Routine Screening for Domestic Violence in Pediatric Practice

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We are indebted to the members of the Newton-Wellesley Hospital Domestic Violence Prevention Council, whose efforts have inspired this guidebook.

We are particularly grateful to those survivors who have shared their own personal stories. It is to them, to other parents who find themselves in a similar position, and to their children that this work is dedicated.

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In the February 7, 2000, issue of *The Boston Globe*, there is a picture of a mother comforting her five-year-old “as he [takes] medication…to help him cope with the stress…held inside since witnessing his mother being physically abused by a former boyfriend…months of beatings that he, his sister, and…brother witnessed, or heard from behind closed doors. But nothing seems to bring him peace.” (81)

“Increasing numbers of deeply traumatized children [are] turning up at battered women’s shelters, in classrooms, and at the pediatrician’s office. Only recently have specialists focused on children who live with family violence, and how to treat them…. Child advocates estimate that…more than 40,000 Massachusetts children each year see violence at home—from yelling and shoving to bloody beatings, and murder…. Unreported cases could triple that number.” (81)

It is time for pediatricians to take on this challenge.
# Table of Contents

Letter to the Reader ......................................................... iv  
Introduction ............................................................... 1  
A Survivor’s Story ......................................................... 3  

I.  Domestic Violence Is a Major Public Health Problem .......... 4  
II.  Is There Agreement as to What Is Meant by “Domestic Violence”? .. 5  
III.  The Impact on the Mother of Screening for Domestic Violence .... 6  
IV.  The Impact on the Pediatrician of Screening for Domestic Violence . 7  
V.  Who Is a Batterer? ...................................................... 9  
VI.  Who Is the Patient for the Pediatrician? ................................. 9  
VII.  The Impact of Domestic Violence on the Developing Child ....... 10  
VIII.  Helping Children Cope ............................................... 11  
IX.  Child Abuse—A Generational Issue ................................... 12  
X.  The Frequency of Non-Acknowledgement in the Medical  
    Interview ............................................................... 12  

XI.  Barriers to Problem Recognition and Intervention in the Primary  
    Care Setting ............................................................ 13  
XII. Is There a National Mandate to Conduct Screening for  
     Domestic Violence? ................................................... 14  
XIII. Preparing the Office .................................................. 15  
XIV. How to Conduct Screening ........................................... 15  
XV.  Empower, Refer, and Follow Up ...................................... 17  
XVI.  The Importance of Documentation .................................... 18  
XVII. Overcoming Barriers Through Education ............................ 19
October 1, 2000

Dear Colleagues:

Who would deny the value of asking a female parent whether she has experienced abuse in her life, past or present?

But is it realistic to expect pediatricians to do so, given that there isn’t enough time, as it is, to ask all the questions we should be asking? (88) Most doctors have very busy practices. Many of you have told me that the average well-child visit is no more than 12 to 15 minutes.

Most pediatricians believe we are far too busy to routinely ask about domestic violence. Even if we believe we should be asking, we search for shortcuts.

- One shortcut is to ask about domestic violence in the presence of an older child. (88) We rationalize doing so by saying to ourselves that the child knows it is going on anyway, even as we acknowledge there are dangers of asking such questions with the child present.

- Another is to use a questionnaire that parents fill out in the office while waiting to see us.

- Finally, we prioritize whom we ask. We may ask ourselves, “Does the child look like he or she might have been abused or has been witness to domestic violence?”

- Pediatricians will make their own judgments about the reliability of shortcuts.

- If we pediatricians are so busy, how do we justify taking the time to ask such questions?

When colleagues ask me, I try to share with them the idea of “repetition compulsion,” which informs my daily work when I listen to families. It is based on the premise that within each of us reside memories of conflicts from past experience. These memories are filed away in the dustbin of our respective histories. For example, the choice of medicine as a career, for some, may be the outcome of growing up with a parent who was severely ill. Becoming a doctor could be the result of trying to make up for that experience.

But for many, including the parents we see, there may not always be a creative outcome. For some individuals, painful memories may persist. If parents could talk about them, they might say, “Why did it happen? Was it my fault? Even if it wasn’t, whose fault was it? I can’t get over my anger (or sadness or anxiety) that it happened. Maybe someday I’ll understand it.”
I believe that if I don’t follow up by asking about the pain expressed by a parent, she or he will continue to raise that issue over time. Bearing that in mind keeps me from believing I am too busy to ask such questions. The opposite is true. It has saved much time over the years.

Physicians are busy struggling to cope with many of the absurdities of managed care, but that is a separate story.

Because of managed care, some of us, however reluctantly, reduce the time we spend listening to patients. If we do reduce the time we spend listening to patients, I worry whether we compound our problem. I would even propose that searching for that hidden pain—either the experience of domestic violence or other issues in the lives of families—could be the best antidote to feeling abused by managed care.

In short, taking time could mean saving time. And, with practice, we will do better.

Is it easy to ask a parent if she has been the victim of domestic violence? No, even though it gets easier over time. The answer should not be that we don’t have the time to do so. We can’t afford not to take the time.

How we do it, when we do it, and simply doing so routinely will be a function of how we incorporate the art of being a physician into our daily lives.

Sincerely,

Howard S. King, MD, MPH
INTRODUCTION

The purpose of this guidebook is to help pediatricians when they are confronted with one of our major public health problems—domestic violence. The challenge for pediatricians is how we should behave when one “intimate partner” in a family may be abusing another and children are involved.

But there is another challenge for pediatricians and other physicians—to become aware of the opportunities and advantages in our stressful health care environment.

Doctors willing to take the time to listen to patients can now be reimbursed. New methodologies for prevention are emerging. Patient satisfaction surveys focus on the issue of access and have the potential to encourage patient empowerment.

Every patient represents an opportunity for the physician to explore the effect of hidden attitudes on the health of the family. Explore what patients might be saying underneath their comments: “My needs are unfulfilled.... I don’t feel I can trust anyone.... I am hungry for meaningful relationship....” If we could reframe the demands, we might hear the feelings underneath.

Another opportunity: reframe the insurance term “benefits.” Benefits could be as much for the soul as for the body. The diagnosis of depression could mean more than a prescription for Zoloft. It could also become an invitation to help patients talk about their losses. Documentation could mean more than justifying a particular reimbursement. It could also provide the opportunity to document the patient’s story.

But who in their right mind would suggest that the problem of domestic violence might also provide opportunities to the physician? Who thinks of opportunities when we hear of women being verbally, even physically, abused? Who thinks of opportunities when women are thrown against the wall, raped, or strangled?

If, like “Alice in Wonderland,” we are willing to follow the child into the maze of the family system and be unafraid to find what is down below, we could better understand the problems the child presents, viewing them in a family context. The challenge is to search for problems of family life which, if discovered early, may reduce long-term pain and morbidity for so many people.

If we provide parents with time to tell their story, they could teach us how the problem developed, its causes, and how we might go about helping them gain resolution.

Doctors often feel alone, vulnerable, and fearful of financial risk. But think of what could happen if we help parents develop feelings of competence and become better
decision-makers for themselves and their children—not only could victims of domestic violence develop such competence, but they could also become our partners in improving the quality of care and even controlling health care costs.

Many of these parents grew up in abusive homes themselves. The abuse may go back several generations. We have the opportunity to provide a supportive and empathic environment for listening. The office visit could become a corrective experience, different from anything they have experienced in dealing with authority figures. Our compassion and outreach might become behavior that they could model for themselves as they interact with other family members.

As challenging and problematic as such parents could be at the beginning, with proper support they could even become “agents for change” with others facing similar issues.

There is the opportunity to be patient. We want to rescue these victims. (And we should do everything we can to be supportive, to help them plan, to give them information. To help them find shelter. To help them regain their self-esteem.) But it is their life, not ours. Our task is to help them to regain control as opposed to telling them the right thing to do.

There is one other opportunity. It is difficult to do this work without becoming aware of how our own life experiences get in the way of listening to such parents. To be successful in this area, we need to be aware of our own attitudes, to talk about them with our peers, and to gain insight about their origins. By doing so, we may gain personal resolution and self-acceptance, which will make it easier to help others.
A SURVIVOR’S STORY

I have been away from my abuser for thirteen years. If I had known as a young mother what I know now, I would have left him sooner. As a victim, it was impossible to put myself inside the minds of my children because there was immediate daily survival to think about. I have learned that children carry the scars of domestic violence much longer than we, the survivors.

Children, particularly those who witness frequent brutal episodes, have a much more difficult experience when going through the healing process because they are often unable or afraid to verbalize their thoughts.

I remember being at the pediatrician’s office with that terribly familiar knot of fear in my stomach. The fear that if our doctor ever found out what I was experiencing at the hands of my husband, he, too, would think I was low class and worthless. He might have my husband arrested, and then who would take care of us? Even worse, what if he reported me as an unfit parent? I thought I would be dragged through the court system, humiliated further, and maybe even thrown in jail. It was bad enough that I already believed I was an unfit wife.

I was good at something, though. I could create the illusion of the perfect family. I would dress the children in their Sunday best, all sparkling clean, and bask in the compliments bestowed by the secretarial staff (I often wondered if anyone else in the waiting room was doing the same). I would plan to make it past the scrutiny of the nurse, hoping she wouldn’t ask any personal questions. She never asked, not once. I wouldn’t be going to court, my children wouldn’t be taken away, my secret was safe.

It wasn’t until several years later, when I had to take my daughter to Children’s Hospital to be evaluated for what I now know were the early symptoms of post-traumatic stress disorder, that the secret of domestic violence finally came out. I didn’t tell but my daughter did, in a private interview with the hospital pediatrician, who asked what was happening at home. I was asked if I would like to have the name of a psychologist and I said, “No.” I thought I was past it, I was fine, and my children were safe. I never realized that the children were just as traumatized as I had been. I mistook their silence to mean that they had forgotten, or that the violence at home had not left any scars on them.

The full impact of what my children experienced as witnesses recently hit me full force when my daughter, at age twenty-one, explained, “Mom, I really don’t remember much of my childhood. I don’t remember any fun times with you and Daddy. I only remember fist fighting. I remember seeing a lot of blood, and being very afraid, a lot...” (D.R.)
I. **DOMESTIC VIOLENCE IS A MAJOR PUBLIC HEALTH PROBLEM**

Every day, physicians are besieged by government, health plans, and the media to adhere to policies that will cut needless health care costs. But consider the costs cut if we could reduce the repeated visits resulting from domestic violence by appropriate intervention.

“Nearly one-third of American women (31 percent) report being physically or sexually abused by a husband or boyfriend at some point in their lives, according to a 1998 Commonwealth Fund Survey.” (89)

23 percent of women seeking routine prenatal care have experienced violence or intimate partner abuse in their relationships. (55), (56) Complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and tobacco, alcohol, and illicit drug use. (89)

Beyond injuries, abused women are often diagnosed with somatic and stress-related illnesses, chronic pain syndromes, depression, post-traumatic stress disorder, and substance abuse disorder. (47), (48), (65) Such women have higher levels of health care use compared with women with no history of abuse. (49), (65)

40 percent of mothers reported violence in their families as a way of “settling disagreements.” (33)

A child is present in the home during 50 percent of rapes. (34)

“The long-term social, psychological, physical as well as the financial costs of non-recognition are staggering.” (10)

Given the frequency of domestic violence, we felt it appropriate to familiarize our colleagues with this major public health phenomenon. Among the parents we meet daily, there are many who may have experienced domestic violence in an earlier adult relationship or as a child in a troubled family. Pediatricians may not be aware of how domestic violence history can impact the seemingly routine concerns parents bring to the pediatric visit.

We have an opportunity to intervene at an earlier and more remediable stage in the cycle of domestic violence, before abuse escalates to injury or homicide.

We pediatricians are not alone. There are resources within the hospital and in the community to help us. But we can be the catalysts for change if we allow ourselves to acknowledge our role in uncovering the problem and making the referral.
II. **IS THERE AGREEMENT AS TO WHAT IS MEANT BY “DOMESTIC VIOLENCE”?**

While it is important that clinicians agree on what is meant by domestic violence, it is no surprise that this term means different things, depending upon a particular community’s perspective. The victim-advocacy, medical, and legal communities define domestic violence differently. Consider the following:

“Domestic Violence is a pattern of coercive control which one individual intermittently exerts over another by means of physical, emotional, sexual, or spiritual abuse.” (The Support Committee for Battered Women, Waltham, Massachusetts)

“Abuse is behavior that physically harms, arouses fear, or prevents a victim from doing what he/she wishes. It is the intent of abusive behavior to undermine the will of the victim and to substitute the will of the perpetrator for the will of the victim. Perpetrators batter victims to achieve and maintain power over their victims.” (Massachusetts Department of Public Health)

Chapter 209A defines abuse as “actual physical abuse or an attempt to harm another, placing another in fear of imminent serious physical harm, or causing another to engage in sexual relations by force, threat of force or obligation.” (Massachusetts Abuse Prevention Act, Massachusetts General Laws 209A)

These differences present opportunities to pediatricians for better understanding and advocacy. For example, in contrast to the Massachusetts D.P.H. definition, The Support Committee’s definition not only expands the definition to a broader range of abuse but also offers the possibility of earlier intervention to physicians who become aware of subtler forms of abuse, including chronic lack of respect. The statutory definition provides a framework for the medical community to work collaboratively with their legal colleagues, not only to protect victims, but also to determine the methods necessary to reduce the likelihood of such problems.
III. THE IMPACT ON THE MOTHER OF SCREENING FOR DOMESTIC VIOLENCE *

It makes a huge difference for a woman to know that someone else is concerned, that she is not alone, that intimidation and violence are never justified, and that resources are available.

When an abused woman who is treated in a health care setting experiences respect, caring, and interest in her thoughts, perceptions, and well-being, she may discover that she can make her own choices without fear of retaliation. She may also begin to change how she perceives herself and what she feels she can expect from others.

In several studies, the majority of female patients favored physician inquiry about domestic violence and reported that they would reveal a history of abuse if asked directly. (57), (58), (65)

“Just asking about abuse and listening to the response is already a significant intervention, one which creates an opportunity for prevention as well. Letting victims know that they are not alone, that they don’t deserve to be abused, that they are not responsible for the violence, that resources are available, that you are concerned about their safety, and that this is a place they can come to for help, can give them hope. Even briefly discussing the dynamics of abuse gives them the tools to recognize a pattern of escalating violence before it becomes more deadly.” (86)

*The reader should note that this guidebook is written as if it is discussing the predominant parental couple in our culture, i.e., a male and a female parent. We need to be sensitive, however, to the fact that gay and lesbian parents are a part of our patient population. Assessment guidelines regarding domestic violence apply regardless of gender, for both victims and batterers. Also, statistics support the fact that most, but not all, batterers are male. Therefore abusers are referred to in this guidebook as male, and victims or survivors are referred to as female.
IV.  THE IMPACT ON THE PEDIATRICIAN OF SCREENING FOR DOMESTIC VIOLENCE

A great challenge for victims of domestic violence is to discover the capacity to change well-established patterns. It is no less true for pediatricians as well as all physicians.

In everyday medical practice, it falls upon us to advise patients to try to change their patterns of behavior. If patients do not, we consider them “noncompliant” with treatment recommendations.

Yet, when responding to the disclosure of domestic violence in a routine screening, the pediatrician should consider a different attitude. In this situation, we are most effective when we assume the role of a supportive advocate and referral source. The parent is the best judge of how to move toward safety and when to take steps to get help or leave.

When we attempt to take control over a victim’s decision-making by pushing for change, it can produce shame and frustration in the victim, who may not be able to meet those expectations. We run the risk of becoming another controlling person in the victim’s life, despite our best intentions. We also run the risk of mimicking the dynamics of abuse and unintentionally traumatizing these parents again by distancing ourselves from them, seeing them as ill, or by over-controlling the clinical interaction. (86)

This subtle but important change in the pediatric role can create stress and frustration for us. One study found that “the need to gain control and expediently solve the problem was one of the major obstacles to [our] willingness to address domestic violence.” (7) As one doctor said, “The fact is I’m not sure I’d have any effect anyway. I certainly find that most of my advice on smoking and alcohol and other self-destructive behavior has no effect on people and it gets very frustrating. And to see this as rarely as I do, I get the feeling that it would be another one of those frustrating situations where I get involved and invest myself and yet have nothing come of it.” (7)

The model of noncompliance combined with such frustration can lead to the perception that the victim is to blame for the continuing abuse. It is a challenge to recognize that victims themselves have to choose the safest time to act only after they have assessed survival needs for themselves and their children, or that their coping skills have become deeply impacted by the abuse itself. (87)

“Women may be threatened with death if they reveal that they are being abused by their partners, and some of these threats are carried out. Thus, the process of disclosure is often very frightening and may not occur unless the woman feels that she can improve, and not
worsen, her situation.” (82) A victim may someday leave an abuser, but not at the time that would meet the pediatrician’s own need to see the situation resolved, even if it is out of concern for the family’s well-being.

Another common impact on the pediatrician is the distress from knowing that the violence at home may not quickly resolve, and that family members continue to be at risk for physical and emotional injury. Except for child abuse, parents need to change in their own time with support. Despite that, physicians often become angry with community support groups for not pushing the victim to quicker resolution.

You may want to consider consulting with experienced community advocates for support during the process of identifying domestic violence, empowering victims to plan for safety by referring them to resources. “Clinicians working with victims of abuse may find some of what they hear overwhelming . . . and draining. Collegial support may be extremely helpful not only for assistance with patient care but also to help the physician cope with his or her own distress as well.” (86) As with any new skill, becoming competent with this type of intervention can bring great satisfaction to the pediatrician as well as enhanced preventive care to the patient and family.

The rewards were expressed by Leigh Kimberg, MD, in a recent interview: “Since I can’t rescue victims, I realize all I need to do is to be empathetic and supportive, and this simple intervention can really help empower someone.... By backing off from a rescuing role and instead respectfully appreciating someone’s strengths...my relationship with my patients becomes more important in their lives.” (78)
V.  **Who Is a Batterer?**

Most battering men are not easy to spot in a crowd. They often come across as polite, reasonable, and likeable. A batterer can also be a woman, either in a heterosexual or same-sex relationship. Far from being irrational, the batterer’s behavior is purposeful in how it helps him gain and maintain control over his victim. In addition, the batterer’s unpredictable outbursts serve to keep the victim on the defense.

Despite this, some batterers are troubled by the consequences of their violence. They frequently feel relieved, therefore, when a professional helper poses direct questions. Sometimes, using a questionnaire may be helpful.

Batterers often accompany their partners in the health care setting and may be either charming and considerate, or aggressive and controlling. They may even present as “accusers” by reporting their partners as neglectful of the children. Interviewing parents separately and alone is essential to protecting the safety of the victim.

VI.  **Who Is the Patient for the Pediatrician?**

The traditional answer would be “the child.”

Parents typically present us with concerns about their children. But when parents are not doing well individually or as a couple, it has a deleterious effect upon their child’s development. We are obligated, therefore, to ask, on a regular basis, how parents are doing. If we suspect that there could be an ongoing problem in their relationship, we need to find time to inquire about it, either on our own or with a consultant.

The American Academy of Pediatrics states that “the abuse of women is a pediatric issue,” and that “intervening on behalf of battered women is an active form of child abuse prevention.” Helping parents helps children. When we are concerned about the psychosocial health of the child in a family that struggles with domestic violence, we need to keep the family system in focus at all times.
VII. THE IMPACT OF DOMESTIC VIOLENCE ON THE DEVELOPING CHILD

“Witnessing violence in the home can be as traumatic for a child as being a direct victim of violence.” (8) “Children who witness domestic violence are more likely to exhibit behavioral and physical health problems, including depression, anxiety, and violence toward peers. They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and commit sexual assault crimes.” (89)

“Among the symptoms, recurrent images of traumatic events or fatigue caused by sleep disturbances may disrupt a child’s concentration in school.” (16)

During adolescence, having witnessed violence “may lead to poor grades, dropping out of school, or self-medication with drugs or alcohol.” (17)

“Children who grow up in violent homes are more likely to be aggressive [or submissive] with peers.” (18)

Children who grow up in violent homes are more likely to become batterers as adults (19), (20) or, if victimized as adults, are less likely to access resources for domestic violence prevention.

The parent’s “ability to be empathetically attuned to her children suffers.” (8) Physical violence combined with psychological abuse undermines the parent’s sense of self-worth and autonomy, putting the abuser in control of that relationship. (4)

“Children whose mothers are being assaulted are also likely to be victims.” (82) The U.S. Advisory Board on Child Abuse and Neglect suggests that domestic violence may be the single major precursor to child abuse and neglect fatalities in this country.” (89)
VIII. HELPING CHILDREN COPE

It is concern for children that motivates this guidebook. A home in which domestic violence occurs is “possibly the single most important setting of abuse for children.” (79) That environment is not only acutely threatening but also has implications for the child’s ultimately becoming an adult victim or batterer. (19), (20)

Reaching out to parents conveys a crucial message to children living with domestic violence. If we do not expose what is going on between the batterer and the victim, it could seem as if we have abandoned children and left them hearing primarily the messages of the batterer. (79)

Besides reaching out to the parent, what else can we do for children that will give them an extra measure of support and strength? For pediatricians familiar with the “magical thinking” of children, the following suggestions will be no surprise. Children should:

1. Not feel they had anything to do with the conflict between their parents, nor with the abuse of one parent by the other.
2. Not end up feeling that the victimized parent is at fault.
3. Learn that loving someone does not mean “owning” that person.
4. Understand that everyone is responsible for his or her own behavior.

Finally, we should reinforce with every child that any feeling is permissible, but that violent feelings should never be transformed into violent actions.

If we could transmit these messages to the children of parents involved in domestic violence, we will help interrupt the cycle of abuse that is often repeated from one generation to the next.

Children exposed to family violence may be helped to cope with their experience through specialized community services and mental health professionals trained to work with the effects of violence on children. The American Academy of Pediatrics recommends that every effort should be made to secure counseling for children who have been exposed to family violence. (82) Call your local domestic violence advocacy agency or hotline for referral resources; refer to Appendix III for a sample resource list in the Boston area.
IX. CHILD ABUSE—A GENERATIONAL ISSUE

This section highlights the close link between child abuse and intimate partner abuse. “There is a high correlation between spousal abuse and child abuse; in 40-60 percent of the homes where there is interparental violence, child abuse also occurs.” (21)

When a pediatrician identifies child abuse, he or she needs to actively consider that intimate partner abuse may also be present. (88) Helping the parent protects the child.

“Addressing family violence requires an understanding of the complex interconnections among child abuse and neglect, child witness to violence, partner violence, and the transmission of violent behavior from one generation to the next. Physicians are therefore in a unique position to protect children from child abuse and from subsequent dysfunction in later life by addressing violence across the life span.” (2)

X. THE FREQUENCY OF NON-ACKNOWLEDGEMENT IN THE MEDICAL INTERVIEW

Health care professionals are often unaware of the prevalence of domestic violence and do not inquire. They may lack education about how to respond to abuse. They may be unable to tolerate hearing women talk about abuse because of the feelings it evokes in them. (7) Under these circumstances, it is almost impossible for parents to discuss these issues with their health care provider.

“In 40 percent of cases where physicians interacted with battered women in the emergency room, physicians made no response to the abuse.” (14) Less than 15 percent of female patients report being asked about abuse by health care professionals or disclosing abuse to them. (52), (57), (58), (59), (65) “In 92 percent of domestic violence cases, physicians failed to give any referral or follow-up.” (15)

As part of differential diagnosis, physical injuries more readily prompt screening inquiries than do nonphysical symptoms. In a recent California study, “in circumstances that involved physical injuries, an estimated 79 percent of primary care physicians often or always ask patients direct questions about intimate partner abuse...[whereas only] 10 percent routinely screen during new patient visits and 9 percent screen during periodic check-ups.” (65)
Many factors may get in the way of pediatricians’ addressing domestic violence. They include patient attitudes, physician feelings, and the issue of time, as well as the nature of relationships within the medical structure. (7), (62), (63)

1. Too close for comfort. (7) It may be relatively easy for pediatricians to ask parents about domestic violence when they are members of a different social or ethnic group. But asking about abuse can be difficult when it happens to people who remind us of ourselves, even if we did not have a violent pattern in our own families. It can be particularly difficult if it has the potential to bring up painful memories from our own life experience.

2. Fear of offending. (7) Pediatrician inquiry can be viewed as betrayal of trust and endanger the physician-parent relationship. Fear of “overstepping the bounds of what is private...[may involve] the same tension that had to be overcome in addressing such issues as smoking, alcohol, drug abuse, sexual issues.” (7) Such feelings of discomfort and intrusiveness can be overcome with practice and by understanding that it is both legitimate and important to ask.

3. A sense of powerlessness. (7) This happens when pediatricians feel they will be unable to change things because of their inability to control a victim’s behavior as well as a victim’s inability to control the circumstances of family life.

4. Time constraints. (7) In 15 minutes, you can’t ask all the questions!

How can we, as pediatricians, learn to bridge the gap between our own experience and the experience of victims of domestic violence? Carole Warshaw, MD, suggests that if we take uninterrupted time to listen to victims talk about their lives, it may “allow us to free ourselves temporarily from our clinician mode and attend to our own responses.” (10)

In addition, personal experiences with our own family abuse could have taken place when we were children or may have occurred in our adult relationships with our own intimate partners. Drawing upon these memories may help us develop the capacity to understand the experience of abuse for others. Warshaw goes on to speculate that, for physicians, “although medical training is [hardly] the same as being in a battering relationship, there are a number of [interesting] similarities.” (10)
For example, she observes:

“Medicine is an arena [where] we [also] want to succeed, especially once we have invested...time and energy and know that we would feel like failures if we left or gave up. When our efforts [seem] not [to be] responded to, it becomes easy to blame ourselves for not working hard enough, not knowing enough or...being devoted enough, particularly when those feelings are continually reinforced...[over time]...our self-esteem starts to diminish . . . “ (10)

Consider, then, the benefits we might derive from listening to victims of domestic violence at the same time we are helping them.

Just as we encourage victims to reassess the direction and value of their own lives, pediatricians may be encouraged to do the same for themselves.

Acknowledging some of our own experiences, including medical training, may help us reassess our own priorities. It may also help us conclude that the emotional component of patient care is as important as the physical.

As we become increasingly skillful in helping such parents, prevention and picking up problems earlier becomes more likely.

XII. IS THERE A NATIONAL MANDATE TO CONDUCT SCREENING FOR DOMESTIC VIOLENCE?

Improving the response to domestic violence has made early intervention a high priority within the health care system.

National public health organizations have endorsed the use of interventions, such as protocols in clinical settings, for the identification of patients experiencing abuse. (65), (67), (68), (69)

Several national medical organizations have developed practice guidelines for intimate partner abuse that encourage routine screening and interventions. (65), (70), (71), (72), (82)
Every pediatric office should contain:

- Posters about domestic violence
- Brochures on domestic violence
- Reference materials, including materials for batterers and parental stress hotline information
- Telephone numbers of local domestic violence hotlines and battered women’s shelters posted in the waiting room, exam room, and bathroom.

Remember that a parent may decide it is not safe to take these materials home. See Appendix III for sample Information and Intervention Resources.

Domestic violence screening should be routine in well-child visits. The pediatrician should be particularly aware of mothers and children who manifest signs of injury or depression, or who present with multiple somatic complaints of stress-related illnesses. “The physician must be prepared to ask questions about violence on a number of occasions in order to allow the [parent] to become ready enough to disclose the information.” (86)

Screening guidelines:

- Ask questions routinely in the course of taking the social history, in a nonjudgmental tone, to express concern for the parent’s own health and family members’ well-being. “If asking about abuse does increase the [parent’s] distress, let him or her know that you understand how hard it is to discuss, and that you are glad she/he felt she/he could tell you, that you want to make sure she/he feels safe before leaving, and that you can refer the parent” to an appropriate resource. (86)
**XIV. HOW TO CONDUCT SCREENING (CONTINUED)**

Screening guidelines (continued):

- Interview the parent alone, without his or her partner or children, and in private. (13), (82), (88) When separating parents is difficult in the presence of a vigilant, controlling partner, use a medical excuse or frame the practice as a routine procedure. (79) (It is assumed that the child would be appropriately supervised by family or a staff member when you are meeting with the parent.) Do not discuss your concerns with the parent’s partner or any family member, and do not “warn” the abuser that you know. If you have concerns about a parent who speaks a different language, use translation resources other than a family member, such as AT&T Language Line Services, contracted interpreter services, or a staff member.

- Avoid value-laden terms like “domestic violence,” “abused,” “battered,” “wife beater,” or “perpetrator.” These labels can needlessly cause shame and discourage further disclosure. Instead, use words like “hurt,” “frightened,” “badly treated,” or “use of physical force.” (13)

- Be aware of vague code words that abusers may use in referring to their violence, like “fighting,” “anger,” “not getting along,” “taught a lesson,” “punish,” “temper,” “self defense,” “stress,” “drinking,” or derogatory references to the abuser’s partner. (4)

- “Let [parents] know that the information they give you will be confidential within the confines of the law. Mandatory reporting requirements for...child abuse should be explained at the outset so that the [parent] can decide whether or not she/he feels it is safe to disclose.” (86)

Sample introductions (choose or adapt):

- “I have begun to ask all of the parents in my practice about their family life as it affects their health and safety, and that of their children. May I ask you a few questions?” (8)

- “Because we realize that stress can play an important role in people’s health, I ask every parent whom I see about stress in the family as it affects their health and safety. I would like to ask you a few questions.”

- “Sometimes when I hear about symptoms like yours, it reminds me of situations when somebody has hurt a parent or the child(ren). May I ask you a few questions?”
Sample introductions (choose or adapt) continued:

- “Has your child witnessed violence on the streets, in the neighborhood, or seen someone badly treated in the home? What happened? What did the child see or hear?” (8)

- “How do you or other people in the house settle arguments? Do they yell, hit, or push?” (8)

Asking the questions:

- “Have you been pushed, hit, kicked, or otherwise frightened by someone within the past year? If so, by whom?” (3)

- “Has (have) your child(ren) been pushed, hit, kicked, or otherwise hurt or frightened by someone within the past year? If so, by whom?”

- “Have you been under stress lately? Are you having problems with your partner or your child(ren)? (5) Have your arguments ever become physical? (5) What’s the furthest you’ve gone with your anger?” (4)

(If “yes” response to any of the above) “Have you noticed any changes in your child(ren) you feel might be related to these events? If so, what changes?” (8)

XV. EMPOWER, REFER, AND FOLLOW UP

The pediatrician should assess the safety risk factors with the mother and should assess whether the child was abused. Appendix I provides a guide for responding to safety concerns.
XVI. The Importance of Documentation

As vigorous criminal prosecution of domestic assault increases, accurate and legible medical records can be a source of invaluable information, and can often substitute for the physician’s personal testimony in court. (2)

Pediatricians should record the use of screening questions on all preventive service summaries, for example:

“The parent was routinely asked about the possibility of verbal abuse, threats, and physical violence at home. If so, the parent was offered information about community resources for safety planning and counseling.”

(For teens and pre-teens in dating relationships)

“The patient was routinely asked about verbal abuse, threats, and physical violence in dating relationships. If so, the patient was offered information about community resources for teen dating violence prevention.”

Because the safety of victims and their children is a priority, answers to screening questions should not be recorded in electronic medical records. Although it may seem unlikely that security could be breached, assume that abusers can gain access to computer-stored information. Separate written documentation can be kept by the pediatrician in a theoretically more secure confidential medical record.
XVII. OVERCOMING BARRIERS THROUGH EDUCATION

There is a growing interest in developing effective physician training to screen patients for domestic violence; pediatric practice can benefit from some of the information gleaned from recent research. One study proposed that training had the potential to increase knowledge, comfort, and skills for addressing domestic violence. More recent studies have proven the effectiveness of a two-minute screening for early detection of abuse of pregnant women. (89) Nevertheless, without institutional changes and regular in-service education, training, by itself, might be insufficient to change how physicians conduct themselves in this area.

Initial training is a beginning but not sufficient to change a practice or value. “Most physicians are not trained to deal with severe psychological trauma, and to provide an empathetic response. Personal experiences and attitudes about victimization may limit the physician’s ability to care for people who have been abused.” (86)

The following are suggestions for approaches to improve awareness-raising and education for pediatricians:

1. Quarterly focus groups. It would seem useful for health professionals to meet periodically, perhaps with a facilitator, to talk about the challenges as well as the successful ways of incorporating domestic violence screening into pediatric practice.

2. Pre-training assessment. (7), (63), (64), (65)

3. Training videos. (6)

4. Increased awareness of physician’s own history. (65)

5. Experiential training through role-play.

6. Post-training assessment and follow-up. (65)

Physicians need to become knowledgeable about the expected time course of change; ending domestic violence in a family usually involves a prolonged course and does not respond to a quick fix.

Domestic violence screening is learned from education and training that offer more than cognitive understanding of the issues. It is a skill, like much of medicine, that improves by doing. If pediatricians incorporate these skills regularly in their practice, they will find themselves increasingly comfortable and successful.
XVIII. BECOMING ACQUAINTED WITH COMMUNITY RESOURCES

To help parents make informed choices, pediatricians should become familiar with community resources such as hotlines, shelters, legal services, victim assistance, child witness programs, child guidance counseling, parental stress programs, batterer intervention programs, and mental health professionals who are trained to handle family violence cases.

Pediatricians should also have an action plan, such as the one suggested in this guidebook, which has been reviewed by community authorities on domestic violence. “Because of time constraints in a busy office practice...an interdisciplinary approach may be most appropriate. Pediatricians can call on nurses, social workers, or advocacy groups with expertise in assisting and counseling victims.” (82)

XIX. CODING ISSUES

Blue Cross and Blue Shield of Massachusetts, Tufts Health Plan, and several other local health plans allow physicians to bill for counseling and crisis intervention.

The appropriate codes are the same evaluation and management codes that primary care physicians use for illness encounters, i.e., 99211 to 99215 (as well as for new patients).

There is a variety of diagnosis codes available in the ICD-9 manual. Choose the one that is the most applicable and the least stigmatizing for the patient. (Even if you interview only the parent, the “patient” of record is the child.) The most commonly used diagnosis is Adjustment Disorder of Childhood.

Although there are ICD-9 codes for adult maltreatment (995.80) and counseling a victim of spousal and partner abuse (V61.11), we do not recommend using them. At this time, concerns for protecting the safety of victims by insuring confidentiality, as well as the importance of gaining parents’ trust, override any other benefits of using these codes.
XX. **TEEN DATING VIOLENCE**

Many pediatricians interview the pediatric patient without the parent present when the patient is a middle school or high school student. At that time, it is appropriate to ask if the adolescent is in a dating relationship. If so, the physician can ask adapted questions to screen for teen dating violence (2) and offer support, information, and referral. It is also appropriate to ask teens’ parents if they have concerns about their teen’s safety in dating relationships, and to offer educational pamphlets and resources. There are community resources available that provide guidelines.

Newton-Wellesley Hospital has developed an internal e-mail document titled “Domestic Violence Q & A”, which contains information on what parents need to know about teen dating violence.” It is suitable to distribute to any parent who is concerned. It covers forms of dating abuse, barriers to teens asking for help, warning signs, tips for parents, and resources.

Another resource for teens is a pamphlet published by Casa Myrna Vasquez, Inc., “You Deserve to Be Healthy and Safe in Your Relationships.” (11) It includes questions for teenagers asking about the safety of the relationship and gives helpful phone numbers.

XXI. **TWO PERSPECTIVES ON SURVIVING ABUSE**

Looking back, as a child: As I sat ever so bravely tolerating Dr. Fish bandaging my badly infected toes, I hoped with all my heart that he would find some reason to send Mommy out of the room, so that I could tell him how I really hurt myself this time. The truth was, I really didn’t hurt myself, and Mommy hurt me—again.

It all started three days ago when Baby Sam got really sick and I heard Mommy say he was going to die. It was in the middle of the night, and Daddy had just come home and was talking funny. He got really mad at Mommy, hit her hard in the face, then left. When Mommy turned around and saw me out of bed, she became really angry with me. Before I knew what was happening, she was dragging me by the hair, and putting me in the closet with the boxes of blankets and stuff. There was enough room to fit my body between the box and the door, but my toes got stuck under the door. I knew I had better not make a sound, because the last time I talked back, my hands were tied behind me with a belt and a sock was shoved in my mouth so that the neighbors wouldn’t hear me scream while I was being punished. Anyway, I just leaned backward and went to sleep on the box.
When the closet door finally opened, the room was very bright. I was told to stay in my room, and not make a sound. That would be no problem, because I couldn’t walk very well, so I put my dirty socks on to cover up my yucky looking toes, and went to bed. I tried really hard not to cry, because Dr. Fish always told me what a big brave girl I was, and since I loved him so, I didn’t want to prove him wrong.

So there I was, having my toes bandaged. Dr. Fish asked no one in particular how this happened, and Mommy quickly spoke up (while hugging me ever so tightly) to tell Dr. Fish that I scraped them, then pointed out how “clumsy I had been lately.” Dr. Fish agreed that I had an awful lot of bruises, and said it was something I would grow out of eventually.

Looking back, as an adult: As an abused child and witness to domestic violence, I quickly came to see my pediatrician as my friend and ally. If only he had asked me the right questions, I would have told him anything he wanted to know. Since I was never given the opportunity to speak up, these incidents continued until I was nine years old. It was then that a school official finally noticed I was showing up for school with just one too many bruises. (D.R.)

XXII. CONSTRAINTS OF THE MEDICAL MODEL

In some ways, “the biomedical framework actively obscures and discounts the lived experience of the people it attempts to serve. It reduces information to standard diagnostic categories or problems that then can be manipulated and controlled.... When symptoms are seen as isolated events in the body rather than as a response to ongoing social conditions outside the context of medicine, the notion that this was a solitary episode that will not recur is reinforced.... It helps us to maintain distance.” (10)

“Any attempt to challenge this model requires not only a change in how we learn to think but also a change that supports our ability to tolerate our own feelings while functioning in a professional mode.” (10)

We would encourage pediatricians to consider modifying the traditional medical model so that parents become not only our helpers but also better decision-makers in regard to health issues. It is likely that we will increase our professional satisfaction by understanding parents’ lives and backgrounds as we focus on the entire family system.
XXIII. CONCLUSION

At times, when routinely screening for domestic violence, it can be hard not to feel frustration. As one physician said:

“I get to the point where I feel discouraged because I feel like, with someone that’s in an abusive situation, until that person’s ready to take care of it, I’m banging my head against the wall. I’m doing it over and over again, and it’s like my own abuse in a sense.... At what point do I just say, ‘We’ll take up your hypertension today, and I’m sorry your family life isn’t going so well?’” (7)

Yet, as difficult as this diagnosis might be in the best of times, we shouldn’t be surprised if parents are not able to extricate themselves from such situations. Many of us find it equally difficult to extricate ourselves from the traditional form of medical practice. Many of us also experience difficulty doing something new and exposing ourselves, even if only temporarily, to feelings of inadequacy in the course of learning new skills.

Here are some modifications to medical practice that would make us more skillful at detecting issues of domestic violence. We should:

1. Broaden our thinking to consider the emotional component of parents’ lives.
2. Identify our patient as the child within the family system rather than the child alone.
3. Become more proactive in searching for problems of family life.
4. Reflect on how we ourselves might have been affected by abuse, either professionally or in our personal lives.
5. Seek more active collaboration with other individuals and agencies.

We gain by becoming more competent in the area of domestic violence. If we take it on, it can be empowering both for our patients and ourselves. It may even encourage us to take risks in other areas of preventive health care.

In an era of payment by capitation and physicians’ assuming greater financial risk, pursuing issues of domestic violence is not a luxury; it is a necessity. In order to help parents evolve from being high-risk users of multiple services into becoming our partners as health activists, not just for themselves but for their families, it seems essential that we take it on.

And most important, we may gain increased satisfaction by pursuing this quality of care.
APPENDIX I

DOMESTIC VIOLENCE SCREENING RESPONSE

Follow-up to screening questions:

A. When the parent does not disclose abuse and the pediatrician is not concerned:

- State that you want to “leave the door open” if for any reason the parent feels in danger or is concerned about stress in the family, and would like to talk to you or someone else.

- Rescreen at periodic intervals, such as a yearly checkup, especially if the parent is beginning a new relationship or if there are symptoms consistent with those of abuse. (6)

B. When the parent does not disclose abuse but the pediatrician is concerned:

- State that you are concerned for the parent’s safety (and the safety of the children), that no one deserves to be hurt, that when there is fear of physical harm, things usually do get worse. State that you want to “leave the door open” if for any reason the parent feels in danger, or is concerned about stress in the family, and would like to talk to you or someone else.

- Schedule a follow-up appointment and rescreen at that time.

C. When the parent does disclose abuse:

- Initial responses:
  a. Listen without judging.
  b. Explain that violence or threats are never acceptable, that there is no excuse (alcohol, drugs, financial pressures, jealousy, depression), and that no one deserves to be hurt. Reframe the violence as wrong and criminal. Tell the parent that many families struggle with these problems, and that there are resources that can help,
  c. Explain that it is likely that physical violence will continue and probably escalate, and that you are worried about the parent’s safety (and the safety of the children). If the disclosing parent is the abuser, explain that getting help will prevent additional violence and avoid criminal charges, and that the issue of abuse is a health care issue for the parent who is abusive as well as for the partner and their children.
d. Refer to appropriate resources, such as your local 24-hour hotline or the National Domestic Violence Hotline, 800-799-7233. Referral to couples therapy is contra-indicated because it may actually increase the risk of violence to the victim.

e. Ask if the parent feels safe leaving your office or going home; help the parent assess safety risks by asking about the parent’s own level of fear, recent restraining orders, weapons in the home, a recent separation, past violence, substance abuse, threats to others or threats of suicide. If the parent feels it is not safe to leave or return home, offer to provide a phone in a private office to call a hotline or shelter program to discuss safety planning. The parent can also call her local police department, which may have a Domestic Violence Officer who can discuss legal and safety options.

● Follow up:
  a. Explain that you take seriously what the parent has told you and that you are very concerned. If you do not have time to continue the interview, explain that you would like to make an appointment to discuss it further. Set a follow-up appointment time.

  b. State that you are concerned with the parent’s and the family’s continued health and well-being, as well as with preventing future trauma. State that you respect the parent’s choices and will continue to provide care and to recommend appropriate resources in the future when the parent is ready.

● Practice guidelines:
  a. When the parent is the victim of abuse, respect the parent’s assessment of the danger and the feasibility of options, even if the parent chooses not to follow through with recommendations in the near future. A parent may choose to stay in or return to an abusive relationship out of fear for her life, her children’s safety, or economic survival. Family, religious convictions, and shame are further barriers to leaving. The pediatrician can become an invaluable resource until and when a parent is ready and able to leave an abuser.

  b. Do not “warn” or discuss your concerns with the abuser.

  c. If you or your staff see or hear an assault, call the police. Because an assault is often dangerous, do not physically intervene.

  d. Evaluate the need to report the violence to an outside agency. (1) Remember that mandated reporting guidelines for child abuse include a child witnessing the physical abuse of a parent. Because a victim may be at increased risk for battering during a child protective investigation, she should be told a report is being made and receive safety-planning services. (79) In the Commonwealth of Massachusetts, there is no mandatory reporting of adult abuse, although hospitals and physicians may be required to report certain injuries, wounds, and diseases, and there are other reporting mandates.
APPENDIX II

“DO VICTIMS COST HEALTH PLANS MORE?”

Is it true that domestic violence costs health plans more?

The direct medical cost for battered women has been estimated at approximately $1.8 billion per year. (44) “Higher use of emergency room services has been reported.” (22), (40), (41), (42). “The American Medical Association Council on Scientific Affairs reports that [such] victims may have delayed physical effects, including arthritis, hypertension, and heart disease.” (43)

Is it the pediatrician’s responsibility compared to the Emergency Department physician, the family practitioner, the obstetrician? It could be the pediatrician’s if the pediatrician were the first to become aware of the possibility of partner violence in the pediatrician’s interaction with parents and the parent-child relationship. If so, the pediatrician may have the first chance to intercede in the cycle of violence.

A study conducted at a large health plan in Minneapolis and St. Paul, Minnesota, in 1994 found that an annual difference of $1775.00 more was spent on abused women who utilized hospital services than on a random sample of general enrollees. (89) This study demonstrated that these patients cost the health plan 92 percent more than a random sample of controls. “The study concluded that early identification and treatment of victims and potential victims will most likely benefit health care systems in the long run. (89) [The amount may have been underestimated because the study did not take note of “the health care costs of children who witness the violence and may develop a variety of physical and behavioral problems.”] (35)

Is cost relevant? From the standpoint of the health plans that have to justify every dollar they spend, cost is relevant. An awareness of the savings resulting from early detection of domestic violence should encourage “health plan administrators who are in a position to allocate money for physician and staff training on intimate partner violence and prevention.” (35)

We suggest the following:

1. Training need not be expensive.
2. Such training has the additional reward of increasing the likelihood of expanded screening for additional high-risk behaviors.
3. A parent who gains great self-confidence by moving away from the role of victim becomes a better decision-maker in regard to health care issues. Such parents become valuable partners to pediatricians as they work together with us to improve health and regain control over health care costs.
These attributes are difficult to measure. In the end, pediatricians have to make a personal decision as to whether these efforts are worth making, not just because they reduce health costs. The effort to routinely screen for domestic violence improves the quality of care as well as the satisfaction derived from a redefinition of what is meant by good pediatric practice.
APPENDIX III

SAMPLE RESOURCE LIST THAT CAN BE ADAPTED TO LOCAL AREAS

NEWTON-WELLESLEY HOSPITAL
DOMESTIC VIOLENCE PREVENTION COUNCIL

INFORMATION AND INTERVENTION RESOURCES

JANUARY 2000

24-Hour Hotlines - Adults
The Support Committee For Battered Women, Waltham, 800-899-4000
Casa Myrna Vasquez, Boston, 800-992-2600
HAWC (Help for Abused Women and their Children), Salem, 978-744-6841
Women’s Protective Services, Framingham, 800-593-1125
New Hope, Norwood and Attleboro, 800-323-4673
Boston Area Rape Crisis Center Hotline, 617-492-7237
National Domestic Violence Hotline, 800-799-7233

Hotlines - Teens
The Support Committee for Battered Women, Waltham, 800-899-4000
Dating Violence Intervention Project Crisis Hotline, 617-661-7203
DOVE (Domestic Violence Ended) Youth Hotline, 617-773-4878
Peer Listening Line, Fenway Community Health Center (gay, lesbian, bisexual, or transgender youth), 800-399-7337
Samariteens (for teens feeling depressed or suicidal), 800-252-8336
National Runaway Switchboard, 800-621-4000
Youth Only AIDS Line, 800-788-1234
Boston Area Rape Crisis Center Hotline, 617-492-7237

Lesbian/Gay/Bisexual/Transgender Domestic Violence Resources
Fenway Community Health Center Violence Recovery Program, 800-834-3242 or 617-927-6250 (teens can call the Peer Listening Line, 800-399-7337)
Network for Battered Lesbians and Bisexual Women, 617-236-7233
Gay Men’s Domestic Violence Project, 617-497-7317
Massachusetts Office of Victim Assistance, 617-727-5200
Suffolk District Attorney’s Office, 617-210-8800
Middlesex District Attorney’s Office, 617-629-0222

Other Domestic Violence Prevention Resources
Asian Shelter Advocacy Project, Boston, 617-338-2355
National Immigration Project, National Lawyers Guild, 617-227-9727
Massachusetts Office of Victim Assistance, 617-727-5200
Suffolk District Attorney’s Office, 617-210-8800
Middlesex District Attorney’s Office, 617-629-0222
Archdiocese of Boston, Family Life Apostolate, 617-783-2451
Jewish Domestic Violence Coalition of Greater Boston, 617-457-8888

Website Resources
Peace Begins at Home (Massachusetts), http://www.besafe.org
National Domestic Violence Hotline (National), http://www.ndvh.org
Safe Transitions: Domestic Violence Intervention Program,
   http://www.bidmc.harvard.edu/safetran/
Domestic Violence Shelter Tour and Information Site, http://www.dvsheltertour.org/
Victim Services Site, http://www.victimservices.org
Massachusetts Medical Society Campaign Against Domestic Violence,
   http://www.massmed.org/community/domvio
American Bar Association Commission on Domestic Violence (legal info, abusers and
   the Internet), http://www.abanet.org/domviol
Center for the Prevention of Sexual and Domestic Violence (includes clergy and sexual
   abuse info), http://www.cpsdv.org
Dating Violence Intervention Project (Massachusetts),
   http://www.ultranet.com/~thouse/dvip.html
Student Civil Rights (Massachusetts Attorney General’s Office),
   http://www.stopthehate.org
Yahoo’s Domestic Violence Link,
Resources for Children
AWAKE (Advocacy for Women and Kids in Emergencies), Children’s Hospital, Boston, 617-355-7979
Children’s Charter Project, “We Can Talk About It,” Waltham, 781-894-4307
Child Witness to Violence Project, Boston Medical Center, 617-414-4244
The Massachusetts Society for the Prevention of Cruelty to Children, 800-442-3035
Human Resource Institute Trauma Center, Brookline, 617-731-3200 x421

Certified Batterer Intervention Programs
Emerge, Cambridge, 617-422-1550 (Spanish: 617-422-1549)
Common Purpose, Boston, 617-739-3831
Respect Program, Framingham and Milford, 508-478-6888 x103

Legal Services
Greater Boston Legal Services, 617-494-1800
Cambridge and Somerville Legal Services, 617-494-1800
Harvard Legal Aid Bureau, 617-495-4408
Harvard Law School Battered Women’s Advocacy Project, 617-495-3139

Newton-Wellesley Hospital Employee Assistance Program
The EAP is available to assist employees in finding the right resources for themselves or for their family, friends, or co-workers. The EAP is a benefit at no cost to employees that offers private and confidential problem-resolution counseling. More information about the EAP can be found in the MOX Hospital Library EAP Cabinet. Melinda Strauss, EAP Coordinator, can be reached at 617-243-6522.
I. Questions to Ask

I have begun to ask all the parents in my practice about their family life as it affects their health and safety, and that of their children. May I ask you a few questions?

1. Have you been pushed, hit, kicked, or otherwise frightened by someone within the past year? If so, by whom?
2. Has (have) your child(ren) been pushed, hit, kicked, or otherwise hurt by someone within the past year? If so, by whom?
3. Do you feel more stress these days? Are you having problems with your partner or your child(ren)? Do arguments tend to become physical? What’s the furthest you’ve gone with your anger?
4. (If yes to any above) Have you noticed any changes in your child(ren) you feel could be related to those things? If so, what changes?

II. Responding to Parents

When a parent discloses partner abuse, say that you will support whatever decision he/she will make, express concern for family safety, and offer help. If a parent does not disclose, the screening may be over but the pediatrician remains a future resource.

1. Parent DOES NOT disclose abuse, pediatrician IS NOT concerned:
   ● “Leave the door open” to discuss any further issues.
   ● Rescreen at periodic intervals.
2. Parent DOES NOT disclose abuse, pediatrician IS concerned:
   ● Express safety concerns for the parent and child(ren).
   ● Reframe domestic violence as wrong, and as an important health problem.
   ● “No one deserves to be hurt or to live in fear.” “Children learn to behave as adults from what they experienced when they were young.”
   ● “Leave the door open” to discuss any future problems.
   ● Schedule a follow-up appointment to rescreen.
3. Parent DOES disclose abuse:
   - Listen without judging.
   - Express safety concerns for parent and child(ren).
   - Reframe domestic violence as an important health problem. “No one deserves to be hurt or to live in fear.”
   - “Help is available for you.” “You are not alone.”
   - Refer to resources/hotline, provide office phone if parent would like to talk to a domestic violence counselor.
   - Help parent assess safety risks (fear, restraining orders, weapons, past violence, substance abuse, threats to others, threats of suicide). “Do you feel it is safe to leave this office or return home?” Provide office phone to call hotline for safety planning if needed.
   - Do not “warn” or discuss your concerns with the abusive partner. If the disclosing parent is the abuser, explain that getting help will prevent additional violence and avoid criminal charges, and that violence is an important health problem for the abuser as well as for the victim. Refer to batterers intervention services.
   - Schedule a follow-up appointment.

4. Remember that mandated reporting guidelines for child abuse include a child witnessing the physical abuse of a parent. Because a victim may be at increased risk during a child protective investigation, she should be told that a report is being made and receive safety-planning services.
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