

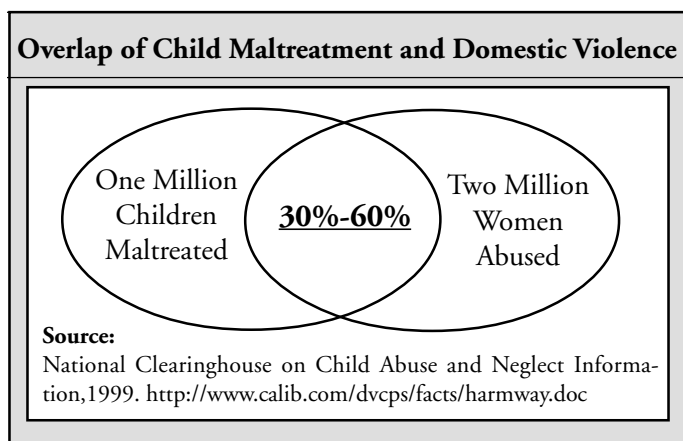
General Pediatricians' Approaches to Screening for Intimate Partner Violence in the Pediatric Setting

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Introduction

Child maltreatment and intimate partner violence are intricately related. This overlap was made clear in a 1999 federal report, entitled "In Harm's Way: Domestic Violence and Child Maltreatment" (National Clearinghouse, 1999)(see Figure 1).

Figure 1: "In Harm's Way" Graphic Demonstrating the Relationship Between Child Maltreatment and Intimate Partner Violence



Studies show that within groups of children with suspected abuse or neglect, 45% to 59% of their mothers have been battered (National Clearinghouse, 1999; Tjaden & Thoennes, 2000). Children of battered mothers are 6 to 15 times more likely to be abused themselves (National Clearinghouse, 1999). Child abuse occurs in 33% to 77% of families in which there is abuse of an adult (Tjaden & Thoennes, 2000). However, just witnessing violence in the home may be as traumatic to children and have as significant psychosocial and developmental consequences as being directly abused (Wolfe & Korsch, 1994; Groves, 2002; Osofsky, 2003). Children who observe or overhear domestic violence significantly outnumber children who are themselves physically injured. In the United States, it is estimated that between 3.3 and 10 million children yearly witness physical assaults between their parents (National Clearinghouse, 1999; Tjaden & Thoennes, 2000; Groves, 2002; Osofsky, 2003).

Intimate partner violence is a generic term that refers to a pattern of coercive behavior in which an individual establishes and maintains power and control over another with whom he or she has an intimate relationship. Intimate partner violence is synonymous with domestic violence (DV), spousal abuse (SA), wife battering, dating violence, and date rape. It includes not only physical abuse but also verbal, emotional, economic, and sexual abuse and may involve intimidation, threats, and isolation. In the United States, it is currently estimated that between 2 and 4 million women experience intimate partner violence by their male partner annually (National Clearinghouse, 1999; Tjaden & Thoennes, 2000). Nearly 25% of U.S. women will be abused by a current or former partner sometime during their lives (Tjaden & Thoennes, 2000).

It is becoming increasingly apparent that all forms of violence, including intimate partner violence, are a significant threat to the health and well-being of children (Tjaden & Thoennes, 2000; Committee on Child Abuse, 1998). Children who witness violence suffer significant psychological and behavioral problems that can interfere with their ability to function at school, at home, and with their peers and can lead to substance abuse with drugs and alcohol (Campbell & Lewandowski, 1997). These children can be anxious, socially withdrawn, depressed, preoccupied with physical aggression, and have fewer interests and social activities. Their behavioral problems have been reported to include aggressiveness, hyperactivity, conduct disorders, reduced social competence, school problems, truancy, bullying, excessive screaming, clinging behaviors, and speech disorders. They can also have physical symptoms such as headaches, bedwetting, disturbed sleep, failure to thrive, vomiting, and diarrhea. Posttraumatic stress disorder-type (PTSD) symptoms can include recurrent images of the battering, sleep disturbances, excessive worry about the mother's safety, and avoidance of certain activities and thoughts (Campbell & Lewandowski, 1997). Males raised in a household where the mother was beaten by her partner are more likely to be abusive to their own female partner in the future (Tjaden & Thoennes, 2000; Anda, Felitti, Chapman, Croft, Williamson, Santelli, Dietz, & Marks, 2001).

The American Academy of Pediatrics' Committee on Child Abuse and Neglect published a milestone statement in 1998 that advocated screening for domestic violence in pediatric practices (Committee on Child Abuse, 1998). The AAP recommended to pediatricians that questions about family violence become part of anticipatory guidance and that identifying and intervening on behalf of battered women may be one of the most effective means of preventing child abuse (Committee on Child Abuse, 1998). Studies to date have looked at general pediatrician's attitudes toward child abuse (Siegle, Hill, Henderson, Ernst, & Boat, 1999; Parkinson, Adams, & Emerling, 2001; Lapidus, Cooke, Gelven, Sherman, Duncan, & Banco, 2002), barriers to screening for intimate partner violence in the pediatric setting (Erickson, Hill, & Siegel, 2001; Seigel, Joseph, Routh, Mendel, Jones, Ramesh, & Hill, 2003), and the pediatric experience with screening for intimate partner violence in the community practice and pediatric emergency department setting (Wright, Write, & Isaac, 1997; Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer, 2002). This study was conducted to explore in further detail general pediatricians' attitudes, approaches, and practice patterns regarding screening for intimate partner violence in their office settings.

Methods

Survey Sample

The survey sample included a total of 346 pediatricians from southeastern Pennsylvania, southern New Jersey, and Northern Delaware who were divided into two subsets: (1) physicians involved in various medical and resident teaching sites for a major children's hospital and (2) a random sample of physicians not associated with the hospital's teaching program.

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Questionnaire

A 49-item questionnaire designed by the investigators consisted of questions about demographic characteristics, practice patterns and attitudes toward screening for domestic violence, and child abuse and domestic violence training. The survey questions were drawn from a search of the literature for commonly cited barriers to domestic violence screening in the primary care setting, situations in which primary care providers feel compelled to screen, and the risks faced by children who come in contact with domestic violence. Also included were 24 5-point, Likert-type questions (1 = strongly disagree, 5 = strongly agree) to assess respondents' perceptions of effects on children of witnessing domestic violence, obstacles to screening, effectiveness of intervening in domestic violence as a way to combat child abuse, and experience in handling domestic violence cases.

Survey Procedure and Data Analysis

The survey was exempted from Institutional Review Board review. Pocket cards detailing an approach to screening for intimate partner violence were included in the mailer as incentive to complete the survey. Mailers were tracked by numerical codes on the questionnaire and on the return envelopes to maintain confidentiality. Two mailings and phone follow-up were conducted in early 2000. The data were analyzed using the SPSS software package.

Results

Surveys were completed and returned by 210 (60.5%) of the 346 pediatricians on the original mailing list. Four surveys were returned incomplete or were refused during phone follow-up. Eighteen surveys were returned undelivered. Seventeen physicians could not be located or were out of the survey area. Seven pediatricians had retired or were no longer practicing medicine. Excluding these groups, the revised sample of pediatricians who received a survey numbered 305, yielding an adjusted response rate of 68.9%.

Personal demographics of respondents are listed in Table 1. Slightly more respondents were women than men (53% vs. 47%). The median age reported was 42 with nearly two thirds under 50. By far, most identified themselves as Euro-American/Caucasian (84%) with the next largest group Asian/Pacific Islanders (11%).

Table 1. Personal Demographics

(*Percentage totals greater than 100% are due to rounding)

Demographic	Number	Percentage*
<i>Gender</i>		
Male	98	46.7
Female	111	52.9
No Response	1	0.5
<i>Age</i>		
<40	69	32.9
40-49	64	30.5
50-59	33	15.7
60-69	13	6.2
>70	1	0.5
No Response	30	14.3
<i>Ethnicity</i>		
Caucasian	177	84.3
Asian/Pacific Islander	22	10.5
African American	7	3.3
Other/ No Response	4	1.9

Table 2 shows respondents' practice demographics. Ninety-five percent of respondents were boarded in pediatrics and 19% had completed fellowships. There was a fairly even distribution of respondents across length of time in practice. The majority of practitioners practiced in a suburban setting (65%), and the fewest practitioners worked in a rural setting (7%). Most respondents worked in a pediatric group practice (70%) and the majority of the remainder, in a hospital-based practice (21%). Sixty percent of practitioners reported teaching medical students.

Table 2. Practice Demographics

(*Percentage totals of less than 100% are due to rounding)

Demographic	Number	Percentage*
<i>Pediatrics Boarded</i>		
Yes	200	95.2
No	9	4.3
No Response	1	0.5
<i>Fellowship-Trained</i>		
Yes	40	19.0
No	167	79.5
No Response	3	1.4
<i>Length of Time in Practice</i>		
0-5 yrs	44	21.0
6-10 yrs	40	19.0
11-15 yrs	42	20.0
16-20 yrs	37	17.6
>20 yrs	47	22.4
<i>Practice Location</i>		
Rural	14	6.7
Suburban	134	63.8
Urban	57	27.1
No Response	5	2.4
<i>Practice Type</i>		
Hospital-based (community)	23	11.0
Hospital-based (university)	21	10.0
Pediatric group	146	69.5
Pediatric solo	15	7.1
Multi-specialty	2	1.0
Other/ No Response	3	1.4
<i>Teach Medical Students</i>		
Yes	126	60.0
No	78	37.1
No Response	6	2.9

Respondents were asked how much education they had received on domestic violence and on child abuse and neglect during their medical training (Table 3). Almost two thirds of respondents reported no domestic violence training in medical school and residency and an even greater proportion had no domestic violence training during fellowship. Training in child abuse and neglect in medical school was more common, with only one fourth of respondents reporting no training and greater than 50% having one to ten hours. In residency, only 10% of individuals had no child abuse training, and a larger proportion had more hours of training than in medical school. During fellowship, there was somewhat of a bimodal distribution of child abuse training. Almost one third of respondents had no training, almost 20% had greater than 15 hours, and the remaining respondents (fewer than 20%) fell in-between in their amount of

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training. Most respondents had not taken a class or continuing medical education course on domestic violence in the past year (89.5%) or in the past three years (70.5%). However, 51.9% of physicians responded that they would take further training on screening and treating domestic violence if offered, 42.4% were not sure, and 5.2% would not take such training if available.

Table 3. Hours of Training on Domestic Violence and Child Abuse and Neglect During Medical Education

Hours of Domestic Violence Training	Medical School n(%)	Residency n(%)	Fellowship n(%)
0	127 (60.5)	124 (59.0)	35 (85.4)
1-4	63 (30.0)	54 (25.7)	5 (12.2)
5-10	8 (3.8)	16 (7.6)	0 (0)
11-15	4 (1.9)	6 (2.9)	0 (0)
>15	5 (2.4)	5 (2.4)	1 (2.4)
Total	207 (98.6)	205 (97.6)	41 (100)
No Response	3 (1.4)	5 (2.4)	N/A

Hours of Child Abuse Training	Medical School n(%)	Residency n(%)	Fellowship n(%)
0	53 (25.2)	20 (9.5)	24 (63.2)
1-4	79 (37.6)	31 (14.8)	4 (10.5)
5-10	41 (19.5)	52 (24.8)	2 (5.3)
11-15	9 (4.3)	23 (11.0)	1 (2.6)
>15	25 (11.9)	78 (37.1)	7 (18.4)
Total	207 (98.6)	204 (97.1)	38 (100)
No Response	3 (1.4)	6 (2.9)	N/A

When asked about their views on screening for domestic violence, 74.8% of respondents thought that general pediatricians should screen for domestic violence in the families of their patients, but only 3.3% had a screening protocol for domestic violence in their practice and only 6.2% had a management protocol. In addition, 35.7% of respondents felt comfortable providing intervention to a victim of DV, 37.6% did not feel comfortable, and 24.3% were unsure. The majority of respondents (62.8%) thought the prevalence of domestic violence in the families of their patients was 5% or less, 13.3% of respondents thought the prevalence was 6% to 10%, and only 5.8% thought the prevalence was greater than 10%. Respondents who were not sure totaled 18.1%.

Physicians were given a list of scenarios and asked under which circumstances they screened for domestic violence in their patients' families. Only 8.1% of respondents screened every patient's family for domestic violence. However, more than half of respondents reported screening in the following situations: when they suspected the child was being abused or neglected (84.3%), when the child had evidence of physical injury (75.2%), when the child had a pattern of acting violently (63.3%), when the child seemed depressed (60.0%), when the child seemed socially withdrawn (54.3%), or when the child had behavioral problems (51.9%). A number of respondents screened when the adolescent abused drugs or alcohol (44.3%), when the child did poorly in school (31.9%), or when the child had developmental delays (16.2%).

Respondents were asked to rate their agreement with 24 Likert-type statements on a scale of 1 (strongly disagree) to 5 (strongly agree). The statements and responses appear in Figure 2.

Discussion

The responses from our survey indicated that a majority of physicians received training and education regarding child maltreatment in medical school, in residency, and during fellowship. These same respondents indicated that few physicians received education and training in domestic violence during medical school, while serving in their residency, or during fellowship. Additionally, very few physicians reported attending in-service training regarding domestic violence, though most indicated they would attend such training if it were made available. In spite of the paucity of training, three fourths of the physicians surveyed indicated that physicians should screen for domestic violence in their patients. It may be reasonable to conclude that if more physicians were trained in the dynamics of domestic violence, even more would conclude that screening is an appropriate intervention. The responses to the opinion component of the survey indicated that respondents believed most strongly that exposure of children to domestic violence would result in behavior problems, poor school performance, and drug or alcohol abuse. There is much research to support their opinions (Graham-Bermann & Edleson, 2001). This research indicated that physicians recognize the need to screen for domestic violence, believe they should be intervening, believe they could help, yet are not intervening appropriately and believe they are ill prepared and poorly equipped to intervene as needed.

In summary, many pediatricians are ready to play their part in screening for intimate partner violence in their practice setting. Prior studies have shown that such screening can uncover the presence of intimate partner violence as well as identify cases of child maltreatment that were previously unknown (Siegel, Hill, Henderson, Ernst, & Boat, 1999; Parkinson, Adams, & Emerling, 2001; Lapidus, Cooke, Gelven, Sherman, Duncan, & Banco, 2002). We recommend that training be made available to pediatricians on topics related to dynamics of domestic violence, treatment options and their expected efficacy, the pediatrician's role in assessment and intervention, and the resources offered by collaborating disciplines. Training should be designed to address the unique needs of pediatricians, such as screening procedures, proper responses to positive findings, reporting responsibilities, and issues related to confidentiality and the physician/patient relationship. Appropriate screening protocols must continue to be developed and validated, and appropriate policies and procedures for pediatrician intervention in domestic violence must be further addressed by such professional organizations as the American Academy of Pediatrics and the American Medical Association.

About the Authors

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Figure 2: Pediatricians' Response to Likert-Type Questions

(5-Point Scale: 1 = Strongly Disagree, 5 = Strongly Agree)

Likert-Type Statement	95% CI (Upper Bound)	95% CI (Lower Bound)	Mean %	SD
Children who witness SA/DV are more likely to have behavioral problems.	4.62	4.46	4.54	0.60
Children who witness SA/DV are more likely to have poor school performance.	4.39	4.24	4.32	0.55
Children who witness SA/DV are more likely to have drug and alcohol problems.	4.31	4.13	4.22	0.67
Intervening to prevent SA/DV is an effective way to combat CAN.	4.18	4.00	4.09	0.67
More pediatricians would screen if there was social work help readily available.	4.12	3.89	4.00	0.83
Children who witness SA/DV are more likely to have psychiatric illnesses.	4.00	3.78	3.89	0.81
Pediatricians don't screen because there is a lack of training during medical school and residency.	3.87	3.63	3.75	0.85
Lack of office protocol is an obstacle to screening for SA/DV.	3.84	3.58	3.71	0.93
Pediatricians don't screen for SA/DV because they have a personal discomfort with handling such cases.	3.80	3.59	3.7	0.76
Pediatricians don't screen for SA/DV because they don't have enough time to handle a positive response.	3.78	3.51	3.64	0.96
There is not enough time in a general pediatrics practice to screen for SA/DV.	3.28	3.14	3.42	1.01
Children who witness SA/DV are more likely to have developmental delays.	3.39	3.17	3.28	0.81
Pediatricians don't screen for SA/DV because they feel powerless to intervene.	3.26	2.98	3.12	0.99
Pediatricians don't screen for SA/DV because they don't want to offend the patient's family.	3.19	2.91	3.05	1.01
Pediatricians don't screen for SA/DV because they don't want to get drawn into a social service or criminal justice proceeding.	3.08	2.82	2.95	0.92
Pediatricians don't screen for SA/DV because victims are unwilling to disclose when they are asked by physicians.	2.85	2.59	2.72	0.91
Pediatricians don't screen for SA/DV because there is a low prevalence of this problem in their practice.	2.73	2.48	2.60	0.89
Pediatricians don't screen for SA/DV because they fear for their own safety.	2.49	2.26	2.38	0.83
Pediatricians don't screen for SA/DV because the victim is an adult and has the responsibility to take his or her own actions.	2.42	2.20	2.31	0.80
Screening for SA/DV is an intrusion on the privacy of the family.	2.11	1.88	2.00	0.85
Screening for SA/DV is not in the realm of pediatrics.	2.07	1.85	1.96	0.76
Screening for SA/DV is possibly a conflict of interest with the child's welfare.	2.01	1.79	1.90	0.77
Pediatricians should not screen for SA/DV because only the child is the patient.	1.80	1.62	1.71	0.65

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