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Intimate Partner Violence

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Abstract

Objectives: After completing this article, readers should:

1. Know the prevalence of intimate partner violence and childhood exposure to intimate partner violence
2. Identify risk factors associated with intimate partner violence.
3. Understand that child maltreatment is significantly more likely in the setting of intimate partner violence.
4. Recognize the impact of intimate partner violence exposure on children's social-emotional and physical health, and on their health care use.
5. Understand strategies for screening and responding to intimate partner violence in the pediatric setting

You are seeing a healthy, previously full-term 4 month old for well child care. As a part of your routine social history, you inquire about intimate partner violence (IPV). The infant's mother discloses that her partner frequently yells at her, pushes her and makes her feel afraid. Upon further questioning, you find that she describes the infant as “fussy.” His physical exam is unremarkable, but you note that he missed his two month visit and is behind on his immunizations. How do you proceed?

Keywords

intimate partner violence; child maltreatment; screening

Definition

Family violence and domestic violence are often used synonymously, and refer to violence occurring between any family member dyad including parent-child, intimate partner-intimate partner, or sibling-sibling. IPV refers specifically to violence perpetrated between romantic partners, and has been defined by the Family Violence Prevention Fund as “a pattern of purposeful coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was or wishes to be involved in an intimate or dating relationship with an adult or adolescent victim and are aimed at establishing control of one partner over the other”(http://www.endabuse.org/userfiles/file/HealthCare/pediatric.pdf; p. 2).

Epidemiology

Over the course of a lifetime, between 1/4 and 1/3 of women in the United States are abused by an intimate partner. Every year, 2 to 4 million women, and 50,000 to 1 million men, report IPV victimization. IPV occurs in families of all races/ethnicities and socioeconomic classes. Certain socio-demographic factors, however, have been associated with increased risk of IPV including young age (with the highest rates in women 18 to 24 years old), lower socioeconomic status, mental health problems, and substance abuse. Separated or divorced women report higher rates of IPV than married women.

Male-perpetrated IPV was first recognized as a significant public health problem in the 1960s. Since this time, we have achieved a greater understanding of the epidemiology and health consequences of male-perpetrated IPV. However, recent peer-reviewed papers and population-based surveys have reported that women perpetrate IPV as often as or more frequently than men (Archer 2000). These studies are often limited by failure to identify acts of self-defense and to recognize that men are much more likely than women to induce fear, but the point that IPV is not necessarily unilateral is important to consider (Anderson 2002). Despite the prevalence of female-perpetrated IPV, however, women are significantly more likely than men to be injured or killed by their partners.

Fifteen million children in the United States are exposed to IPV each year. Almost half of these children are exposed to severe IPV such as one parent beating up another parent or one parent using a knife or gun against another parent. Rates of IPV are disproportionately high in families with children less than five years old. Childhood exposure may include being present in the room while the violence is occurring, overhearing the violence from another room, or observing the aftermath of a violent argument including parental injuries or destruction of property. It is unclear whether exposure to male- or female-perpetrated IPV differentially impact child health, and the majority of the literature on the IPV-child health relationship focuses on the impact of male-perpetrated IPV. Therefore, the remainder of this review will focus predominantly on male-initiated violence.

Clinical Aspects

Child Abuse

In 1998, the American Academy of Pediatrics recommended routine IPV screening during well-child care stating that “identifying and intervening on behalf of battered women may be one of the most effective means of preventing child abuse” (American Academy of Pediatrics 1998; p. 1091). This statement was based upon the well-documented overlap between child maltreatment and IPV. Although the associations between physical IPV and child maltreatment are most prominent in the literature, risk for child maltreatment is also elevated in families with psychological abuse.

In populations of families either reported to Child Protective Services for child maltreatment or in domestic violence shelters, the co-occurrence of child maltreatment and IPV ranges from 30-60%. Rates of overlap between IPV and child maltreatment in community-based samples are notable, though lower than rates in these high risk samples; poverty, parental depression and substance abuse increase the risk of co-occurrence.

Children living in homes with IPV also may be accidentally injured by being “caught in the crossfire” of parental altercations. Infants and toddlers may be injured if they are being held in a parent's arms during a physical altercation. Older children, on the other hand, may be injured while trying to intervene to stop a fight.

Social-Emotional Health

Since the 1980s, increasing attention has been focused on infants and children as the “silent victims” of IPV, and research related to the social-emotional health consequences of childhood IPV exposure has grown exponentially. Childhood IPV exposure likely leads to adverse child health through a number of pathways including trauma, altered stress physiology, and disruption of the caregiver-child attachment relationship. Children exposed to IPV also frequently perceive the world as hostile and unsafe, and learn via social modeling that aggression is an acceptable means by which to resolve conflict.

Strong evidence links childhood IPV exposure with a wide variety of adverse social-emotional health outcomes in childhood. Specific problems vary according to age and developmental stage but include developmental delay, depression, anxiety, peer aggression, and post-traumatic stress disorder (PTSD)/hypervigilance. Infants may display trauma symptoms including excessive crying and resisting comfort. IPV also may disturb infant routines like sleeping and feeding, and may impact maternal-infant attachment. Common symptoms in toddlers include extreme separation anxiety, excessive tantrums, and aggression with peers.

School age children living in homes with IPV are more likely than their peers to exhibit aggressive and antisocial behaviors, and are more likely to be anxious, fearful, and hyper-vigilant. IPV exposure in school age children also has been linked with poor peer relations, perhaps due to poor self-esteem and sensitization to hostility. Adolescents in homes with IPV have higher rates school failure, substance abuse and risky sexual behaviors. These adolescents are more likely than their peers to enter into a violent dating relationship.

Physical Health and Health Care Use Patterns

Research about the impact of IPV on children's physical health and health care use is in its infancy, though some patterns are emerging. Compared to peers, children exposed to IPV are less likely to attend well-child visits and to be fully immunized, and more likely to have emergency department visits. Children exposed to IPV also may incur greater overall health care costs than their peers. Less is known about the impact of IPV on children's physical health, though recent studies have associated IPV exposure with higher incidence of childhood asthma and with infant failure to thrive and childhood malnutrition.

Childhood IPV exposure also adversely affects adult health. Felitti and colleagues published a series of articles examining the association between “Adverse Childhood Experiences” (ACE), including exposure to a battered mother, and a host of adult health outcomes (Felitti 1998). The authors enrolled over 20,000 men and women and found a consistent, graded relationship between the number of ACE and poor adult health outcomes. When analyzed separately, exposure to a battered mother was consistently linked with adverse adult health sequelae ranging from depression to substance use to cancer.

Diagnosis

Screening for IPV

Screening caregivers for IPV may improve the pediatric provider's understanding of the child's current illness, home environment and ability to follow physician recommendations. Screening also communicates that IPV is a common public health problem, reduces the isolation commonly associated with IPV, and conveys that IPV exposure affects children. Additionally, abused women may be more likely to seek health care for their children than for themselves, making the pediatric setting an important site for screening. Mothers generally support screening for IPV in the pediatric setting, and feel that the pediatric office is a safe location to discuss IPV and its consequences. Most major medical organizations (AAP, American College

of Obstetrician-Gynecologists, American Medical Association) recommend routine IPV screening.

In contrast, in 2004 the United States Preventive Services Taskforce (USPSTF) published guidelines stating that there was not enough empirical evidence to recommend either for or against routine IPV screening. Criticisms of these guidelines include that: 1) asking about IPV should be viewed as a routine behavioral health inquiry rather than as a “screening test”; 2) benefits of screening may extend beyond decreasing violent episodes, and these benefits should be considered in evaluating the merits of screening; and 3) IPV is a complex issue and qualitative research or studies outside of the traditional medical literature should be considered. Benefits and risks for children related to screening mothers for IPV remain uninvestigated.

Options to routine screening include not screening at all or performing targeted screening. In the pediatric setting, targeted screening would include children in whom concern exists for child abuse and neglect. Pediatric providers also should be concerned for IPV if the patient's mother: 1) appears depressed or overly anxious; 2) has obvious physical injuries; 3) repeatedly cancels or misses appointments or has difficulty following through with medical advice; 4) is abusing alcohol or other drugs; and if the child: 1) has emotional problems including depression, anxiety or ADHD; 2) has frequent non-organic symptoms such as headaches or stomachaches. Additionally, certain situational factors may precipitate IPV including pregnancy, parental separation or divorce, or efforts to leave the current relationship. The risk of a targeted screening approach, however, is that many women affected by IPV will not be identified.

When screening patients' mothers, the topic of IPV can be introduced with a statement such as:

- “The safety and well-being of mothers affects the safety and well-being of children, so I ask all mothers a number of questions about themselves and about their safety.”

The psychometric properties of numerous IPV screening questions have been tested in health care settings. The general consensus is that precise, behaviorally-anchored questions are more sensitive and specific than general questions such as “Do you feel safe at home?” or “Are you a victim of IPV?” A comprehensive compendium, published by the Center for Disease Control and Prevention, of IPV screening questions can be found at <http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf>. Notably, most of the validated IPV screening instruments have been tested exclusively on women; two sets of screening questions have been validated in a pediatric setting.

When a child ≥ 3 years of age is in the examination room, abused women have expressed concern about providers using behaviorally-anchored questions. When young children are present, women worry that the child may be traumatized or may inadvertently later relay the conversation about IPV to the perpetrator. If the child and mother can be separated (such as during hearing and vision screening), providers can screen the mother when she is alone. If not, the provider should use more general questions such as “How do you and your partner work out arguments?” and “In general, how would you describe your relationship with your partner: a lot of tension, some tension, or no tension?” Attention to the response and to non-verbal cues is important. If there is concern based upon the response or the reaction to these questions, the provider should attempt to interview the woman alone to pursue more specific questions. A woman may answer “no” many times before she discloses.

Management

Documentation

In the pediatric setting, the child is the patient and both legal guardians have access to the medical record. If the perpetrator is the child's father, he has access to the chart and could become aware of the caregiver-provider IPV conversation, potentially increasing the risk of violence. In contrast, it may be legally beneficial (for example in restraining orders or child custody cases) to document IPV in the child's medical record. While the risks of documentation are more theoretical than evidence-based, it is important to discuss the risks and benefits of documentation with the mother and abide by her wishes. A second option is to include in the chart a code known to other providers in the practice that would not be readily understandable to others such as +MIPV (for positive maternal IPV).

Response to a Positive IPV Screen

If a child's caregiver discloses IPV, the response should include: 1) an empathetic statement supporting the woman, and emphasizing that she does not deserve to be treated that way; 2) questions about escalation of violence, weapons, and comfort going home in order to assess the woman and child's current safety; 3) detailed history and physical exam looking for possible child abuse; 4) provision of social work assistance or national (1-800-799-SAFE) and local IPV resources; 5) safety planning (Table 1); and 6) an assessment of whether the child would benefit from mental health intervention or from frequent visits with their primary care provider. If violence is escalating or the family is in immediate danger, safe housing must be established; IPV hotlines can help to facilitate this. Additionally, most IPV organizations offer not only shelter, but counseling as well as legal and social advocacy for abused women; familiarizing oneself with the services offered by local IPV organizations therefore can be helpful. If the woman wishes, call the hotline from the pediatric office. The pediatric office also may be a safe place for an IPV advocate from a local organization to meet the woman to provide assistance. Establishing a trusting caregiver-provider relationship is critical, and providers should recognize that addressing IPV and helping women make positive changes often takes time.

Providers should recognize that advising the woman to leave the relationship may not be the safest solution for her or her children. The risk of homicide for women increases by 75% around the time of leaving an abusive relationship. Additionally, leaving an abuser may mean going into a shelter, removing children from their current school and losing significant economic support.

Management

Mandated Reporting

With any disclosure of IPV, a careful assessment of the child's well-being and safety is essential. Pediatric providers are obligated to report to Child Protective Services (CPS) suspicion of child abuse or neglect, or any concern that the child is in imminent danger. It can be helpful to have the mother file the report with you, and to document, as appropriate, ways in which she has attempted to protect the child. CPS should be made aware of the co-occurring IPV, and careful safety planning is critical.

States vary with regard to whether pediatric reporters are mandated reporters of childhood IPV exposure. Some states' laws explicitly state that pediatric providers are mandated reporters of childhood exposure to IPV. In other states, it is not explicitly written that pediatric providers are mandated reporters of childhood IPV exposure, but case law has interpreted IPV exposure as falling under emotional abuse thereby making pediatric providers mandated reporters. In

some states, health care providers also may be mandated reporters of IPV. Providers should know their specific state's reporting requirements prior to screening. Websites such as www.endabuse.org or <http://www.childwelfare.gov/> may be helpful in discerning state specific laws about mandated reporting.

If practicing in a state *with* mandated reporting laws for either IPV or childhood exposure to IPV, providers should inform the mother of your responsibility to report *before* screening. If practicing in a state with less specific reporting laws and there is no suspicion of child maltreatment, consider each situation individually to determine what is best for that child and mother.

While proponents of mandated reporting for childhood IPV exposure state that it is justified due to the negative health outcomes, others are concerned about such requirements. Apprehension about mandated reporting for IPV exposure stems from fear that reporting is punitive to the victim, implying that she failed to protect the child. Universal reporting also incorrectly assumes that all children are affected in the same way by IPV exposure, and may increase demands on an already overburdened CPS. There are also concerns that mandated reporting decreases women's likelihood to disclose IPV and to seek help.

Summary

- Based on strong research evidence, IPV and childhood exposure to IPV are prevalent public health problems (American Academy of Pediatrics 1998; United States Preventive Services Task Force 2004; McDonald 2006).
- Based on strong research evidence, IPV and child maltreatment commonly co-occur, particularly in families with additional psychosocial risk factors such as poverty, parental depression and substance abuse (Appel 1998; Jouriles 2008).
- Based on strong research evidence, IPV negatively impacts children's social-emotional health increasing risk for internalizing and externalizing disorders and aggression with peers (Kitzmann 2003).
- Based on some research evidence, IPV may negatively impact children's physical health and health care use (Bair-Merritt 2006).
- Based on consensus and some research evidence, screening for IPV in the pediatric health care setting may help identify abused women and connect them to resources (American Academy of Pediatrics 1998).

Suggested Readings

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Table 1**Options for Safety Planning**

Each recommendation should be discussed with the woman to decide whether it is safe and feasible:

- Advise women to collect the following items available in preparation for leaving: money, an extra set of house and car keys, important documents (social security cards, driver's license, birth certificates, passports, marriage license, rent and utility receipts, car registration, bank account numbers and check books, insurance policies and numbers, medical information), and a hidden bag with extra clothing, toiletries and food.
 - Ask neighbors to call the police if they overhear violence.
 - Have a code with family or friends that communicates that the IPV is occurring or is about to occur and establish what the family or friends will do if the woman uses the code.
 - Remove or disarm weapons in the home.
-