 This approach is similar to how assessing for other family stresses such as unemployment, divorce, or parent death would be approached.

The best way to ask about IPV in child health care settings has not been settled, but several caveats are important. It is essential to use a framing statement that gives an indication of why the inquiry is being made. This can include statements of how common IPV is and how children are affected. For instance: “Violence in the home is common and can affect children’s physical and emotional health. That’s why I have begun asking all my families about it.”

There are few studies regarding approaches to IPV in pediatric settings; however, one study found that in an acute care setting, a general approach was more acceptable11 even though specific behaviorally oriented questions are more effective in adult health care settings.15 Examples of screening questions can include: “Are you worried about your safety in your home?” (more general) or “Do you ever feel afraid of your partner?” (more specific).

It is also important to consider the presence of either the abusive partner and/or the child in the room. If children who are verbal (older than age 3 years generally) are present, there is a risk of the child relaying a positive answer; thus, increasing the risk for abuse. On the other hand, the child may witness the parent lying, which reinforces the keeping violence a secret. If possible in the clinical setting, approaching the parent separate from the child using a self-administered written assessment or computer-assisted technology may be the best choice.16 Further conversations after a disclosure should occur in private without the child.

**Response to a Positive Assessment**

It often takes several attempts before a person discloses that they are being affected by IPV; that reluctance is often because the victim is fearful that disclosure will heighten danger within the abusive relationship. Therefore, it is essential to have a plan in the event of an IPV disclosure. There are three essential elements of a response in pediatric health care settings:

1. Give support and validation. Disclosure takes courage. This can include simple statements such as “I’m glad you told me.” “No one deserves to be treated this way.” “It is not your fault.”

2. Perform a child safety assessment. The pediatrician should ensure the safety of the child. This includes a through physical examination for signs of abuse or neglect; assessment of direct threats to the child by the abusing partner and parent ability to keep the child safe when things escalate (e.g., sending child to a neighbor’s house or calling a family member to take child). If any aspect of this assessment is concerning for direct abuse or threat of abuse, child protective services should be notified and a safety plan initiated (see section on reporting below).

3. Connect to IPV advocacy services. The pediatrician should have procedures built in place to connect families with local IPV services, which are typically provided by local domestic violence agencies or shelters. Providers should familiarize themselves with local IPV advocacy services and how best to access them. A “warm” handoff is considered better than simply providing the parent with a phone number. This means having the abused parent call the IPV service agency directly from the office. Most of these agencies understand the need for immediate response and are willing to arrange quick follow-ups including the possibility of an advocate meeting the parent and child in the office or nearby location. Such organizations can arrange immediate shelter placement, provide legal or emotional consolation, or help arrange an order of protection. They will also perform a lethality assessment, which gauges risk of death based on occurrence of certain types of abuse/threats such as those involving firearms or strangulation.17 Local law enforcement agencies are sometimes trained in lethality assessments as well. Additionally, clinicians should be mindful about providing information via printed materials that can be discovered by the abusing partner, which could trigger violence escalation.

**REPORTING TO CHILD PROTECTIVE SERVICES**

The legal mandate to report suspicion of physical child maltreatment to local child protection authorities is understood by most pediatricians. Less clear are issues of emotional abuse and exposure to IPV. State laws vary on whether exposure to IPV is part of the mandated reporter obligation so it is important for providers to be familiar with these laws. As stated above, when there is concern that the child has been directly maltreated, or is in imminent danger or not safe in
the home a report to child protective services is indicated. In the case of IPV exposure it can be helpful to have the parent who is being abused make the report. This is important as the parent who is being abused may be thought of as “failing to protect” the child if she or he does not leave the relationship. In states where providers are mandated to report situations of child exposure to IPV the parent who is being abused should be immediately informed.

**DOCUMENTATION**

IPV exposure documentation in the child’s chart presents legal and ethical challenges. There is no right way to do this and approaches should be crafted according to the context of practice. It should be remembered that both parents and legal guardians have access to the child’s chart. If the abusing parent becomes aware that disclosure was made to the child’s provider, the risk of violence can increase. On the other hand, documentation can be beneficial with regard to continuity of care or legally beneficial to the parent who is being abused in custody situations. An option many have adopted is a coded approach, which uses acronyms not immediately understandable to others but that relay the information to the care team.13

**CONCLUSION**

As a first step, reaching out to local IPV services organizations can reveal a wealth of services available to pediatricians. Collaboration with such organizations can open a variety of helpful services to those affected by IPV. It is known that abused women are more likely to seek care for their children and not themselves, thus assessing parents in child health care settings presents a vital opportunity.18 Beginning universal assessment may seem like a daunting experience; however, a way to ease into it may include making posters and pocket cards with information about IPV and connected resources available in the clinical setting. For a list of IPV resources, see Table 1.

**REFERENCES**


**TABLE 1. Intimate Partner Violence Resources**

| • National Domestic Violence Hotline (www.thehotline.org; 1-800-799-7233) |
| • Futures Without Violence (www.futureswithoutviolence.org/) |
| • Centers for Disease Control and Prevention (https://www.cdc.gov/violenceprevention/intimatepartnerviolence/resources.html) |