

PedsCases Podcast Scripts

This is a text version of a podcast from PedsCases.com on “**Domestic Violence.**” These podcasts are designed to give medical students an overview of key topics in pediatrics. The audio versions are accessible on iTunes or at www.pedcases.com/podcasts.

Domestic Violence

Developed by Ambreen Surmawala and Dr. Melanie Lewis for PedsCases.com.
December 27, 2019

Introduction:

Hey everyone, my name is Ambreen Surmawala and I am a 4th year medical student at the University of Alberta. This PedsCase will discuss Domestic Violence, a prevalent, but often difficult issue to address in the clinical Pediatric setting. A special thank you to Dr. Melanie Lewis, a Professor in the Department of Pediatrics at the University of Alberta, for her support and contribution to this podcast.

Let's start with a clinical case:

Nina, a 28-year-old female, accompanied by her husband, Jerry, is bringing their 18-month old daughter, Sophie, to your clinic for a routine well child check. When reviewing her chart, you notice she has rescheduled several appointments over the past few months, including 3 no-shows. You recall that this is her first child and start your interview by discussing how she is coping. Nina apologizes for the missed appointments and admits that amidst “various ongoing stresses”, she has been unable to take Sophie for her 12 month immunizations. She also reports that Sophie has not been eating well lately and is worried about possible weight loss. You validate her concerns and decide to proceed with Sophie's examination.

Is there anything else you should be concerned about, and how can you address it?

This PedsCase will discuss the following objectives and then return to the clinical scenario:

1. Discuss the depth of impact of domestic violence (DV)
2. List the risk factors of DV
3. Identify signs of exposure to violence in pediatric patients or their parents
4. Develop an approach to managing DV presentations

What is Domestic Violence?

Domestic violence, often referred to as intimate partner violence (IPV), is characterized as repetitive behaviors aimed at enforcing control or dominance within an intimate relationship. These behaviors range from actual or threatened physical, sexual, emotional, and psychological abuse to social and economic manipulation or coercion against one's will. The impact of these occurrences include direct consequences of the event itself, as well as fear of future similar or more severe events. Understandably, it spans far beyond the couple, to any associated children, other family members, community groups and society as a whole.

Epidemiology

Let's quickly talk about the prevalence of IPV. Recent Canadian statistics approximate 96 000 victims of IPV aged 15 to 89 years in 2017 alone. Many cases likely go undetected but IPV still accounts for 30% of all violent crimes reported to the police. It is estimated up to 362 000 children in Canada are directly exposed every year, with even more indirectly subjected to the consequences of this violence. Most research focuses on females as they comprise 80% of all victims, and because they are much more likely to be injured or killed as a result of IPV. This podcast will also be focusing on male-instigated violence but female offences should also be identified and treated similarly.

Impact of Childhood Exposure to IPV

It is important to note that domestic violence is not restricted to the home setting. It can occur in any type of intimate relationship, including former or current, same sex or heterosexual, and amongst married, common-law or dating partners. Witnessing violence involves direct observation of the incident or any of its outcomes, including visible injuries and emotional distress. The short and long term effects of this exposure can vary based on factors such as the child's age and maturity, the frequency, severity and proximity to the events, association to the offender, accessibility to healthy social supports and stability in other aspects of their life.

The presentation of a child exposed to IPV can vary. Most changes are difficult to observe in a short clinical encounter but can be inferred from the parents' accounts. Infants may be inconsolable, have developmental delays, dysregulated sleep, abnormal attachment patterns or inadequate feeding resulting in failure to thrive. Parents of toddlers might complain of increased attention seeking behaviors. Preschoolers may demonstrate insecure attachment patterns, refuse to engage with peers or may become increasingly aggressive and recreate the events they've witnessed through pretend play. In school aged children, there is increased incidence of absenteeism due to somatic complaints and concentration difficulties, leading to poor performance and increased diagnoses of ADHD. Social skill development can also be impaired, resulting in ongoing peer conflicts. Adolescents may appear emotionally disengaged and participate in risky behaviors with a disregard for possible consequences. They are also

at a higher risk of forming unhealthy intimate relationships of their own, by becoming an offender or victim of IPV, and propagating a cycle of violence. Older children who are more cognizant of the incident may feel guilt or burden themselves with blame. These are all considered non-adaptive responses to the negative exposures. However, in some cases, school aged or adolescent children may develop positive coping strategies such as seeking refuge in healthy friendships, focusing on extracurricular activities, or finding other safe spaces away from the violence. They may also take on more responsibilities in and around the home, including caring for their siblings or the victimized parent, through a role reversal known as “parentification”.

In addition to the effects of witnessed violence, there is a 25-50% chance of comorbid child abuse or neglect in families facing intimate partner violence. Some children may be at increased risk including those with chronic illnesses, congenital defects, low birth weight, difficult sleep or feeding patterns and those with other special needs. Though domestic violence is an independent risk factor, other parent related risk factors for child abuse include previous history of abuse, poverty or low income living, single parent households, alcohol and substance abuse, and adolescent pregnancy.

The long term effects of domestic violence can span all aspects of a child’s life and follow them into adulthood. These include mental health disorders such as depression, anxiety, PTSD, conduct disorder, substance use disorders, and borderline and antisocial personality disorders. Data shows that exposure to greater than 10 incidents before the age of 16 doubles the likelihood of suicide attempts. Some studies also suggest that exposure to IPV and associated maltreatment, especially under the age of 2 years, is linked to impaired cognitive development. This has been indicated by decreased IQ scores and learning disabilities.

The Physician’s Role

Unfortunately, the physician recognition and intervention rate for intimate partner violence is low due to barriers such as inadequate education on the topic, unfamiliarity with local resources, perceived shortage of time to address risks during appointments, hesitation of exploring the topic due to fear of transgression, personal experience with violence and patients’ fear of disclosing. The Physician’s role lies in appropriate screening, assessing the safety of the parent and child, assisting in the development of an emergency plan, documenting discussions and referring to other resources as needed.

The approach to screening can differ based on presence of risk factors and signs and symptoms. IPV is more common in young women under the age of 35 years, those living with a disability or mental health disorder, previous history of injury during pregnancy, and history of alcohol or substance abuse by either partner. Social stressors and IPV should also be considered when a parent is unable to attend scheduled appointments, provides inconsistent histories, or is noncompliant or delayed in seeking treatment for their child or themselves. Victims may hide both emotional and physical

injuries well, but one may pick up on relationship dynamics if partners are overbearing or hesitant to leave the victim alone with the physician. Pregnant patients subjected to violence may present with increased complications such as fetal trauma or placental abruption. Signs and symptoms in children are also nonspecific but may coincide with PTSD or other age-related behavioral responses discussed earlier in this podcast and should also prompt a physician to inquire about IPV.

In the absence of risk factors or indicators of IPV, it can be sufficient to offer a safe space for discussion with statements such as “Raising a child is difficult and we’re here to support you in that journey. It is our job to ensure our patients and their families are safe. If you are ever worried about someone harming you or your child, we want you to know you can come to us for support.” Asking a single open ended question can also encourage discussion and increase detection rates, such as “Every couple has disagreements. How do you and your partner resolve conflicts?”

In the presence of suspicion, these statements can be followed up by tools to directly assess risk. One of these is the HARK questionnaire that asks

“Are you now or have you ever been

- a) **H**umiliated or emotionally abused by a partner
- b) **A**fraid of a partner
- c) **R**aped or forced to have sexual activity by a partner
- d) **K**icked, hit, slapped or otherwise hurt by a partner”

Another commonly used screen is HITS, that quantifies by asking “how often does your partner

- a) **H**urt you physically
- b) **I**nsult you or talk down to you
- c) **T**hreaten you with harm
- d) **S**cream or curse at you

Though the above screens are directed at parents in a pediatric setting, questions can also be tailored to adolescent patients. A discussion can be started by stating “Many teens face bullying or violence from peers, partners or family members so I routinely ask my patients about this.” This can then be followed up on a case by case basis with questions about their own relationships and family members. It is important that questioning about IPV should not be done with the partner, other adults or any child over 2 years of age in the room.

If there are concerning signs and/or symptoms, but there is no disclosure of IPV, assess for other causes of stress such as finances, bullying, loss of a caregiver, witnessed violence in the community, or interaction with legal authorities for other reasons. Physicians should also explain their concerns including the short and long term impacts of IPV to build rapport and offer a safe space for disclosure at the patient’s discretion.

If there is disclosure of IPV, the physician must assess the safety of the victim and children involved. In case of imminent danger, security, police, or child and family services should be contacted. If there is no immediate threat, the physician should conduct a focused mental health evaluation to assess the needs of the victim, the appropriateness to send them home and their readiness to discuss a plan of action. As victims may be in various stages of readiness for change (recall these are pre-contemplation, contemplation, preparation, action, maintenance and relapse), this will help guide the next steps and appropriate resource referrals. On a case by case basis, a personalized safety plan can be created to include the following:

- 1) A list of safe spaces to take shelter if there is a need to flee from the home
- 2) A secret signal to alert neighbors or children when to call 911
- 3) A prepared emergency kit containing important documents including ID/passport/social insurance number (SIN), bank statements, and home agreements, money, jewelry and other items of sentimental value, clothing, child's items including birth certificate, immunization records, favorite toy.
- 4) List of things to do after termination of the relationship that will establish independence such as opening a new bank account, changing locks, etc
- 5) Names of friends, family, or neighbors who will be easy to access when in crisis and will empower them in times of weakness, sadness or loneliness

The next step would be accurate documentation. If the patient chart can be accessed by other staff, the physician may choose to document the discussion in non-specific terms such as "family problems" or "difficult social situation". If there are physical injuries or disclosure of specific incidents, details should be reported in a restricted section. Documentation can then be accessed later to aid any legal processes such as police reports, restraining orders, social services involvement, and custody cases.

If the physician is able to accurately identify patients and families in need of support, case specific resources can be provided, including a list of region specific crisis hotlines and local emergency shelters. Some regions may have an easy to remember navigation service such as 2-1-1 in Alberta. Physicians can also provide resources to the family such as the Zebra Child Protection Center and with the parent's permission, refer to other child specific mental health services, and grief and trauma counselling. Being part of a primary care network has the added benefit of providing comprehensive approach and better continuity of care through involvement of a multidisciplinary team.

**It is important to note that even without evidence of imminent danger, if a physician discovers that children are being exposed to domestic violence they are obligated to report to Child & Family Services or the equivalent in their province or state. These services are available to provide case specific advice to Physicians without violation of FOIP.

Prognosis and Prevention

In the absence of appropriate intervention, children and families may face ongoing violence leading to long term physical and mental sequelae and increased risk of death. Early identification and intervention is key to interrupt the cycle of violence but prevention is most effective in reducing long term consequences. Some schools have started to implement programs for effective communication and conflict resolution strategies for children at a young age. Physicians can also discuss these with parents and older children at well child visits and encourage healthy disciplinary practices, rule consistency, and open reciprocal communication.

Now back to our case example of Nina and Sophie.

Your examination of Sophie is largely normal but you do notice she has dropped one percentile line on her weight growth chart. You attempt to inquire further about her daily routine but Nina appears distracted by Sophie's continuous crying. You capitalize on this and ask Jerry to take Sophie out of the room for a walk. Now that you have Nina alone, you initiate a conversation about her personal relationships with a normalizing statement such as "sometimes having children can put a strain on our personal relationships" and then inquire "How have things been with your husband lately?". She hesitantly admits to him being increasingly controlling and making it difficult for her to see family and friends. She denies any immediate safety concerns for herself or Sophie but describes several instances of verbal aggression by her husband towards her. At this point, Nina stops the discussion and states it is time for her to feed Sophie. You acknowledge that this is a difficult topic to discuss and thank her for sharing with you today. You suggest some meal supplements for Sophie and frequent follow up with a longer appointment slot to touch base with Nina as well. You also provide her with counselling resources and develop a personalized safety plan together, should her situation escalate in the meantime. She is grateful for your support and books a follow up appointment in 1 month.

Summary: Now let's go over some take-home points.

- 1) Domestic violence, also known as Intimate Partner Violence, is classified as any behavior intended to exert dominance in a relationship and can be physical, psychological or social in nature.
- 2) Children who are directly targeted or witness IPV, can face short and long term impacts on their physical and mental health.
- 3) As the signs and symptoms can be non-specific or non-evident, Physicians should routinely screen for IPV, and use more directed questions when there are child or parental risk factors present.
- 4) Physicians have a duty to report IPV to Child and Family Services (or the equivalent in their state/province). These agencies can also be consulted confidentially for Physician guidance.

- 5) All discussions should be securely documented and appropriate resources, referrals and follow-up appointments should be made to address any ongoing or future concerns.

Conclusion

Thanks for listening to this Podcast on Domestic Violence! I hope you found it informative and applicable to Pediatric practice!

References:

1. Austerman, J. (2017). Violence and Aggressive Behavior. *Pediatrics in Review*, 38(2), 69–80. doi: 10.1542/pir.2016-0062
2. Bair-Merritt, M. H. (2010). Intimate Partner Violence. *Pediatrics in Review*, 31(4), 145–150. doi: 10.1542/pir.31-4-145
3. Berkowitz, C. D. (2004). Domestic Violence: A Pediatric Concern. *Pediatrics in Review*, 25(9), 306–311. doi: 10.1542/pir.25-9-306
4. Binesh-Marvasti, T., McQueen, S., Ahmed, W. S., Frankfurter, C., Sorouri, K., Faheim, M., & undefined, undefined undefined. (2018). Family Medicine: Domestic Violence/Elder Abuse. In *Toronto Notes 2018: comprehensive medical reference and review for the Medical Council of Canada Qualifying Exam (MCCQE) Part 1 and the United States Medical Licensing Exam (USMLE) Step 2* (34th ed., pp. FM26–FM27). Toronto, Ontario, Canada: Toronto Notes for Medical Students, Inc.
5. Burczycka, M. (2018, December 5). Section 2: Police-reported intimate partner violence in Canada, 2017. Retrieved from <https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54978/02-eng.htm>
6. Cahill, L., & Sherman, P. (2006). Child Abuse and Domestic Violence. *Pediatrics in Review*, 27(9), 339–345. doi: 10.1542/pir.27-9-339
7. Canadian Women's Foundation Fact Sheet: Moving Women Out of Violence. (2018, February). Retrieved from <http://www.canadianwomen.org/facts-about-violence>.
8. Delaney-Black, V., Covington, C., Ondersma, S. J., Nordstrom-Klee, B., Templin, T., Ager, J., ... Sokol, R. J. (2002). Violence Exposure, Trauma, and IQ and/or Reading Deficits Among Urban Children. *Archives of Pediatrics & Adolescent Medicine*, 156(3), 280. doi: 10.1001/archpedi.156.3.280
9. Enlow, M. B., Egeland, B., Blood, E. A., Wright, R. O., & Wright, R. J. (2012). Interpersonal trauma exposure and cognitive development in children to age 8 years: a longitudinal study. *Journal of Epidemiology and Community Health*, 66(11), 1005–1010. doi: 10.1136/jech-2011-200727
10. "Intimate Partner Violence: Information for Primary Care." *EMentalHealth.ca Resource Directory*, 7 July 2013, medicalstudents.ementalhealth.ca/index.php?m=fpArticle&ID=21126.

11. Intimate Partner Violence . (2018, October 23). Retrieved from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html?CDC_AA_refVal=https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html
12. Knapp, J. F. (1998). The Impact Of Children Witnessing Violence. *Pediatric Clinics of North America*, 45(2), 355–364. doi: 10.1016/s0031-3955(05)70011-0
13. Public Health Agency of Canada. (2019, May 13). Provincial and territorial child protection legislation and policy - 2018. Retrieved from <https://www.canada.ca/en/public-health/services/publications/health-risks-safety/provincial-territorial-child-protection-legislation-policy-2018.html>
14. Sinha, M. (2015, November 30). Intimate partner violence. Retrieved from <https://www150.statcan.gc.ca/n1/pub/85-002-x/2013001/article/11805/11805-3-eng.htm>
15. Sohal, H., Eldridge, S., & Feder, G. (2007). The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC Family Practice*, 8(1). doi: 10.1186/1471-2296-8-49