Objectives  After completing this article, readers should be able to:

1. Understand the strong association between child abuse and domestic violence.
2. Screen for domestic violence in cases where child abuse has occurred.
3. Discuss how exposure to violence affects the health of children.
4. Refer children who have been exposed to domestic violence for treatment.

Case Presentation

MR, a bright, chatty 6-year-old boy, disclosed physical and sexual abuse by his father. There is a history of domestic violence in the home, which he shares with his 7-year-old sister and his mother. The children witnessed their father hitting their mother, choking her, pushing her against the wall, and kicking her in the stomach on several occasions while she was pregnant with her third child. MR heard his father say that he wished his mother would die. Once during a physical assault when MR tried to pull his father off his mother, his father slapped him. His mother delivered a stillborn baby, after which MR’s behavior declined. He threatened to kill himself by cutting his wrists to be in heaven with the deceased baby. He attempted to choke his sister and to hurt the family dog and described hearing voices telling him to do bad things.

MR reported that his father got into the bathtub with him every day and “washed” MR’s private area with soap and water. At times, his father grabbed MR’s penis forcefully enough to cause pain. He said that his father asked him to touch and kiss his (father’s) penis. His father pulled his ear, slapped him on his buttocks and face, and bit him with a belt. MR said that his father did a lot of things and that he didn’t remember them all.

MR’s mother said that she told the father to leave the apartment. According to her, when he left, the boy became depressed, cried frequently, did not eat, and had difficulty sleeping. For a while, she let the father visit, but when he continued to abuse her and the children, she stopped the visits. After she got an Order of Protection, the father said that if she ever used it against him, he would kill her.

Despite the problems, MR’s mother continues to have difficulty separating emotionally from the children’s father. MR is doing better in therapy, although he often asks to sleep over at the clinic where he is being treated.

Introduction

Pediatricians and other health-care professionals are uniquely positioned to identify victims of domestic violence and child abuse within the same family and to offer potentially lifesaving assistance. Among 3 million cases of child abuse reported each year in the United States, one third are substantiated, and approximately 1,200 children die as a direct result of abuse and neglect. The statistics for domestic violence victims are equally daunting. According to the Commonwealth Fund, at least 33% of women in the United States experience domestic violence at least once in their lifetime. In the year 2000, more than 1,200 women were killed by an intimate partner. A direct connection between domestic violence and child abuse is not surprising, given that more than 50% of victims of domestic violence live in households that have children younger than 12 years of age. In 35 studies reviewed by Edelson, 50% demonstrated that domestic violence and child abuse occur together between 30% and 60% of the time.

The risk of physical abuse in children increases with the level of violence in the household. With one self-reported act of domestic violence, child abuse occurs 5% of the
time. However, in households that experience 50 or more episodes of domestic violence, nearly 100% of children are physically abused by their fathers and 30% by their mothers. The converse also is true: Domestic violence occurs in 40% to 60% of households where an abused child resides, a figure far higher than the 13% overall prevalence of domestic violence.

Domestic violence also places children at increased risk of sexual abuse. One study found a 150% increase in the risk of child sexual abuse in households where domestic violence took place.

Defining Child Abuse and Domestic Violence

Child abuse and domestic violence are two of the most compelling social problems of our time. Child abuse and neglect are physical or mental injury, sexual abuse, and negligent treatment of a child by a person responsible for the welfare of the child. Domestic violence is a pattern of behavior of an adult or adolescent intended to establish and maintain power and control over another adult or adolescent that includes physical trauma, psychological abuse, forced sexual behavior, and economic coercion. Domestic violence occurs in same-sex relationships and in heterosexual relationships. An abuser leaving the relationship does not mean that the abuse stops. Typically, the victim is a mother abused by her children’s father, but approximately 15% of domestic violence victims are men.

Identifying Child Abuse and Domestic Violence

For the last 4 decades, since the definition of the battered child syndrome was published in the Journal of the American Medical Association, (1) the medical profession has been a prime mover in explaining the concept of child abuse to other professionals and in advocating for legislation to protect vulnerable children. Accordingly, pediatricians and other medical professionals, along with law enforcement, legal, and social service professionals, receive ongoing training in the risk factors as well as presenting signs and symptoms and their interpretation in children who present with injuries or histories suggesting abuse. Although reviewing the identification of child abuse is beyond the scope of this article, it is important to highlight circumstances that put a child at increased risk for being abused, as outlined in Tables 1 and 2. Numerous excellent resources can help the practitioner identify children who have been abused (see Resources at the end of this article).

In 1998, The American Academy of Pediatrics (AAP) stated that the abuse of women is a pediatric issue and stressed the importance of recognizing domestic violence. Often, the pediatric office visit may be the only instance in which a domestic violence victim is separated from the abuser and able to disclose her situation safely. The pediatrician needs to take advantage of this window of opportunity and intervene for the sake of both the child and the parent.

Examples of the questions that a clinician can ask when screening for both child abuse and domestic violence are given in Table 3. Just as important as the type of questions asked is the atmosphere in which screening occurs. It is essential to establish an environment of trust and security by communicating concern nonjudgmentally. Additionally, the clinician should look for suggestive signs or symptoms that a parent might be the victim of domestic violence, such as bruising, depression, anxiety, failure to keep appointments, and frequent office visits for complaints not substantiated by medical evaluation. Because several visits may be required for a mother to feel safe enough to discuss her situation, the clinician needs to maintain an index of suspicion not only at the first visit, but during all child care visits.

Children also can be questioned, although they may be reluctant to talk about what they have seen or heard.

Table 1. Child-related Risk Factors for Child Abuse

- Low birthweight and prematurity
- Chronic illness
- Congenital defects
- Colicky infants
- Infants who are difficult to feed
- Children who have special needs
  - Physical disability
  - Cerebral palsy
  - Hyperactivity and impulsiveness

Table 2. Parent-related Risk Factors for Child Abuse

- Child not meeting parent’s demands or expectations
- Parent abused as a child
- Use of corporal punishment to discipline children
- Poverty, low income, overcrowded living conditions
- Single-parent household
- Isolation
- Alcohol and substance abuse
- Adolescent parents
- Domestic violence
Domestic Violence

Children who have been exposed to domestic violence may be more fearful of interactions with clinicians, and several visits may be necessary to establish a trusting relationship, especially when the clinician is male, because a child from a home in which a male is abusive may identify all males as being potentially dangerous.

If domestic violence is to be discussed with an older child present, the parent should be asked first if she or he is comfortable discussing the matter with the child in the room. In many instances, children older than 3 years may be affected negatively by such discussions. On the other hand, an open discussion could be beneficial to some children who are already aware of violence in the household. With this approach, the clinician must be concerned with the possibility that the child may disclose to the abuser that such a discussion took place, thereby endangering him- or herself and the victimized parent.

Adolescents may feel tremendous guilt that they are not able to prevent a parent from being battered. At the same time, they may be afraid of being injured or even killed if they try to intervene. Examples of how to ask an adolescent if there is domestic violence in the household where they reside are given in Table 4.

Screening for domestic violence is complicated by many states having mandatory reporting laws that require reporting of serious injuries and, in some cases, suspected cases of domestic violence. However, in the pediatric setting, because the parent is not the patient and is not seeking treatment, there is no legal obligation to report a parent who is a victim of domestic violence. Several states require a report if a child is exposed to parental domestic violence, regardless of whether the child has been abused. In these states, exposure to domestic violence is defined as child maltreatment or neglect. The fluid nature of state reporting laws requires that pediatricians be familiar with the requirements of the state in which they practice. In instances that are not clear-cut, the clinician should have access to resources that can provide guidance, such as a hospital risk management department, a local child protection center, or legal counsel.

Table 3. Asking a Parent About Domestic Violence

<table>
<thead>
<tr>
<th>Suggestions for Introductory Statements or Questions</th>
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<tbody>
<tr>
<td>• I have begun to ask all of the women/parents/caregivers in my practice about their family life as it affects their health and safety and that of their children. I have some resources I can offer in this regard. May I ask you a few questions?</td>
</tr>
<tr>
<td>• Violence is an issue that, unfortunately, affects everyone today, so I have begun to ask all families in my practice about exposure to violence. I can offer some resources. May I ask you a few questions?</td>
</tr>
</tbody>
</table>

Indirect Questions

| • What happens when there is a disagreement with your partner/husband/boyfriend or other adults in your home? |
| • Do you feel safe in your home and in your relationship? |

Direct Questions

| • Have you ever been hurt or threatened by your partner/husband/boyfriend? |
| • Do you ever feel afraid of (or controlled or isolated by) your partner/husband/boyfriend? |
| • Has your child witnessed a violent or frightening event in your neighborhood or home? |
| • Has your child ever been caught in the middle and been hit or otherwise hurt during an argument between you and your partner/husband/boyfriend? |

Signs and Symptoms of Child Abuse

Although a comprehensive review of the symptoms and signs of child abuse is beyond the scope of this article, important indicators are outlined in Tables 5 and 6.

Signs and Symptoms of Domestic Violence

It is easy to miss the cues that a child has been exposed to domestic violence. To avoid this pitfall, it is crucial that the pediatrician consider violence as a diagnostic possibility when evaluating a child. Signs and symptoms that occur as the result of exposure to domestic violence are nonspecific and are similar to those found in a child who has been abused. In addition to information that can be elicited by interviewing the child directly, the pediatrician also should be alert to nonverbal cues. Although nonspecific, these signs may indicate possible exposure to household violence. Examples are disruptive behavior, aggression toward others and objects, temper tantrums, somatic complaints, withdrawal, passivity, clinging, and dependent behavior. Children also may demonstrate an excessive fear of strangers, which may manifest when the child is being examined for the first time by the pediatrician, especially when the doctor is a male if a male partner has abused the mother. Findings on history and physical examination that may indicate a child’s exposure to domestic violence are nonspecific. Signs and symptoms such as failure to thrive, developmental regression, somatic complaints, and aggressive or antisocial behavior are found in a wide range of pediatric conditions. Therefore, it is important that the practitioner maintain suspi-
When seeing a child or adolescent exhibiting such signs and symptoms, it is also appropriate to ask about an injury she or he has sustained. Even if the adult is reluctant to disclose that the injury was the result of abuse, it provides the opportunity to validate violence as an appropriate topic for discussion.

Intervening in Cases of Domestic Violence and Child Abuse

Once a child is identified as living in a household where domestic violence is occurring, the first step is to ensure the safety of the child. The AAP places intervention in cases of domestic violence within the purview of pediatrics by recognizing the significantly increased risk of child abuse when a parent is victimized. If a child is physically harmed as the result of a violent episode in the home, all 50 states mandate that a report be made to the local child protection authority. The reporting standard in all states is suspicion of abuse; certainty of abuse is not required. Such reports open investigations of the allegations and immediately assure the safety of the child and provide support services for the family.

As noted previously, the pediatrician must be aware of local reporting laws to determine if a report needs to be made for a child who resides in an environment where domestic violence is occurring.

It is important to have protocols in place to respond immediately to a parent who discloses a history of domestic violence. Community contacts should be identified ahead of time so the family can be moved quickly into a safe environment. Contacts may include the police, domestic violence shelters, social service agencies, or hotlines. An excellent 24-hour resource for clinicians and victims is the national hotline (1-800-799-SAFE). Web sites that contain useful information for the clinician are listed in the resource section at the end of this article. In some instances, it may be necessary to ensure that a parent’s abuser does not threaten office personnel, which may require working with local law enforcement personnel.

A woman may not be ready or willing to leave an abuser. In this case, once it has been determined that any involved children are safe, the clinician should help the mother create a contingency plan, which should include what to do in instances of additional episodes of battering, such as how to contact the police or a local domestic violence hotline. The mother also should be given a list of resources to contact if she decides to leave at a future date, such as telephone numbers for local domestic violence shelters. Parents can prepare for contingencies in advance by having an emergency bag ready in a safe location that contains clothing, money, identification, and other important papers; developing a code word to use with friends when calling for help; and teaching children how to call for help safely. Table 7 lists items

<table>
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<th>Table 4. Asking an Adolescent About Domestic Violence</th>
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<tr>
<td><strong>Introductory Statements or Questions</strong></td>
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<tr>
<td>- Many teens your age experience threats, name calling, uninvited touching, sex, or violence, so I ask all my teenage patients about it. May I ask you a few questions?</td>
</tr>
<tr>
<td>- I don’t know if this is a concern for you, but many teens I see are dealing with violence or bullying issues, so I've started asking questions about violence routinely.</td>
</tr>
<tr>
<td>- Sometimes when I see an injury such as yours, it’s because somebody got hit. How did you get this injury/bruise?</td>
</tr>
<tr>
<td>- Now I am going to ask you confidential questions. The answers will be confidential, unless your health is in immediate danger.</td>
</tr>
<tr>
<td><strong>Indirect Questions</strong></td>
</tr>
<tr>
<td>- Are you in a relationship or seeing anyone? or Do you have a boyfriend or girlfriend? What happens when you disagree with him or her?</td>
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<tr>
<td>- How are your parents getting along?</td>
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<tr>
<td>- How are disagreements handled in your family?</td>
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<tr>
<td><strong>Direct Questions</strong></td>
</tr>
<tr>
<td>- Sometimes, if someone is being hurt in her or his own relationship, he or she may have seen it happen in his or her own family. Have you seen anyone get hurt in your home?</td>
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<tr>
<td>- How often do you have yelling or screaming fights? Do any of them involve pushing or shoving?</td>
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<tr>
<td>- Teens see a lot of violence these days. Seeing parents or other adults fight can feel as bad as being hit yourself. Has this happened to you?</td>
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<tr>
<td>- We all have disagreements sometimes with family members or friends. Have you ever been hurt or threatened by anyone?</td>
</tr>
<tr>
<td>- Have you ever been hurt—hit, kicked, slapped, shoved, pushed—by a friend or person you know?</td>
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<tr>
<td>- Have you ever been forced to do something sexual that you didn’t want to do?</td>
</tr>
<tr>
<td>- Do you ever feel afraid of or controlled by someone you’re dating or by a friend?</td>
</tr>
<tr>
<td>- Has anyone hit you at home in the last year?</td>
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</tbody>
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342 Pediatrics in Review Vol.27 No.9 September 2006
that a parent should have on hand in the event that it is necessary to leave the household precipitously. As discussed previously, it may be necessary to counsel the mother without her children present to prevent a child from inadvertently communicating to the abuser that the victim is seeking help.

Queries should be made regarding firearms in the household. The presence of firearms increases the risk of homicide, and they should be removed if this can be done safely. Keep in mind that the highest period for risk of injury or death is when the victim of abuse attempts to leave. Finally, if the nonoffending parent is open to mental health counseling, she and her children should be referred for treatment to professionals skilled in working with victims of domestic violence.

It is important to obtain a thorough medical, developmental, and psychological history on a child who has lived in a household where violence occurs or where a child has been abused. In cases of domestic violence, a parent statement that “my child did not see or hear anything” does not mean that the child has not been affected. Parents may be unaware that a child has witnessed parental fighting or may be in denial that this experience is harmful to the child. In addition, the atmosphere of a violent household can affect the well-being of a child negatively, regardless of what she or he has witnessed. Because of difficulty in accessing medical care in a chaotic household, a child may be behind in basic health care maintenance, such as immunizations and screenings tests, and may require referrals to medical subspecialists. In addition to any developmental evaluation that may be required, the pediatrician should be willing to refer for psychological evaluation and treatment. Witnessing violence can be as traumatic as being a victim of violence and can result in a child manifesting characteristics of posttraumatic stress disorder, which may include symptoms such as sleep disturbance, difficulty concentrating, flashbacks, and re-enactment of the trauma through play. These symptoms may interfere with school, social relationships, and emotional development. Evaluation is particularly important when symptoms persist after physician intervention, in cases where trauma was particularly violent, and in situations in which the parent unrealistically minimizes the impact domestic violence has had on the children.

**Documentation**

The pediatrician needs to be aware that unlike the documentation of child abuse, recording domestic violence in a child’s chart is controversial. If the abuser is a parent...
Table 8. Options for Documenting Domestic Violence in the Pediatric Chart

- Document that an inquiry has occurred.
- Document results of inquiry by using nonspecific terms or code words, such as "family problems" or "difficult home situation."
- Maintain a section of the child's chart that is confidential (not released with a request for medical records). Document any findings of intimate partner violence in this section.
- If possible, document the existence of intimate partner violence in the woman's health chart or in social work notes, where there is more confidentiality.

or guardian, he or she has the right to access a child's medical record. Any disclosure of domestic violence in the chart may put the victim at additional risk. Options for safe documentation are listed in Table 8.

Issues Regarding the Treatment of Children Exposed to Both Child Abuse and Domestic Violence

Children who have been exposed to both child abuse and domestic violence present with treatment issues that may appear to be overwhelming. Such children may require intensive monitoring and treatment to ensure their well-being. Treatment also is complicated by the involvement of several agencies, including health, behavioral health, child protection, law enforcement, and legal services. In addition, parents and other family members are involved in evaluation and treatment. In this setting, it is vital that all work be coordinated to prevent confusion among both the family and practitioners and to maximize adherence to treatment goals. All involved practitioners should communicate about issues as they arise. This communication may be through regularly scheduled face-to-face meetings or conference calls. Electronic means of communication, such as e-mail, is another efficient means of communication, but such communication must not jeopardize confidentiality.

Prognosis of Children Exposed to Abuse or Violence

Pediatricians must be extremely concerned about the prognosis of children exposed both to abuse and domestic violence. Studies of children exposed to violence clearly show an additive effect of proximity and frequency of exposure. In addition to suffering from mental health conditions, such as posttraumatic distress syndrome or depression, children exposed to violence may demonstrate poorer health and increased rates of chronic illness.

Of particular concern is the increased risk for children who have been abused or exposed to domestic violence of becoming abusive as adults. However, it is important to remember that many children demonstrate substantial resilience. It is striking how often children who have been living in violent households find an adult with whom to have a healthy relationship, maintain normal peer interactions, and do well academically. For less resilient children, clinicians must communicate an optimistic stance that removing the children from a violent environment and providing a healthier nonviolent lifestyle more likely will result in learned nonabusive behaviors.

Conclusion

Many programs have identified domestic violence and child abuse as national problems to be reckoned with in the 21st century. The National Call to Action has made the elimination of child abuse its mission. The 1999 publication of The National Council of Juvenile and Family Court Judges entitled “Effective Intervention in Domestic Violence and Child Maltreatment Practices: Guidelines for Policy and Practice” offers recommendations for keeping families safe as communities respond to domestic violence and child abuse. (2)

Primary care practitioners are critical in the identification of violence that jeopardizes the safety of children and families and cascades from generation to generation. By identifying children who have been abused and exposed to domestic violence, enlisting the strengths of parents and children, and referring families to appropriate treatment that includes educational, mental health, and legal services, clinicians can give children and families the chance for safe, secure lives and help break the cycle of violence.

References


Suggested Reading

Edelson JL. The overlap between child maltreatment and woman battering. Violence Against Women. 1999;5:134

Child Abuse Resources
National Clearinghouse on Child Abuse and Neglect Information: http://nccanch.acf.hhs.gov/

Domestic Violence Resources
National Domestic Violence Hotline: 1-800-799-SAFE
National Domestic Violence Hotline Website: http://www.ndvh.org/
Family Violence Prevention Fund: http://www.fvpf.org

PIR Quiz
Quiz also available online at www.pedsinreview.org.

9. In a household that has high levels of domestic violence, the likelihood of a child being physically abused by his or her father is nearly:
   A. 30%.
   B. 40%.
   C. 60%.
   D. 80%.
   E. 100%.

10. A number of child and parental factors can place a child at increased risk for child abuse. A factor that is less likely to lead to child abuse is a(n):
   A. Adolescent parent.
   B. Child hospitalized for meningitis.
   C. Colicky infant.
   D. Father who has evidence of drug abuse.
   E. Parent abused as a child.

11. The pediatrician is in a unique position to detect information concerning domestic violence in a family. The timing and who should be included in the discussion of this concerning situation can be a difficult decision for the health-care professional. It is important to recognize that including the child in these discussions can have a negative effect on the child as early as the age of:
   A. 10 years.
   B. 8 years.
   C. 6 years.
   D. 4 years.
   E. 3 years.

12. Children who have experienced both child abuse and domestic violence are at increased risk to become abusive adults. One factor that may help them both recover and become well-adjusted adults is:
   A. Experiencing posttraumatic stress disorder.
   B. Having personal resilience.
   C. Sustaining physical injuries rather than psychological stress.
   D. The age at which they experience the abuse.
   E. The mother being the abuser.