Screening For Domestic Violence In The Pediatric Emergency Department

It is a typically busy Saturday night. Your next patient is a one-year-old with a runny nose brought to the ED by her pregnant 20-year-old mother. During your examination of the child, you notice that the mother has a bruise on her cheek. She reports that she slipped down the stairs and appears whom you when you ask her injury. You wonder about the real cause of the accident, but aren’t sure how to ask if she was a victim of domestic violence. Besides, what could you do for her anyway?

Similar scenarios are commonly encountered by all emergency medicine (EM) physicians. However, physicians are often hesitant to ask about Domestic Violence (DV). In a study by Sugg, physicians reported that exploring domestic violence in the clinical setting was analogous to “opening Pandora’s box,” citing lack of comfort, fear of offending, powerlessness, loss of control, and time constraints as concerns.1

DV, or intimate partner violence (IPV), is commonly defined as a pattern of coercive behaviors including repeated battering and injury, psychological abuse, sexual assault, progressive isolation, deprivation and intimidation.2-4 Women who are injured as a result of DV/IPV often present to the emergency department. However, the majority of these women are not identified as victims. In one study, 37% of female patients with injuries presenting to the emergency department were injured by their partner, but only 5 to 7% of

December 2006
Volume 3, Number 12

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CME Objectives

Upon completing this article you should be able to:
1. Discuss the epidemiology of Domestic Violence/Intimate Partner Violence (DV/IPV), especially as related to its presentation in the emergency department (ED).
2. Be familiar with the barriers to screening for DV/IPV in the ED.
3. Discuss approaches to dealing with and responding to DV/IPV in the pediatric ED setting.
4. Recognize the increased risk of harm to children who live in homes affected by DV/IPV.

Date of original release: December 1, 2006.
Date of most recent review: November 1, 2006.
See "Physician CME Information" on back page.
these battered women were identified by emergency department (ED) staff. In another study, 44% of women murdered by their partner had visited an emergency department within two years of the homicide; over 90% of these women presented to the ED for evaluation of injuries incurred as a result of DV/IPV. Another ED study found the incidence of acute DV/IPV with a current male partner to be 11.7%. The cumulative lifetime prevalence of DV/IPV exposure was 54.2%. The American College of Emergency Physicians encourages emergency personnel to screen patients for domestic violence and appropriately refer those patients who indicate that domestic violence may be a problem in their lives.

There has been heightened awareness of DV/IPV as a pediatric problem as well. In a recent position paper, the American Academy of Pediatrics stated that “recognizing and intervening in domestic violence may be the single best way to prevent child abuse.” Approximately 3.3 to 10 million children witness the abuse of a parent or adult caregiver each year. Children living in families with domestic violence are more likely than their peers to be victims of abuse; the incidence of child abuse in families experiencing domestic violence ranges between 30 to 60%. One study found that children of abused mothers were 57 times more likely to have been harmed because of DV/IPV between their parents, compared with children of non-abused mothers.

Children who live with domestic violence face increased risks of exposure to traumatic events, neglect, direct abuse, and losing one or both of their parents. Several studies have shown that exposure in one’s home environment to domestic violence as a child leads to the increased likelihood of adult health issues and risk taking behaviors, such as behavioral and emotional problems, cognitive problems, depression, and risks of violence in adult relationships. Children who are raised in homes with domestic violence are at an increased risk of perpetrating or experiencing violence in adulthood, and are more likely to be victims of child abuse. In addition, a child’s exposure to DV/IPV can lead to moderate to severe post traumatic stress disorder (PTSD).

While a physician may be the first non-family member that a victim of domestic violence may turn to for help, current rates of screening for domestic violence are low (8 to 21%). This is particularly true in the pediatric setting, in part because pediatricians may feel they lack training in family violence screening and intervention skills. ED staff and EM and pediatric emergency medicine (PEM) physicians are in a unique position to recognize DV/IPV and intervene on behalf of the victim and children. However, while physicians may observe patterns of injury, repeated injuries, and the adverse mental outcomes of domestic abuse, they may fail to recognize them as DV/IPV.

Without institutional policies and procedures for detecting and treating victims of DV/IPV, many abused women will remain unidentified and without intervention. Only recently has the health care system become an important site for DV/IPV programs. In 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) required that all accredited hospitals implement policies and procedures in their facilities to identify, treat, and refer victims of DV. However, most of these programs focus on screening and identification, and few focus on treatment of victims of DV/IPV. In one study, pediatric ED providers supported both DV/IPV resource information and routine screening.

This issue of Pediatric Emergency Medicine Practice focuses on screening for DV/IPV in the pediatric ED.

**Abbreviations Used In This Article**

- **ACEP** – American College of Emergency Physicians
- **DV** – Domestic Violence
- **IPV** – Intimate Partner Violence
- **ED** – Emergency Department
- **EM** – Emergency Medicine
- **EMS** – Emergency Medical Service
- **ISF** – Institute For Safe Families
- **JCAHO** - Joint Commission on Accreditation of Healthcare Organizations
- **PEM** – Pediatric Emergency Medicine
- **PTSD** – Post Traumatic Stress Disorder
- **USPSTF** – The US Preventative Services Task Force

**Critical Appraisal Of The Literature**

The literature supporting routine or universal screening of women for DV/IPV is evolving, and questions remain about the ultimate effect on health outcomes at this point. To date, many professional organizations, government agencies, and advocacy groups have recommended universal screening programs...
based upon consensus of opinion. The emergency medicine literature contains a number of reports that present data from both single and multi-analyses that explore provider perceptions around IPV, barriers to screening, and various screening protocols. Screening initiatives have been consistently shown to increase the identification of patients experiencing acute episodes of abuse and seeking treatment. However, sustaining screening programs has proven to be difficult. At present, standard protocols for IPV screening and chart prompts for both screening and interventions are supported by evidence from a number of EDs. Additionally, ongoing training for health care providers is necessary to initiate and maintain screening.

Moving beyond the general ED that serves adult patients, pediatric EDs have explored their role in DV/IPV screening. In 1997, a survey of 125 pediatric emergency medicine fellows demonstrated a significant disparity between prior child abuse training (97.6%) when compared to DV training (29.6%). Fellows reported much more first hand experience with handling child abuse cases than with DV/IPV cases and only 4.2% of fellows reported having protocols in place for responding to battered women in the pediatric ED. Multiple barriers were identified to screening for women for DV, including lack of protocol, lack of formal training, lack of DV/IPV experience, belief that DV/IPV was outside the purview of pediatrics, and a variety of potential attitudinal barriers including frustration with what could be done in response to a positive screen and inadequate time to respond. Seven years later, a survey of 130 pediatric chief residents again demonstrated a continuing disparity between child abuse and DV/IPV training with 60% receiving 11 hours or more of child abuse training in residency and 80% receiving less than four hours of DV/IPV training. The disparity extends to experience with child abuse versus DV cases with 78% of respondents working in programs without a formal evaluation protocol, while nearly all had some experience with child abuse cases. On a positive note, 93% of pediatric chief residents who responded to the survey thought pediatricians should screen for DV/IPV in patients’ families, although only 20% universally screened. Eighty percent voiced an interest in receiving training in how to effectively screen and intervene for DV/IPV. A qualitative study explored the perspectives of 59 mothers, 21 nurses, and 17 physicians in a pediatric ED on IPV screening and found that mothers viewed DV/IPV as a common problem that warranted routine screening in the pediatric ED. The study concluded with the following recommendations about DV/IPV practices in pediatric EDs: 1) Those assigned to screen must demonstrate empathy, warmth, and a helping attitude; 2) The child’s medical needs must be addressed first and screening for DV/IPV should be performed in a minimally disruptive manner; 3) A clear and organized process around determining risk to the child from the IPV environment must be maintained, especially when child protective services needs to be involved; and 4) Resources and referrals for women who request them must be available.

**Epidemiology, Etiology, Pathophysiology**

Among adults 18 and over, approximately 5.3 million intimate partner victimizations occur among women and 3.2 million occur among men each year in the U.S., resulting in nearly two million injuries and 1300 deaths. Since most DV/IPV incidents are not reported to the police, it is believed that available data greatly underestimates the true magnitude of the problem. There are an estimated 4.8 million acts of intimate partner rapes and physical assaults per year with over two million resulting in injury. More than 500,000 of these injuries result in medical treatment for the victim.

Approximately one in three to four adult women have experienced a physical assault by an intimate partner. In a survey of college women, 88% of respondents had experienced at least one episode of physical or sexual abuse, and 64% had experienced both. A national study found that 29% of women and 22% of men had experienced physical, sexual, or psychological DV/IPV during their lifetime. DV/IPV is chronic in nature. Of the women raped by an intimate partner, 51.2% were victimized multiple times by the same partner. DV/IPV is also a major cause of family homelessness. Up to half of all women and children living on the streets are homeless as a result of IPV.

While there are no proven psychological or cultural profiles that are specific to battered women, certain groups appear to be at a higher risk for domestic abuse. Women who are between the ages of 17 and 28, women who abuse alcohol, and pregnant women are more likely to be victims of DV/IPV. During pregnancy, at least 4 to 8% of women are abused at least once. Other studies have identified
the prevalence of DV/IPV in pregnancy to be higher, at 18 to 38%.\textsuperscript{18, 41}

Controversy remains regarding the relationship of race and economic status to IPV.\textsuperscript{4} Some data-sets find no relationship between IPV and race, economic status, educational level, or insurance status while other data asserts that lower socio-economic status conveys a higher risk for IPV. In the well designed and well respected National Violence Against Women Survey, the ethnic groups most at risk are American Indian/Alaskan Native women and men, African-American women, and Hispanic women.\textsuperscript{31} Those below the poverty line in the survey were also disproportionately identified as victims of DV/IPV.\textsuperscript{34} Substance use and abuse was frequently seen as a factor in DV/IPV, with alcohol or drug use commonly being seen in males identified as batterers.\textsuperscript{2}

**Pathophysiology**

DV/IPV has been described as a spiral of violence in which threats, intimidation, control, and battering increase over time.\textsuperscript{4} While the types of abuse may vary and scientific models may only explain some of the abuse scenarios, the perpetrator is typically described as maintaining a constant state of power and control over the victim. The abuser may stop some blatant behaviors at times, as outlined in the cycle of violence model, but will continue utilizing different oppressive tactics to victimize the targeted person.\textsuperscript{42}

In approximately 75% of relationships, there are three distinct stages in the cycle: Tension building, explosion, and the honeymoon period.\textsuperscript{42} In the tension building stage, the abuser may use verbal threats as a means of control. Eventually, the increased tension leads up to increasing violence (the explosion stage). Finally, in the honeymoon period, there is an attempt at reconciliation and promises of an end to the abuse.\textsuperscript{4} It is the honeymoon phase that may encourage the victim to stay in the relationship, with the hope that things will get better. However, over time, these periods of reconciliation and peace diminish and the severity of the abuse and violence often increases. The cycle can happen hundreds of times, with each stage lasting a different amount of time, from a few hours to a year or more. Often, as time goes on, the tension building and the honeymoon stages can disappear.

Saltzman describes five main types of intimate partner violence:\textsuperscript{43}

1. Physical violence - the intentional use of physical force. Physical violence includes, but is not limited to: Scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, using a weapon, and using restraints or one’s body, size, or strength against another person.

2. Sexual violence - divided into three categories: 1) Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) Abusive sexual contact.

3. Threats of physical or sexual violence – perpetrator uses words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.

4. Psychological / emotional violence  - involves acts, threats of acts, or coercive tactics, such as humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources.

5. Stalking - In addition, stalking can be included among the types of IPV.\textsuperscript{31} In lay terms, stalking can be described as physically following another person in an unwelcome manner. In more legally precise terms, virtually all state definitions include language that defines a pattern of conduct that is directed at a specific person and is intended and may actually place the targeted person in fear for their safety.\textsuperscript{44} Some statistics related to stalking include:

- Annually in the United States, 503,485 women are stalked by an intimate partner.\textsuperscript{31}
- Seventy-eight percent of stalking victims are women. Women are significantly more likely than men (60% and 30%, respectively) to be stalked by intimate partners.\textsuperscript{45}
- Eighty percent of women who are stalked by former husbands are physically assaulted by that partner, and 30% are sexually assaulted by that partner.\textsuperscript{45}
Differential Diagnosis

Because of the overlap seen between child maltreatment and DV/IPV, in the clinical situation where a child is being evaluated for child maltreatment, particularly child physical abuse, the family should be assessed for the presence of DV/IPV. Thus, DV/IPV should be in the differential diagnosis when child abuse is being evaluated. Additionally, universal screening programs in the pediatric primary care setting have identified “occult” cases of DV/IPV which suggests that family violence needs to be in the differential diagnosis of essentially any pediatric visit. Siegel and colleagues screened 154 women during well-child visits over a three month period of time and found 47 (31%) of the women revealed DV/IPV at some time in their lives with 25 (17%) of them reporting DV/IPV within the past two years. Five of the women’s most recent injury was during their most recent pregnancy. Of these cases, five were associated with child maltreatment cases. Thus, universal screening found unsuspected cases not associated with child maltreatment and supports the notion that DV/IPV should be on the differential diagnosis list for both well and sick visits.

Looking specifically at the pediatric ED, Duffy and colleagues conducted a cross-sectional survey of 157 mothers with children less than three years of age who visited an urban pediatric ED and found that 52% of the women reported histories of adult physical abuse and 21% reported adult sexual abuse. The perpetrators were intimate partners in 67% of the adult physical abuse victimization cases and 55% of the adult sexual abuse victimization cases, again supporting the presence of DV/IPV in the families of caregivers who bring their children in for care to pediatricians and PEM specialists.

Prehospital Care

Emergency Medical Service (EMS) providers often encounter cases involving DV/IPV. In a study of Boston EMS, of 876 patients screened for DV/IPV, 16% were identified as positive or probable for DV/IPV. Among DV-positive patients, the refusal to transport rate was, on average, 23.4%, compared with a 4.7% overall refusal rate for the general Boston EMS population during the same year.

Although education in handling cases of DV/IPV is essential for EMS providers, training for EMS providers is often less than adequate. One study reported that only 67% of providers surveyed had some training, and only 25% felt that they had any training in assessing the scene for potential violence. In a study of urban EMS providers, prior to instruction, only 35% correctly identified the prevalence of DV/IPV against women and only about half knew that DV is common across various ethnic groups and that the victim should not be viewed as responsible for the abuse.

The American College of Emergency Physicians (ACEP) recommends: “Initial and continuing education programs for EMS personnel must incorporate information about domestic violence, including identification of victims, special aspects of care, scene safety and documentation requirements.... special attention should be directed toward the emotional needs of the victim..... EMS personnel need to see that by treating a victim in a respectful, sensitive and sympathetic manner, by confirming that the victim is not at fault and does not deserve to be abused, and by ensuring the victim safety, they will become agents of change in helping to give the support needed to eventually leave the abusive environment. If the patient elects not to be transported to an emergency department, pre-hospital providers should have a written list of community resources, including shelters and hot-line numbers that can be left with the victim.”

ACEP goes on to recommend training in scene safety and the importance of removal of the victim from the perpetrator and involvement of police as soon as it is suspected that DV/IPV is involved, as violence may be directed toward the EMS provider. Because DV/IPV is a crime, EMS providers should be trained in preservation of evidence and comprehensive and exact documentation, using the victim’s own words whenever possible. Precise recording of any injuries is also important.

Communication with emergency department personnel regarding suspicions of DV/IPV or observations made is also recommended as important to the overall care process.

ED Evaluation

While the American Academy of Pediatrics (AAP) and ACEP recommend screening in the pediatric and emergency settings, neither give guidelines on how to proceed with screening, evaluation, and intervention. Screening does not need to be done by the physician. However, the health care team member who asks the questions must be trained in screening methods,
appropriate responses, and interventions; they must also be someone who is authorized to document in the patient’s chart. Once the screening is done, further assessment and intervention can then be provided by the initial provider who does the screening, another health care team member, a designated DV advocate, or a well trained volunteer.

There is debate as to the best method of screening. Some studies have found that regular face-to-face screening of women by skilled health care providers greatly increases the detection of DV/IPV victims. However, other studies have shown that written, audio, or computer-based questionnaires may, in fact, be superior in identifying DV/IPV. When utilizing face-to-face screening, the screening process should not be done with the partner in the room. Debate remains as to whether or not children should be in the room during DV/IPV screening. In general, screening can occur with children under the age of two to three years in the room. However, when children are over age three, there is concern that children being in the room may be a barrier to the mother’s ability to disclose because of the nature of the information to be discussed. There is also the very real potential that the verbal child might relay to the batterer the responses to the questions, once at home. (See the Controversies/Cutting Edge section).

There is also the question of the value of routine versus targeted, indicator-based screening. According to the Family Violence Prevention Fund, routine screening of all adolescent and adult patients increases opportunities for identification and effective intervention, validates DV/IPV as an important health care issue, and enables providers to help victims and their children. By simply asking about abuse, the health care provider communicates support for the victim, even if she chooses not to disclose the abuse, and thereby increases the likelihood that the victim will subsequently discuss the issue at a future date. While health care providers should strive for routine screening of all patients, an alternative is targeted screening involving high risk groups, such as women in the prenatal, perinatal, or postnatal period, teens, women who have recently moved or started a new relationship, patients who appear fearful of their partner, or patients who have any other suspicious behaviors or injuries. Screening should not occur if the provider cannot secure a private space, if there are concerns that conducting an assessment might be unsafe for the patient or provider, or if there is not an appropriate interpreter.

If screening does not occur, document the reasons why it was deferred in the patient record.

The provider also needs to know what questions should be asked and how to ask them. Be aware of any personal bias you may have. All patients should be asked about both current and prior DV/IPV. Use interpreters when necessary. Setting a context for the questions can help make the assessment more comfortable for the patient and provider. For example: “Because the health and safety of the mother affects the health and safety of the child, I am going to ask you a few questions that I ask everyone.”

Questions should be direct and non-judgmental in simple language that is culturally and linguistically appropriate. Technical questions such as “Have you ever been the victim of domestic violence?”

**Table 1: Sample Questions For Domestic Violence Screening**

- “Because your health and safety can affect the health of your child, I will need to ask you some questions that may be personal...is that ok?”
- “Because violence in the home is so common, I ask all parents about it. Is that ok?”
- “How are things at home?”
- “How is your relationship with your partner?”
- “What happens when you get into an argument?”
- “Would you say that your partner is the jealous type?”
- “Does your partner try to control what you do or where you go?”
- “Does your partner ever hit you or threaten you?”
- “Do you ever feel afraid of your partner?”
- “Does your partner ever hit you or your children?”
- “Do you feel like you or your children are in danger?”
- “Does your partner ever hit the kids?”
- “Does your partner ever hit animals?”
- “Are you afraid to leave?”
- “Is your partner becoming more violent?”
- “Are there any weapons in the home?”
- “Does your partner have access to weapons?”

**Table 2: Sample Responses For Domestic Violence Screening**

- “DV is common in many women’s lives, but that doesn’t make it all right.”
- “There is help available if you want it.”
- “No one deserves to be hurt.”
- “What would you like to do about this?” or “What would you like to happen?”
might not elicit an accurate response. Most experts recommend more simple language and direct questions, such as, “All couples fight. What happens when you and your partner fight?” or “Are you or have you ever been in a relationship where your partner has threatened you or physically hurt you?” See Table 1 and Appendix A on page 15 for additional screening questions. Some states have mandated reporting laws for DV/IPV so each provider should make themselves aware of the reporting requirements for each location in which they provide care.

Don’t forget to ask about child maltreatment as well. Ask questions such as, “How do you discipline your children?” or “Does anyone ever hit your children?” Remember, if there are concerns about child abuse, all 50 states have reporting requirements, regardless of whether or not there is concurrent DV/IPV. Be aware of the mandates in your state. Some states require mandated reporters to notify child protection services when a child has been a witness to domestic violence, regardless of whether or not the child has been directly abused. However, when filing a report in the face of DV/IPV, work with the victim to make the report, and provide protective services with information on how the victim has tried to protect the children, when applicable.

What if she says “YES?”

In a study of women who were victims of DV/IPV, physicians were encouraged to affirm the abuse, know local resources for DV/IPV victims, make appropriate referrals, educate victims about how the abuse affects their health, and document the abuse. The first step is to take a deep breath and listen.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Client</th>
<th>Provider</th>
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<tbody>
<tr>
<td>Pre-Contemplation</td>
<td>* The stage of denial</td>
<td>* Ask about IPV</td>
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<tr>
<td></td>
<td>* No intention to change</td>
<td>* Raise doubt by sharing observations about the relationship</td>
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<tr>
<td></td>
<td>* Unaware of the problem, or defines the problem differently than others do</td>
<td>* Educate about the impact on patient’s health</td>
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<td></td>
<td>* “He only hits me when he’s high.”</td>
<td>* Empathize</td>
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<td></td>
<td></td>
<td>* Assess safety</td>
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<td></td>
<td></td>
<td>* Don’t push</td>
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<tr>
<td></td>
<td></td>
<td>* Document</td>
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<tr>
<td></td>
<td></td>
<td>* Offer resources</td>
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<tr>
<td>Contemplation</td>
<td>* May be more aware of the problem</td>
<td>* Explore ambivalence</td>
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<tr>
<td></td>
<td>* Likely to be highly ambivalent</td>
<td>* Provide a neutral stance</td>
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<td></td>
<td>* Weighs pros and cons of change; recognizes risks of leaving</td>
<td>* Educate</td>
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<td></td>
<td>* May begin to think about the idea of change, but has not fully decided</td>
<td>* Create a decisional balance chart to weigh the pros and cons of leaving</td>
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<td></td>
<td></td>
<td>* Assess safety</td>
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<td></td>
<td></td>
<td>* Provide resources</td>
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<tr>
<td>Preparation</td>
<td>* Decision making stage</td>
<td>* Make change a priority</td>
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<td></td>
<td>* Ready to accept that there is a problem and intends to make a change</td>
<td>* Encourage movement</td>
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<td></td>
<td>* Needs to establish his or her own personal criteria for change</td>
<td>* Provide a realistic plan</td>
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<td></td>
<td></td>
<td>* “Consultant role”</td>
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<td></td>
<td></td>
<td>* Make victim aware of the dangers of going into the action stage</td>
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<td></td>
<td></td>
<td>* Provide resources</td>
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<tr>
<td>Action</td>
<td>* Commit time and effort into implementing the planned changes</td>
<td>* “Right-sized” steps</td>
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<tr>
<td></td>
<td></td>
<td>* Plan for high-risk situations</td>
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<tr>
<td>Maintenance</td>
<td>* An extended “stage”</td>
<td>* Provide resources</td>
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<tr>
<td></td>
<td>* Will develop new behaviors and coping skills</td>
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<td></td>
<td>* May “relapse” into abusive relationship</td>
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<td></td>
<td></td>
<td>* If the victim returns to the abusive relationship, remind them that this does not imply failure</td>
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<td></td>
<td></td>
<td>* Provide support system that is personally/culturally relevant</td>
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<tr>
<td></td>
<td></td>
<td>* Provide resources</td>
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</tbody>
</table>
Battered women report that being listened to was one of the most important aspects of their interaction with a physician.说些支持的话语。

Despite the physical and emotional abuse sustained by battered women, victims commonly find themselves blamed for the abuse. Victims are commonly asked “Why do you put up with that?” or “Why don’t you just leave?” While they may be well intentioned, these statements are ego deflating, and may delay the victim’s pursuit of change by putting the onus of abuse on the victim. An example of a supportive response is “It is not your fault,” or “Help is available.” See Table 2 on page 6, and Appendix A on page 15 for additional appropriate responses.

Also, be sure to assess immediate safety. Suggested questions include: “Are you in immediate danger?” “Has your partner ever threatened to kill you?” “Has the violence gotten worse?” “Do you have somewhere safe to go?” If there are concerns for immediate safety, refer the patient to a local shelter, and work with the victim to involve police when necessary.

Your physical examination begins with careful observation of the parent, child, and the parent-child interaction. Conduct a full head to toe examination, with special attention to possible signs of child abuse. Disrobe the child to look at all skin surfaces for signs of bruising, scars, or other lesions which can represent old or new injuries. Look closely in the mouth for frenulum tears, which can occur from forcing an object such as a bottle into the child’s mouth. A good musculoskeletal exam should be done to look for signs of bony tenderness or callous formation.

As with cases of suspected child abuse, cases involving domestic violence have both social and legal implications in addition to medical implications. Therefore, thorough and accurate documentation is crucial. However, keep in mind that the perpetrator may also be a parent of the child and have access to the child’s medical record. Ask the victim if it is safe to document DV/IPV in the chart. Consider developing a policy within your department to document abbreviations, such as “+DV,” indicating the presence of DV/IPV. If safe to do so, document the victim and the child’s exact words in quotations. If no explicit policies exist in the pediatric ED around DV/IPV screening and its documentation, it may be wise to consult the policy recommendations and model wording that may be found on the Family Violence Prevention Fund’s website at endabuse.org.

Document all injuries carefully, including any laboratory data and radiology studies. Women who report DV/IPV should be referred to a designated provider, whether it is the ED social worker, DV advocate, or other personnel. The team member assigned to work with the DV/IPV victim can help the physician with the safety assessment, safety planning, education, and referrals. If the victim refuses to speak with the team member or DV advocate, make sure that the victim is connected with resources. Provide referrals to your patient for both local and national resources. If the victim indicated that it is not safe for her to take literature, ask if she can at least write down the national hotline phone number. The hotline workers do not identify themselves when they are called, in case the perpetrator tries to identify the number that the victim is carry-

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**Key Points**

- Domestic violence is common; approximately one in three to four adult women have experienced a physical assault by an intimate partner during adulthood.

- Domestic violence crosses all socioeconomic, racial, and geographic boundaries.

- Domestic violence is a pediatric issue, as 3.3 to 10 million children witness domestic violence each year.

- Domestic violence screening in the pediatric setting may be one of the best methods of preventing child abuse, as children who are in homes with domestic violence are 6 to 15 times more likely to be abused than their peers.

- Patients with domestic violence concerns should be provided with resources, such as the National Domestic Violence Hotline at 1-800-799-SAFE.
Table 4: National Resources For Domestic Violence Victims

<table>
<thead>
<tr>
<th>Resource</th>
<th>Number/Website</th>
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<tbody>
<tr>
<td>National Sexual Assault Hotline</td>
<td>1.800.656.HOPE <a href="http://www.rainn.org">www.rainn.org</a>.</td>
</tr>
<tr>
<td>Family Violence Prevention Fund</td>
<td><a href="http://www.endabuse.org/">http://www.endabuse.org/</a></td>
</tr>
<tr>
<td>National Center for Victims of Crime</td>
<td><a href="http://www.ncvc.org/ncvc/Main.aspx">http://www.ncvc.org/ncvc/Main.aspx</a></td>
</tr>
<tr>
<td>National Violence Against Women Prevention Research Center</td>
<td><a href="http://www.vawprevention.org/">http://www.vawprevention.org/</a></td>
</tr>
<tr>
<td>Stop Family Violence</td>
<td><a href="http://www.stopfamilyviolence.org/ocean/host.php?page=0">http://www.stopfamilyviolence.org/ocean/host.php?page=0</a></td>
</tr>
<tr>
<td>U.S. Department of Justice Office on Violence Against Women</td>
<td><a href="http://www.usdoj.gov/ovw/">http://www.usdoj.gov/ovw/</a></td>
</tr>
</tbody>
</table>

Table 5: Resources On Domestic Violence For Health Care Providers

<table>
<thead>
<tr>
<th>Resource</th>
<th>Number/Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>The National Health Resource Center on Domestic Violence</td>
<td>1-888-Rx-ABUSE <a href="http://www.endabuse.org/health">www.endabuse.org/health</a></td>
</tr>
<tr>
<td>Institute for Safe Families</td>
<td><a href="http://www.instituteforsafefamilies.org/">http://www.instituteforsafefamilies.org/</a></td>
</tr>
</tbody>
</table>

Ten Pitfalls to Avoid

1. Don’t assume your patient is not a victim of domestic violence because “They are from a nice suburban family.” Domestic violence crosses all socioeconomic, racial, and geographic boundaries.
2. Don’t assume your patient is not a victim of domestic violence because they are male. Up to fifteen percent of victims are male.
3. Don’t forget to screen all patients at high risk: Pregnant, peripartum, and postpartum women, teens, and patients with difficult to explain or repeated injuries.
4. When a victim says “yes” to screening, avoid condescending comments such as, “Why don’t you just leave?” These comments further decrease the victim’s self-confidence. Be empathetic; say something like, “Many women are victims of abuse, but that doesn’t make it right.”
5. Don’t coerce a victim into immediately leaving the relationship. This may not be safe. It must be the victim’s decision. Leaving is a process and most homicides occur at this stage. Steps must be taken to ensure safety for the victim and the victim’s children.
6. Don’t forget to screen for concurrent child abuse.
7. Don’t forget to report child abuse. While domestic violence is not reportable in most states, practitioners are mandated to report child abuse in all 50 states.
8. Don’t forget to give resources if it is safe to take them home. Even if the victim is not ready to leave, make sure he or she at least has a hotline number to call for help.
9. Don’t forget to document. Document that you screened even if the answer was no. Document the details of the violence if it is safe to document in the child’s chart. Thoroughly document the extent of the injuries.
10. Last but not least, don’t be afraid to ask. Studies have shown that even though the victim may not report to a physician the first time asked, they do appreciate that the question was asked.
Clinical Pathway: DV Screening In The ED

Domestic Violence Screening

Routine / Universal Screening
- Screen all patients

Targeted Screening
- Prenatal, peri-natal, up to one year post-natal
- Concerning behavior: Controlling partner, fearful, depressed, or suicidal
- Someone with changes in living situations, a new partner, or who has recently moved
- Teens
  - Anyone presenting with an injury

The evidence for recommendations is graded using the following scale. For complete definitions, see back page. Class I: Definitely recommended. Definitive, excellent evidence provides support. Class II: Acceptable and useful. Good evidence provides support. Class III: May be acceptable, possibly useful. Fair-to-good evidence provides support. Indeterminate: Continuing area of research.

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

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Diagnostic Studies

If, in the course of your evaluation for the presenting complaint, the child is discovered to have an injury, proceed as usual, utilizing the appropriate laboratory and radiology diagnostic studies. However, if there are concerns about ongoing child maltreatment, consider a skeletal survey for children under age three and non-verbal children. Consider workup for additional trauma as indicated, such as a head CT and ophthalmologic evaluation to rule out occult head injury, and abdominal labs or imaging when there is suspicion for abdominal trauma. In a three month study of universal DV/IPV screening by Siegel and colleagues, of the five cases of child abuse associated with DV/IPV, two were newly identified because of the DV/IPV screening and were not previously known to the pediatrician prior to the screening.46

Treatment

As an EM or PEM provider, it would be unwise to begin routine screening without a system for intervention in place. The first step in developing a screening and intervention program is to contact local DV/IPV and batterer programs in your community and discuss how you will link the identified victim of DV/IPV with the appropriate resources. This is not a task a busy EM/PEM physician can accomplish alone. By utilizing the resources already available, typically in collaboration with your social work or nursing departments, you can help develop a successful program to help patients begin the process of making their environment safer for the victim and the children. However, as with many other interventions, the victim must be ready to make changes. Health care provider’s must understand the complex nature of the battered woman’s situation, as these women require survival skills and the strength to decide to leave and act upon that decision.63 Imagine the difficulty you face when trying to convince your patients to change even well recognized behaviors to improve health, such as dietary changes, exercise, or smoking cessation.64 Only by considering the context of relationships, fear of bodily harm and threats, limited financial and social resources, and issues of housing, children, and the dangers of leaving can we begin to understand the dramatic issues the battered woman faces.64

The stages of change model has recently been gaining attention as a model that explains how best to assure treatment for victims of DV/IPV.18,64 First described by Prochaska in 1979 and applied to smoking cessation and other areas of behavioral change, the model has been used to guide intervention programs in the prevention of child maltreatment.64

Cost Effective Strategies

Costs of IPV against women in 1995 exceeded an estimated $5.8 billion. These costs included nearly $4.1 billion in the direct costs of medical and mental health care and nearly $1.8 billion in the indirect costs of lost productivity.32 In a study looking at health care expenditures from a health care plan from Minnesota, women who were victims of DV/IPV cost the plan approximately 92% more than a random sample of general female enrollees, which amounted to an annual difference of about $1775 more being spent on the DV/IPV victims.80 The US Preventive Services Task Force (USPSTF), a group of health experts who routinely review published research and make preventive health care recommendations, found that potential benefits to screening for family violence included decreased disability, injury, or premature death. Potential harms included increased risk of abuse when the victims or others confronted the abuser. The USPSTF did not find any studies looking at routine or universal DV/IPV screening in the general population, but did find evidence to support that interventions in families at a higher risk for abuse reduce harm to children. The studies were inadequate to find an effect for women and no studies were found that directly measured potential harms of screening families for family violence. Building off of the cost effectiveness of targeted child abuse prevention programs, one could reasonably assume that similar cost benefit trends will emerge in the screening and intervention programs around DV/IPV, especially when child maltreatment is prevented as a result. We must await such rigorous data, however, since, at present, the results of such studies have not been published in the literature.
this model of change involves a dynamic process with progression through five stages of change: Precontemplation, contemplation, preparation, action, and maintenance.\textsuperscript{64-66} We cannot force people to change.\textsuperscript{64} Pushing the victim of abuse to do more than they are ready to do may alienate the victim.\textsuperscript{62} In addition, leaving the abuser may be the most dangerous time for the victim and her children, and requires safety planning and gathering of resources. See Table 3 on page 7 for an outline of possible stage matched interventions.

Progression through the five stages of change (precontemplation, contemplation, preparation, action, and maintenance) is not usually linear. Once a stage is achieved, the person may regress to previous stages, recycling through the stages.\textsuperscript{64} Relapse is a natural and expected part of progressing, as the person potentially learns from their mistakes.\textsuperscript{64}

The role of the EM/PEM physician should not be to counsel the victim on how to leave or make changes, but to connect the victim with the appropriate resources and personnel who can provide these services. Some national resources are referenced in Table 4 on page 9.

If the parent is noted to have injuries that are concerning for DV/IPV, encourage the mother to seek care for herself. (If you are in an adult institution, workup for both victim and child can be performed simultaneously). If you are in a pediatric institution, refer the victim to an adult ED and ensure appropriate follow-up to encourage her to actually seek out the care.

Special Circumstances

Teens And Dating Violence

Women aged 16 to 24 experience the highest rate of DV/IPV of all age groups.\textsuperscript{67} In a Massachusetts study, approximately one in five female students (20.2\% in 1997 and 18.0\% in 1999) reported being physically and/or sexually abused by a dating partner.\textsuperscript{57} Nearly one in ten older girls reported abuse by dates or boyfriends and 8\% of high school age girls said “yes” when asked if “a boyfriend or date has ever forced sex against your will.”\textsuperscript{69} In a more recent CDC study among students in grades 7 to 12 during 1994 to 1995, the 18-month prevalence of victimization from physical and psychological dating violence was estimated at 12\% and 20\%, respectively. Especially among women, dating violence victimization can be a precursor for intimate partner violence in adulthood. Study findings indicated that 8.9\% of students (8.9\% of males and 8.8\% of females) reported dating violence victimization during the 12 months preceding the survey, and that students reporting victimization were more likely to engage in four of the five risk behaviors (i.e., sexual intercourse, attempted suicide, episodic heavy drinking, and physical fighting).\textsuperscript{70} Forty percent of girls age 14 to 17 knew someone their age who had been hit or beaten by a boyfriend.\textsuperscript{71}

Women who were victims of both sexual and physical abuse as a child were more likely to become adult victims of sexual or physical abuse and/or were more likely to be victimized in high school.\textsuperscript{36} Women who were victimized in high school were found to be at a much greater risk of physical or sexual abuse in college.\textsuperscript{36} In addition, physical and sexual abuse against adolescent girls in dating relationships increases the likelihood that the girl will abuse drugs and/or alcohol, develop an eating disorder, consider and/or attempt suicide, engage in risky behavior, and/or become pregnant.\textsuperscript{68}

For teens, ask about domestic violence in their home and in their relationships. Sample screening questions for teens include, “Many teens your age experience threats, name calling, uninvited touching, or violence, so I ask all teens about violence. Have you ever been hurt or threatened by anyone you know?” or “Have you ever been forced to do something that you didn’t want to do?” If there are concerns, proceed as per your institution’s policies for DV/IPV.

Controversies And Cutting Edge

Effect Of DV/IPV Mandatory Reporting Laws

There is wide variation among states in what is required by health care providers in terms of reporting cases of DV/IPV to legal authorities.\textsuperscript{72} Proponents of mandatory reporting laws for DV/IPV cite potential benefits such as making access to victims assistance easier. Opponents voice concerns that knowing that a report will be made if one discloses DV/IPV to a health care provider may decrease victims’ likelihood of disclosing, makes another person have control over the victim, and may increase the risk of the perpetrator retaliating against the victim since the report may not coincide with the victims safety planning.\textsuperscript{73} Abused women who are victims of DV/IPV were significantly less likely to support mandatory reporting laws when compared to the
views of non-abused women. Rodriquez and colleagues conducted a cross-sectional survey among women in EDs in each state and found that, of DV/IPV victims, slightly more than half supported mandatory reporting whereas, among women who were not DV/IPV victims, over two-thirds supported the mandatory reporting. In an anonymous 10-question survey given to women in various EDs, Hayden and colleagues found that many of the DV/IPV victims felt comfortable discussing DV/IPV issues in the ED, especially if asked directly, but nearly 40% of the DV/IPV victims would not have disclosed if they knew that the health care personnel were required to report it to legal authorities. Houry and colleagues conducted an assessment of the impact of a 1995 mandatory reporting law for DV/IPV in Colorado and found convincing evidence in their survey of 577 patients that the mandatory reporting law only rarely deterred a patient from seeking medical care. In their study, only 12% of patients stated that they would be less likely to seek medical care for a DV/IPV related injury because of the existence of the mandatory reporting law. Thus, at this point, the overall impact of mandatory reporting laws remains unclear; what is certain is that victimized women who have been studied are less likely to see mandatory reporting as a positive whereas non-victimized women see mandatory reporting of DV/IPV by health care providers as positive and beneficial.

Screening With Children In The Room

As briefly discussed previously, most experts agree that it is acceptable to assess for DV with children under ages two to three in the room. However, there is continued debate regarding screening with older children in the room. General questions regarding DV may be acceptable with older children in the room, but when more detailed questions arise, it is better to ask these questions in private. In an interview study of 12 experts who work with children and parents, which included five pediatricians and three family physicians, Zink found that a majority of the experts thought that general screening questions for DV/IPV were appropriate in front of children of all ages. The general questions included: “Everyone has conflicts; how do you resolve them?” “What happens in your house when people are angry?” “Has your child ever been exposed to any-thing that would make him nervous or upset?” “Does your child have nightmares as a result of family disruptions?”

The experts agreed that positive or equivocal responses to these types of questions should prompt questioning in private away from the child who is older than two or three.

Disposition

The social changes in the U.S. in the 1960s and 1970s created an environment in which the problem of domestic violence could be more openly discussed in both the professional and lay public arenas. Prior to this change, DV/IPV was considered a private matter between related individuals and law enforcement did not typically intervene. Victims of violence had little to no recourse and felt shame and embarrassment. Until the mid-1970’s, violence against wives was considered a misdemeanor in most states.

Following a nationwide recognition of the rights of women to be safe in their homes, Pennsylvania enacted the nation’s first domestic restraining law in 1976. In 1990, the first comprehensive federal legislation was introduced responding to violence against women. With the help of advocates nationwide, The Violence Against Women Act (VAWA) was finally signed into law in August of 1994 as part of the Violent Crime Control and Law Enforcement Act of 1994 (PL-103-322).

Programs for domestic violence victims have proliferated across the country. Since 1996, the National Domestic Violence Hotline has answered over one million calls. On October 4, 2005 the United States Senate re-authorized the Violence Against Women Act. This legislation has been a tremendous success in addressing an “appalling problem.” The Violence Against Women Act created:

- New penalties for gender-related violence
- New grant programs encouraging states to address domestic violence and sexual assault including:
  - Law enforcement and prosecution grants (STOP grants)
  - Grants to encourage arrest
  - Rural domestic violence and child abuse enforcement grants
  - The National Domestic Violence Hotline
  - Grants to battered women’s shelters
With laws protecting women from abuse, shelters as a safe haven, and counseling, women are more likely to report abuse and are less fearful and more empowered to get out of the vicious cycle.

While in most states there is no mandate to report DV, all 50 states have laws requiring professionals to report child abuse. When child abuse is identified, the practitioner should make the report with the victim, explaining the situation of domestic violence if possible, and pointing out the measures the victim has taken to ensure the safety of the children, if any.

Summary
If up to one in four women experience domestic violence in their lifetime, it is unlikely that a shift passes without seeing a female patient or a mother of a patient who has been the victim of domestic violence. ED staffs, including pediatric ED staffs, are in a pivotal situation to make a difference and have the potential opportunity to recognize victims of DV/IPV and to help stop the cycle of violence for the victim of DV/IPV and, in so doing, to potentially prevent child maltreatment as well. The material presented in this issue should serve as both a call to action as well as a roadmap for effective action in combating this serious problem that affects the health and well-being of children and families throughout our nation. Take the first steps and learn about the community resources to which you can refer women who are in need of help, and partner with you health care team-members to initiate policies and procedures in your ED to just ask and refer when necessary!

Appendix A: RADAR
FOR PEDIATRICS: A DOMESTIC VIOLENCE INTERVENTION

R = ROUTINELY SCREEN MOTHERS FOR ABUSE
Intervening on behalf of battered women is an active form of preventing child abuse. Victims of violence are very likely to disclose abuse to a health care provider, but only if they are asked about it.

Always interview the parent alone if the child is over two years old.

A = ARE YOU BEING HURT?
Ask questions routinely in the course of taking a social history in the context of safety and discipline. “The safety of moms can affect the health and safety of children, so I want to ask you some personal questions.” “Because violence is common in so many women’s lives, I’ve begun to ask about it routinely.” “Is there anyone who has physically or sexually hurt you or frightened you?” “Have you ever been hit, kicked, or punched by your partner?” “I notice you have a number of bruises; did someone do this to you?”

IF THE MOTHER ANSWERS “YES,” SEE THE NEXT PAGE FOR RESPONSES AND CONTINUE WITH THE FOLLOWING STEPS:

D = DOCUMENT FINDINGS
Document in the pediatric chart that RADAR screening was done. Indicate response as “+”, “−” or “suspected.” Ask Mom if it is safe to document in chart. If yes, use statements such as “The child’s mother states she was…” With her permission, include the name of the assailant in your record. “She says that her boyfriend, John Smith, struck her…” Note any obvious injuries to the mother. Offer her help in arranging for appropriate medical services.

A = ASSESS SAFETY OF MOTHER AND CHILDREN
Before she leaves the medical setting, find out if it is safe for her and her children to go home. Has there been an increase in frequency or severity of violence? Have there been threats of homicide or suicide? Is there a gun or other weapon present? Have there been threats to children or pets? Are the children currently being abused or in immediate danger?

R = RESPOND, REVIEW OPTIONS & REFER
Know in-house and local resources for referral. If the patient is in immediate danger, find out if there is someone with whom she can stay. Does she need immediate access to a shelter? Offer her the opportunity to use a private phone. If she does not need immediate help, offer information about hotlines and resources in the community (see next page). Offer to write down phone numbers if it is unsafe to take information. Remember that it may be dangerous for her to have those in her possession. Discuss the effects of family violence on children. Do the children need a referral? Make a follow-up appoint-
ment to see her and her children and document the options discussed.

IF THE MOTHER ANSWERS “YES:”

Encourage her to talk about it.
“Would you like to talk about what has happened?” “What help do you need?” “What would you do if this happens again?” “How do you think this has affected you’re your children?”

Listen non-judgmentally.
This will begin the healing process for the woman and give you an idea about what kind of referrals she needs.

Validate her experience.
“You are not alone.” “You do not deserve to be treated this way.” “You are not to blame.” “What happened to you is a crime.” “Help is available to you.” “The violence is likely to get worse, and I am worried about you.” “If you are not safe, your children are not safe.”

BE AWARE OF A CONNECTION BETWEEN CERTAIN CLINICAL SIGNS AND DOMESTIC VIOLENCE:

If clinical signs such as depression, suicidal ideation, anxiety, sleeping and/or eating disorders, or substance abuse are present, ask more specific questions. Make sure she is alone. “I am worried about you. It looks as though someone may have hurt you. Can you tell me how it happened?” “Sometimes when people feel the way you do, it’s because they are being hurt at home. Is this happening to you?”

If the mother denies abuse, but you strongly suspect it, let her know there are resources available to her when she chooses to pursue such options in the future. Discuss the effects of family violence on children. Being exposed to violence in the home can be as traumatic for a child as being a direct victim of violence. Let her know that she can come to you in the future if she has questions or needs help. Make a follow-up appointment to see her and her children.

RESOURCES

- 866.SAFE.014 (866.723.3014) Philadelphia Domestic Violence Hotline
- 215.686.7082 Women Against Abuse Legal Center
- 215.985.3333 Women Organized Against Rape
- 215.242.2235 Menergy- For men who are abusive
- 267.625.6135 Menergy en Espanol- For men who are abusive
- 215.564.0488 Men’s Resource Center- For men who are abusive
- 215.496.0707 Children’s Crisis Treatment Center- Trauma focused therapy for children
- 215.438.9070 Anti-violence Partnership- Trauma focused therapy for children

References
Evidence-based medicine requires a critical appraisal of the literature based upon study methodology and number of subjects. Not all references are equally robust. The findings of a large, prospective, randomized, and blinded trial should carry more weight than a case report.

To help the reader judge the strength of each reference, pertinent information about the study, such as the type of study and the number of patients in the study, will be included in bold type following the reference, where available.

12. Edelson, J. The overlap between child maltreatment and...


63. Burman S. Battered Women: Stages of Change and Other Treatment Models that Instigate and Sustain Leaving. Treatment Models that Instigate and Sustain Leaving. 2000;19(4):253-263. (Group randomized control trial, 5 primary care centers)


70. Children Now/Kaiser Permanente Poll. 1995. (Survey)

71. Children Now/Kaiser Permanente Poll. 1995. (Survey)


76. Erickson RA, Hart SJ. Domestic violence: legal, practice, and educational issues. Medsurg Nurse 1998;164 142-147. (Survey 310 practitioners)


CME Questions

79. Which statement best defines DV/IPV?
   a. Violence between strangers.
   b. A pattern of coercive behaviors including repeated battering and injury, psychological abuse, sexual assault, progressive isolation, deprivation, and intimidation.
   c. An uncommon form of violence that rarely presents to EDs.
   d. A form of violence that is almost never seen in dating relationships.

80. Which of the following statements is NOT true?
   a. Women are more likely to be victims of DV.
   b. Nearly 40% of women presenting to the ED for injury have been injured by their partner.
   c. Children living in homes with DV are not usually injured and do not suffer any negative consequences from exposure to DV/IPV.
   d. A physician may be the first person a victim of DV turns to for help.

81. When a victim reports that she is in a relationship with DV, which of the following would NOT be an appropriate response?
   a. “No one deserves to be hurt.”
   b. “Why don’t you just leave if he is hurting you?”
   c. “What would you like to happen?”
   d. “Are the children also being hurt?”

82. What should you do when the victim of domestic violence does not want help but there is also suspicion of child abuse?
   a. Nothing. DV is not reportable in most states.
   b. Nothing, because reporting child abuse could increase the danger for the victim and children.
   d. Nothing, since DV/IPV and child abuse are private matters that do not belong in the health care setting.
83. A 20-year-old mother brings both her six-month-old and 22-month-old for evaluation. You notice that she seems frightened and you want to ask her about DV/IPV. How should you proceed?
a. Don’t ask at this visit because the children are with her.
b. Avoid discussing DV/IPV since it may needlessly upset the mother.
c. Ask her directly, using plain, clear language.
d. Ask her in code language so that the children do not understand.

84. Screening questions for domestic violence should be:
a. Vague so as to avoid insulting the patient.
b. Devoid of feeling to prevent emotional involvement.
c. Direct, clear, and non-judgmental.
d. Done only when there is an obvious injury clearly visible to the physician.

85. Children who witness domestic violence are at increased risk for:
a. Depression and suicide
b. Aggressive behavior
c. Behavioral problems
d. All of the above

86. Victims of domestic violence:
a. Often feel guilt, shame, and embarrassment regarding the DV/IPV.
b. Are always ready to leave the relationship to be safe.
c. Will always tell someone when there is violence at home.
d. Are usually of low socioeconomic status.

87. Recommended DV/IPV screening practices in pediatric EDs include all of the following EXCEPT:
a. Screeners should demonstrate empathy, warmth, and a helping attitude.
b. The child’s medical needs should be addressed first.
c. A clear and organized process around determining risk to the child from the IPV environment must be maintained.
d. You should avoid distributing resources or offering referrals as they are not seen as helpful in this difficult situation.

88. Among adults 18 years of age and older, approximately how many victimizations occur per year from DV/IPV?
a. No more than 100 cases per year
b. Approximately 5250 cases per year
c. Approximately 5.3 million victimizations

89. The main types of DV/IPV include all of the following EXCEPT:
a. Physical violence
b. Sexual violence
c. Gang violence
d. Threats of physical or sexual violence

90. Barriers identified to screening women for DV/IPV in pediatric EDs include all of the following EXCEPT:
a. Lack of formal training in DV/IPV, especially when compared to child abuse training.
b. The availability of detailed protocols in most pediatric EDs.
c. Lack of DV/IPV experience.
d. Belief that DV/IPV is outside of the purview of pediatrics.

91. A survey of pediatric chief residents demonstrated that:
a. Ninety-three percent of chief residents think that pediatricians should screen for DV/IPV.
b. There is more training in DV/IPV versus child abuse training.
c. There is little interest in further training in DV/IPV.
d. There is an overwhelming majority of chief residents universally screening for DV/IPV.

92. All of the following statements regarding DV/IPV are true EXCEPT:
a. DV/IPV is chronic in nature, with 51.2% of women raped reporting multiple victimization by the same partner.
b. It is a major cause of family homelessness.
c. Pregnancy is a risk factor; at least 4 to 8% of pregnant women are abused at least once.
d. DV/IPV almost always occurs as just a one time, acute episode of violence.

93. The age group at the highest risk for DV/IPV among women is:
a. There is no difference between age groups; all groups are equally at risk.
b. No epidemiologic data is available to determine the differential risk among age groups for women.
c. Women aged 16 to 24 years old.
d. Girls aged 8 to 10 years old.
In terms of screening women for DV/IPV with children in the room, the general consensus is:

a. Screening should only be done if the child(ren) are under 12 months of age.

b. Screening is acceptable with children under two to three years of age in the room.

c. No consensus exists so no screening should be done with any child of any age in the room.

d. There is no problem or controversy with DV/IPV screening even with older children.

Class Of Evidence Definitions

Each action in the clinical pathways section of Pediatric Emergency Medicine Practice receives a score based on the following definitions.

Class I

- Always acceptable, safe
- Definitely useful
- Proven in both efficacy and effectiveness

Level of Evidence:

- One or more large prospective studies are present (with rare exceptions)
- High-quality meta-analyses
- Study results consistently positive and compelling

Class II

- Safe, acceptable
- Probably useful

Level of Evidence:

- Generally higher levels of evidence
- Non-randomized or retrospective studies: historic, cohort, or case-control studies
- Less robust RCTs
- Results consistently positive

Class III

- May be acceptable
- Possibly useful
- Considered optional or alternative treatments

Level of Evidence:

- Generally lower or intermediate

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Target Audience: This enduring material is designed for emergency medicine physicians.

Needs Assessment: The need for this educational activity was determined by a survey of medical staff, including the editorial board of this publication; review of morbidity and mortality data from the CDC, AHA, NCHS, and ACEP; and evaluation of prior activities for emergency physicians.

Date of Original Release: This issue of Pediatric Emergency Medicine Practice was published December 1, 2006. This activity is eligible for CME credit through December 1, 2009. The latest review of this material was November 1, 2006.

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