Abstract:
Intimate partner violence (IPV) and teen dating violence (TDV) are widespread, preventable public health problems in the United States. Children exposed to IPV between their caregivers and adolescent victims of TDV suffer not only immediate risks to their physical safety, but also long-term health sequelae. The emergency department presents a unique opportunity for physicians to screen for various forms of family violence and intervene on behalf of the victims. Screening for IPV and TDV is widely recommended by national health organizations including the American College of Emergency Physicians. Effective screening protocols require a multidisciplinary approach informed by knowledge of local community resources.

Keywords:
Intimate partner violence; Teen dating violence; Family violence; Domestic violence; Child abuse; Screening

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Screening for Intimate Partner Violence in the Pediatric Emergency Department

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Intimate partner violence (IPV) is a significant, preventable public health problem in the United States with consequences that affect all socioeconomic and ethnic groups.[1,2] The Centers for Disease Control and Prevention define intimate partner violence as physical violence, sexual violence, stalking or psychological harm by a former or current partner, someone they have an emotional connection with, regular contact with, or have a familiarity of each other's lives.[1] The World Health Organization expands the definition to encompass any controlling behaviors, including physical isolation or restriction from financial resources, medical care or employment.[3]

One to 2 million incidents of IPV occur every year in the United States.[4] Approximately 80–85% of victims of IPV are women[1,4]; the lifetime prevalence of IPV amongst women in the United States is 25 to 54%.[5-8] An estimated 1544 people died as a result of IPV in 2004, approximately 75% of which were women.[9] While IPV is recognized in men as well as in individuals in lesbian, gay, bisexual, and transgender relationships, limited research exists on these populations.[1,2,4]

Screening for IPV is recommended by several national health organizations.[2] The United States Preventive Services Task Force

updated their recommendations in 2013 to endorse screening for IPV amongst asymptomatic women of reproductive age, defined as 14 to 46 years, and offer appropriate interventions or resources if screening is positive.[10] The American College of Emergency Physicians encourages emergency department (ED) healthcare providers to screen patients for IPV and make appropriate referrals for families with positive screens.[11] Similarly, the American Academy of Pediatrics (AAP) recognizes that pediatricians should monitor children for exposure to IPV and consider screening caregivers.[12] The Joint Commission requires hospitals to assess each patient for family violence, although no specific protocol is defined.[13] These recommendations are consistent with patient expectations as surveys of women have shown that the majority believe physicians should complete routine screenings for IPV.[14]

Exposure to IPV can have significant impact on the health and development of children and adolescents and may perpetuate the continuum of family violence. Pediatric emergency medicine providers come in contact with both children whose caregivers are victims of IPV as well as adolescents who are exposed to teen dating violence (TDV). Identification of these at-risk patients is critical to ensuring their immediate safety and minimizing sequelae of exposure to family violence.

EXPOSURE TO IPV IN CHILDHOOD

Exposure to IPV may result in direct and indirect harm to children. Direct harm can occur when children sustain injuries due to violence directed towards their caregiver. One study identified 139 children injured due to violence between other members in their home.[15] Mothers were involved in the altercations 81% of the time. Twenty-nine percent of children were being held by a parent when they were injured. Twenty-four percent were injured when they were trying to break up the fight between their family members. Nine percent of the children who were injured had injuries severe enough to require hospitalization.[15] This study highlights the importance of obtaining a detailed history of how an injury was sustained. Children may sustain injury secondary to IPV between their caregivers even before birth, as it is estimated that 3 to 19% of pregnant women experience IPV.[16]

IPV and child maltreatment have been reported to co-occur at a rate of 40 to 60%.[13,17] One study found if IPV occurred during the first 6 months of a child's life, that child was 3.4 times more likely to suffer from child physical abuse by the age of 5 years.[17] Another study reported children who were exposed to the IPV of their caregivers 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.[18] In addition, the presence of IPV is associated with child fatalities.[19] Therefore, identification of IPV and intervention on behalf of the victims could be one of the most effective ways to prevent child abuse.[20]

Indirect effects of exposure to IPV are extensive and may persist into adulthood. Children exposed to IPV during the first 6 months of life are twice as likely to suffer from psychological abuse or neglect by the age of 5 years.[17] Witnessing abuse of a caregiver can cause more anxiety, depression, withdrawal, somatic complaints, attention problems, aggressive behavior or rule-breaking actions when compared to children whose caregivers do not have a history of abuse.[21,22] Further, witnessing violence against a mother or stepmother in childhood has been demonstrated to be related to poor health risk behaviors in adults.[23] Therefore, detection of IPV in the home is important for both immediate safety concerns as well as preventing poor healthcare outcomes.

SCREENING FOR IPV

An encounter in the ED presents an opportunity for screening and intervention for IPV, especially for families with limited resources who may utilize the ED frequently. Pediatric EDs, in particular, are an ideal clinical setting for IPV screening as it can be done in the context of the evaluation of the child which may minimize risks associated with the perpetrator becoming angry about a victim's disclosure. Further, abused caregivers are more likely to seek care for their children than they are for themselves, thus contact with adult medical providers may be limited.[24] Bair-Merritt and colleagues found that children whose female caregivers endorsed severe IPV had significantly more visits to the ED and urgent cares than children of female caregivers who were not victims of IPV.[25]

Screening for IPV has been demonstrated to significantly increase detection in multiple clinical settings.[26,27] Siegel and colleagues implemented a screen of female caregivers of children presenting for a well-child check in a community pediatric clinic and found that 31% had experienced IPV in their lifetime with 16% experiencing IPV in the last 2 years.[26] More recently, Scribano and colleagues implemented computerized screening for IPV in the waiting area of a pediatric ED. Over 15 months, approximately 13 000 caregivers completed the