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Intimate Partner Violence: The Role of the Pediatrician

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Clinical Report—Intimate Partner Violence: The Role of the Pediatrician

abstract

The American Academy of Pediatrics and its members recognize the importance of improving the physician's ability to recognize intimate partner violence (IPV) and understand its effects on child health and development and its role in the continuum of family violence. Pediatricians are in a unique position to identify abused caregivers in pediatric settings and to evaluate and treat children raised in homes in which IPV may occur. Children exposed to IPV are at increased risk of being abused and neglected and are more likely to develop adverse health, behavioral, psychological, and social disorders later in life. Identifying IPV, therefore, may be one of the most effective means of preventing child abuse and identifying caregivers and children who may be in need of treatment and/or therapy. Pediatricians should be aware of the profound effects of exposure to IPV on children. *Pediatrics* 2010;125:1094–1100

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KEY WORDS

domestic violence, intimate partner violence, family violence, child abuse, screening

ABBREVIATIONS

IPV—intimate partner violence

AAP—American Academy of Pediatrics

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The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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INTIMATE PARTNER VIOLENCE: DEFINITION AND EPIDEMIOLOGY

The Centers for Disease Control and Prevention defines intimate partner violence (IPV) as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation.[1] These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim. Traditionally, research has focused on the subset of IPV that is partner violence against women. It has long been recognized, however, that partner violence against men is a substantial concern as well.[2] IPV occurs in heterosexual relationships and although the research is limited, it is also known to occur in lesbian, gay, bisexual, and transgender relationships.[3]

Patterns of dating violence behavior often start early. Adolescents have a particularly high risk of IPV. Approximately 1 in 5 female high school students report being physically and/or sexually abused by a dating partner.[4] A study of college students revealed that nearly half of them had been the victim of emotional, sexual, and/or physical violence by a partner.[5] Females 16 to 24 years of age are more vulnerable to IPV than any other age group.[3] Given the complexities and unique dynamics in the teenaged population, further discussion of IPV in adolescent relationships is beyond the scope of this report. Information on adolescent dating violence is available from the Centers for Disease Control and Prevention.[6]

It is estimated that approximately 1.5 million women and 830 000 men are physically or sexually assaulted by an intimate partner annually in

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the United States.[7] Many of these victims are victimized more than once, which raises estimates of event incidence to approximately 4.8 million women and 2.9 million men assaulted annually in the United States. When considering additional and more common forms of IPV, such as emotional and psychological abuse, it is believed that 1 in 3 women worldwide will be abused in her lifetime.[8] In 2004, IPV resulted in 1544 deaths in the United States; 75% of the victims were women.[9]

IPV AND THE CHILD

As children develop and grow in a home in which they are exposed to IPV, they face not only the risk of becoming involved in an abusive act but also the risk of significant psychosocial trauma from exposure to abusive events. Each of these risks will be considered separately.

The Child as a Victim of Abuse

Children can become the victims of IPV-related abuse even before birth. Pregnancy may increase a woman's risk of being abused, and it is estimated that 3% to 19% of pregnant women are the victims of IPV.[10] Abuse during pregnancy has been associated with several poor health outcomes for the infant, including preterm labor,[11] low birth weight,[11] intracranial injury,[12] and neonatal death.[13] Rivara et al[14] reported increased health care utilization and costs for children whose mothers have experienced IPV, even when the violence stops before the infant's birth.

The co-occurrence of child abuse and IPV is well documented, and study results have indicated that in 30% to 60% of families in which either child maltreatment or IPV is occurring, the other form of violence also is being perpetrated.[15] One study revealed that if IPV was occurring in the home during the first 6 months of child-rearing, physical child abuse was 3.4 times more likely, and child psychological abuse or child neglect was twice as likely up to the child's fifth year.[16] In many of the studies that examined the co-occurrence of child abuse and IPV, child maltreatment was preceded by IPV. IPV has been called the leading precursor of child maltreatment. Identifying and intervening on behalf of a caregiver who is experiencing IPV, therefore, may be an effective means of preventing child abuse and neglect.[14]

It is also important to remember that children may become the collateral victims of IPV. A child may become the victim of abuse by simply being held in a caregiver's arms while he or she is battered. Older children may be harmed while mediating a crisis or defending the abused caregiver.[17]

The Child Exposed to Abuse

Exposure in the home to IPV as a child is associated with a multitude of behavioral and mental health consequences. It is estimated that millions of children are exposed to IPV each year,[18] and pediatricians should be aware of the profound effects on children who are exposed to such violence.[19,20] A clinical report from the American Academy of Pediatrics (AAP) provides guidance to the clinician on understanding the behavioral and emotional consequences of child maltreatment, including exposure to IPV.[21]

Perhaps the most compelling data to detail the impairment associated with exposure to IPV has come from the Adverse Childhood Experiences study. The original study assessed the effects of abuse and household dysfunction during childhood on long-term health and quality-of-life outcomes.[22] A subanalysis of these data by Dube et al[23] demonstrated that adults who were exposed to IPV as children were 6 times more likely to be emotionally abused, 4.8 times more likely to be physically abused, and 2.6 times more likely to be sexually abused than children who were not exposed to IPV. The behavioral effects of exposure to IPV can be long-reaching, and the medical effects can be profound. Exposure to IPV, along with other adverse childhood experiences, has been shown to be associated significantly with many risk factors for the leading causes of death in adulthood, including smoking, severe obesity, physical inactivity, depression, and suicide attempts.[24]

Children of abused caregivers demonstrate significantly more internalizing behaviors, including anxiety, depression, withdrawal, and somatic complaints, as well as externalizing behaviors, including attention problems, aggressive behavior, and rule-breaking actions, than do children of nonabused caregivers.[24,25] These children frequently have social functioning difficulties and trouble establishing and maintaining relationships with their peers. They may be more likely to be aggressive with peers and demonstrate cruelty, bullying, and meanness to others.[26] Academic performance may be poor. As adolescents, they may adopt the same dynamic of violence in their own dating or peer relationships. Stress and anxiety can persist long after the trauma of IPV exposure, and many children exhibit symptoms consistent with posttraumatic stress disorder. Ultimately, some of these children become abusers themselves.[27]

Given the significant overlap between IPV and child maltreatment, practitioners may wonder when a report to child protective services is appropriate. Individual states have differing requirements for reporting concerns of children exposed to IPV on the basis of age of the child, relationship of the child to the perpetrator of the violence, and physical proximity of the child to

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the violent act. When a report is mandated, the practitioner should inform the caregiver of the practitioner's responsibility to report. In many situations, it is helpful for the caregiver to file a report as well; doing so may lessen later accusations of "failure to protect." When making this decision, as every decision relevant to IPV situations, the safety needs of both the caregiver and the child should be taken into consideration. The Family Violence Prevention Fund offers recommendations for pediatricians in states without specific reporting requirements for children exposed to IPV.[28] These requirements include an inquiry about direct injury to the child, an assessment of potential for danger (threats, weapons, substance abuse), an assessment of the caregiver's ability to plan for the child's safety, and an assessment of support and connections to community resources.

ASSESSMENT FOR IPV

It is clear that IPV is a pediatric issue. Plans for identification and resources to incorporate into a response are important considerations for the pediatrician.

Whom to Ask?

Assessment for IPV may be approached in a universal or "case-finding" manner. There is insufficient evidence at this time to support one approach over another. Some experts advocate a case-finding approach to IPV detection. Using this approach, only caregivers with specific signs, symptoms, or risk indicators for abuse are asked about exposure to IPV. Pediatricians need to be aware that most abused caregivers will seek care for their children but not for themselves, which makes the pediatric setting an ideal place to be alert to the presence of IPV.[29] Although a caregiver may present with overt signs of injury, such as facial bruising, it is much more likely that the signs of abuse will be subtle—depression, anxiety, failure to keep medical appointments, reluctance to answer questions about discipline in the home, or frequent office visits for complaints not borne out by the medical evaluation of the child. In fact, most of the time, indicators of abuse are absent altogether.

Because of this situation, some experts advocate "universal screening"—asking all caregivers about IPV regardless of clinical indicators. Assessing for IPV at every patient encounter in the pediatric setting has been demonstrated to significantly increase the number of victims who are identified.[30,31] It remains unknown whether there are potential benefits and risks of conducting assessments on a universal basis. The US Preventive Services Task Force found that, although screening increases identification of abuse, there is insufficient evidence to recommend for or against universal IPV assessments because no evidence exists that universal IPV assessments reduce morbidity or mortality of the abused caregiver.[32] Future research is necessary to explore effective interventions for IPV and to determine potential harms and benefits of universal IPV assessments. While these studies are being performed, it seems reasonable to incorporate early and repeated questioning regarding IPV as part of anticipatory guidance while remaining mindful of clinical presentations that suggest risk.

How to Ask?

Approaching the subject of IPV may be uncomfortable for both the pediatrician and the caregiver. Many studies have examined the barriers that pediatricians and caregivers face during an assessment for IPV. Common barriers that pediatricians experience include limited time, lack of education/experience with IPV, absence of resources to assist caregivers who have experienced IPV, and a fear of offending or angering the caregiver.[33] Caregivers may have attitudes and beliefs that make them reluctant to disclose IPV, including shame, fear that disclosure will escalate the abuse, or a desire to protect the abuser.[34] Other barriers that inhibit disclosure include the fear that a disclosure will result in a report to child protective services, a perceived lack of provider empathy, or the concern that a child's health care needs are the priority over those of the caregiver.[35] Intrinsic characteristics of the provider/caregiver dynamic, including race and gender, may negatively influence a caregiver's comfort level when being assessed for IPV.[36] Pediatricians should be aware of these barriers and how they may influence the process of conducting IPV assessments.

Two primary approaches to conducting assessments for IPV have been identified: verbally administered assessments and self-administered assessments, including written, computerized, and tape-recorded surveys.[37] Most literature suggests that verbally administered assessments (face-to-face interviews) are associated not only with lower detection rates[38–40] but also, as some have reported, less patient comfort.[41] Studies that directly compared verbal and self-administered assessments revealed that women significantly preferred self-administered assessments.[42,43] Not only are self-administered assessments preferred, but they may overcome many of the barriers described previously. It is imperative that verbal follow-up is provided if a patient discloses abuse on a self-administered assessment. It is likely that there is not a "1-size-fits-all" screening method. The type of assessment used will depend on many factors, such as type of clinical environment, resources avail-

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able, and acceptability to practitioners and parents/caregivers. Several simple screening tools exist, many of which have been well validated and can be incorporated easily into a pediatric setting.[44–46]

If IPV is detected, or if the pediatrician has concerns that IPV may be occurring in the home, further questioning is warranted. The pediatrician should explore the topic with the caregiver in a sympathetic and sensitive manner. The interview should be conducted in a private setting away from all children, family, friends, and the suspected abuser. It is important to remember that even very young children may be affected by the discussion of IPV. The pediatrician should gently introduce the topic in a way that assures the caregiver that the conversation is confidential (if allowed by law), the problem is acknowledged, other resources for help are accessible, and his or her wishes about further disclosure or referral will be respected. These introductory statements can be developed and reviewed in advance for appropriateness with local violence advocacy groups. The Appendix provides nonjudgmental introductory statements that may be helpful in focusing the topic and setting the caregiver at ease.

It is appropriate to document all IPV assessments, although health care professionals must be aware that an abuser may have access to the child's and/or caregiver's health records. A generic statement indicating that an IPV assessment has taken place and resources have been offered per practice protocol provides documentation that inquiry has occurred but does not specify whether a caregiver has disclosed abuse or not.

REFERRALS/SAFETY PLANS

The Family Violence Prevention Fund has published a pediatric guideline for managing situations of IPV.[28] A free training video is available on its Web site (http://fvpfstore.stores.yahoo.net/screentoenda.html). Ideally, a protocol or action plan that has been developed with the input of local shelters, rape crisis centers, and victim advocacy groups should exist. Because of time constraints in a busy office practice or acute care setting, an interdisciplinary approach to IPV is most appropriate. The American Medical Association recognizes that optimal care for the caregiver in an abusive relationship depends on the physician's working knowledge of community resources that can provide safety, advocacy, and support.[47] Pediatricians are encouraged to partner with obstetricians, prenatal clinic nurses and social workers, hospital nurses and social workers, public health administrators, and early childhood education programs to coordinate a community response to the issue of IPV. The American Medical Association and many state medical associations provide directories of agencies that provide services or information about all forms of family violence. A national toll-free hotline (800-799-SAFE) is available to anyone who needs information about local resources on IPV. Additional resources may be accessed at the Family Violence Prevention Fund's Web site (www.endabuse.org/health). The AAP also provides resources to pediatricians on dating violence through the Connected Kids program (www.aap.org/connectedkids).

Pediatricians must understand the dynamics of abusive relationships. Zink et al[48] have suggested that physicians understand the transtheoretical model, known as "stages of change," to help patients with behavior changes and more effectively address the issue of IPV. It has been suggested that the risk of injury and/or death increases at the time a caregiver discloses abuse and attempts to leave his or her abusive partner. Thus, the process of disclosure is naturally very frightening and may not occur unless the caregiver feels that he or she is not in significant jeopardy. Unlike the situation with child maltreatment, there are no mandated state agencies that step in and act to ensure a caregiver's safety during this process. Few states have passed laws that mandate reporting of suspected IPV for individuals being treated by the health care professional, and few states have laws requiring health care professionals to report IPV if it is suspected or discovered during an evaluation of the child. Knowledge of existing state laws for reporting partner violence is essential.* A compilation of these laws is available for public access.[32] In addition, pediatricians should be aware of their state laws regarding the reporting of children exposed to IPV and how it may influence their practice of inquiry for IPV. An updated database of these laws is available through the Child Welfare Information Gateway.[49]

It is important to use discretion when providing printed information about partner violence to patients or their caregivers. If the information is discovered by the abuser, the victim may be at increased risk of violence. If the caregiver feels safe, information about legal and crisis counseling and shelters can be provided in written form. Written plans may be completed by the caregiver to facilitate ongoing safety, and many templates are available for use.[50,51] Because of the strong association between homicide in the home and the presence of both guns and partner violence, it could be life-saving to help an abused caregiver to recognize the value in removing firearms from the home, if it can be accom-

*For additional information and assistance with state laws and related advocacy issues, please contact the AAP Division of State Government Affairs.

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plished safely. The possible role of substance abuse contributing to IPV should be considered. Pediatricians also need to be sensitive to ethnic and cultural attitudes about violence specifically toward women, not because such attitudes are acceptable but because they may have a profound influence on the willingness of women to discuss this problem.

Pediatricians can provide education to agencies that deal with IPV about the risk of maltreatment to children whose caregivers are abused. Every reasonable effort should be made to assess risk of harm and lethality in the home and to protect children from a potentially dangerous environment. Counseling should be secured for children who have been exposed to IPV. Such treatment may be provided in groups or individually, but the focus should be on understanding violence and how to avoid it.

CONCLUSIONS

The evidence is overwhelming that children who are exposed to IPV are at risk of child maltreatment and both short-term and long-term medical, behavioral, and mental health problems. The Institute of Medicine recommends several core competencies on family violence for health care professionals.[52] These core competencies include training on the identification, assessment, and documentation of abuse; knowledge of interventions to ensure victim safety; recognition of culture and values as factors that affect IPV; understanding of applicable legal responsibilities; and violence prevention. Pediatricians who possess knowledge and skills in these areas will be in a position to intervene when IPV is present and provide more effective health care to children and their families.

GUIDANCE FOR THE CLINICIAN

1. Residency training programs and continuing medical education program leaders are encouraged to incorporate education on IPV and its implications for child health into the curricula of pediatricians and pediatric subspecialists.
2. Pediatricians should remain alert to the signs and symptoms of exposure to IPV in caregivers and children and should consider attempts to identify evidence of IPV either by targeted screening of high-risk families or universal screening.
3. When caregivers are asked about IPV, it is ideal to have a plan in place to respond to affirmative screens.
4. Pediatricians are encouraged to intervene in a sensitive and skillful manner and attempt to maximize the safety of caretakers and child victims.
5. Pediatricians should be cognizant of applicable IPV laws in their state, particularly as they relate to reporting abuse or concerns of children exposed to IPV.
6. Pediatricians are encouraged to support local and national multidisciplinary efforts to recognize, treat, and prevent IPV.

APPENDIX: SUGGESTED STATEMENTS TO INTRODUCE THE TOPIC OF IPV

"We all have disagreements at home. What happens when you and your partner disagree?"

"Is there shouting, pushing, or shoving? Does anyone get hurt?"

"Has your partner ever threatened to hurt you or your children?"

"Do you ever feel afraid of your partner?"

"Has anyone forced you to have sex in the last few years?"

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