
Abstract:

Intimate partner violence (IPV) affects millions of adults and children each year. The associated risks for child maltreatment are significant, and IPV exposure can have significant harmful consequences for the child. Routine IPV screening in the context of the health care visit for a child in the emergency department can offer the opportunity to effectively identify child risks and provide appropriate intervention to improve child health and well-being. This article provides an overview of the importance of this issue for pediatric emergency physicians and other pediatric health care providers, the challenges to screening, innovative approaches to screening, and follow-up efforts.

Keywords:

intimate partner violence; screening tools; child abuse

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Intimate Partner Violence— Pediatric Risks of “Not Asking–Not Telling”

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A previously healthy 5-month-old infant presented to the emergency department (ED) with an apparent life-threatening event. He was in the care of his father who brought him to the ED due to episodes of stiffening and unresponsiveness. Upon arrival, he had recovered consciousness and was hemodynamically stable; however, evaluation revealed acute and chronic subdural hemorrhages and numerous bilateral retinal hemorrhages. Because of the constellation of injuries concerning for abusive head trauma, child protective services (CPS) was notified. During the initial medical interview, the mother disclosed that the father hit her and left bruises, threw things when angry, and threatened to choke the child when agitated by his crying. During the police investigation, the father admitted to hurting the child, and he was arrested.

BACKGROUND

In recent decades, health care professionals have increasingly recognized that intimate partner violence (IPV) is a major health concern with devastating effects on children, families, and communities. In 1998, the American Academy of Pediatrics (AAP) declared that “The abuse of women is a pediatric issue.”¹ This statement made a compelling case for recognizing IPV in child health care settings. In this article, we will review

IPV in the context of the pediatric ED and offer practical guidance for successful screening and response protocols.

Futures Without Violence defines IPV as “a pattern of purposeful coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent victim and are aimed at establishing control of one partner over the other.”² Over the course of a lifetime, more than 1 in 3 women and more than 1 in 4 men in the United States experience rape, physical violence, and/or stalking by an intimate partner.³ Approximately one third of homicides of women are committed by intimate partners.⁴ Families of all races, ethnicities, and socioeconomic classes experience IPV. Certain sociodemographic factors, however, have been associated with increased risk of IPV, including young age (with the highest rates in women 16-24 years old), lower socioeconomic status, mental health problems, and substance abuse.² These same factors are also associated with child abuse. In addition, adolescent relationships have a particularly high risk of IPV. Approximately 1 in 5 female high school students report being physically and/or sexually abused by a dating partner.⁵

A growing body of empirical research has demonstrated that IPV can be differentiated into categories with respect to partner dynamics, context, and consequences (Table 1).⁶ This paradigm illustrates that although the partner violence dynamic often occurs between male perpetrators and

female victims, it may also occur bidirectionally and may be better conceptualized as family or interpersonal violence. Further implications of differentiation among types of IPV include the need for improved screening measures and more effective treatment programs tailored to the characteristics of different types of partner violence. Although we recognize that IPV is bidirectional between 2 partners of different or same genders, for the purpose of this article, we will make a distinction of gender to simplify the discussion.

CO-OCCURRENCE OF CHILD ABUSE AND IMPACT OF IPV ON FAMILY WELL-BEING

Children in violent homes commonly see, hear, and intervene in episodes of IPV. Such exposure results in a wide range of negative psychological, emotional, behavioral, social, and physical health consequences. Fifteen million children in the United States are exposed to IPV each year. Almost 50% of these children are exposed to severe IPV, such as one parent beating up another parent or one parent using a knife or gun against another parent.⁷ In populations of families either reported to CPS for child maltreatment or in domestic violence shelters, the co-occurrence of child maltreatment and IPV ranges from 30% to 60%.^{8,9} Poverty, parental depression, and substance abuse increase the risk of co-occurrence. Children living in homes where IPV occurs also may be injured inadvertently by being “caught in the crossfire” of parental altercations.¹⁰

Childhood exposure to IPV likely leads to adverse child health outcomes through a number of pathways including trauma, altered stress physiology, and disruption of caregiver-child attachment.¹¹ Children exposed to IPV also frequently perceive the world as hostile and unsafe, and learn via social modeling that aggression is an acceptable means through which to resolve conflict.¹² Strong evidence links childhood IPV exposure to a wide variety of adverse social emotional health outcomes in childhood.¹³⁻¹⁶ Intimate partner violence may disturb infant routines such as sleeping and feeding and may affect parent-infant attachment. Common symptoms in toddlers include extreme separation anxiety, excessive tantrums, and aggression with peers. School-aged children living in homes in which IPV occurs are more likely than their peers to exhibit aggressive and antisocial behaviors and are more likely to be anxious, fearful, and hypervigilant.¹⁷ Adolescents in homes where IPV is present have higher rates of school failure, substance abuse, and risky sexual behaviors. These adolescents are more

TABLE 1. Differentiation among dynamics of IPV.

Type	Description
Coercive controlling violence	Emotionally abusive intimidation; coercion and control coupled with physical and/or sexual violence; “domestic violence”; most common and studied type
Violent resistance	Violent reaction to partner with pattern of coercive controlling violence in attempt to stop violence; “self-defense”
Situational couple violence	Violence not based in dynamic of power and control; “conflict motivated violence”
Separation instigated violence	Violence first occurring in relationship at separation; could be late manifestation of coercive controlling violence

likely than their peers to enter into a violent dating relationship. When compared with non-IPV-exposed children, children exposed to IPV are more likely to experience failure to thrive, immunization deficiency, and speech pathology. Furthermore, they are less likely to attend health supervision visits and are disproportionately more likely to have ED visits.¹⁸

Child and adolescent experiences have been shown to have significant effects into adulthood, as eloquently demonstrated in the Adverse Childhood Experiences (ACEs) study, which focuses on how these ACEs including exposure to IPV relate to health risk factors and mortality later in life. The authors enrolled more than 20 000 men and women and found a consistent, graded relationship between a number of the ACEs and poor adult health outcomes. The presence of IPV was associated with significantly increased odds of child sexual abuse, physical abuse, and neglect.^{19,20} Health care costs and utilization for children whose mothers experience IPV are increased with greater ED visits, mental health services, and primary care visits.²¹ Although there are many potential negative outcomes, there are also many children who survive a childhood of witnessing IPV relatively unaffected without evidence of negative developmental outcomes. Furthermore, there are others who may develop strong coping abilities or resilience through these experiences.²²

BARRIERS TO IPV SCREENING

Despite the multiple, negative impacts of IPV exposure it is not routine to screen for IPV in most pediatric clinical settings, including the ED. Previous research has identified numerous barriers that limit screening for IPV. These include provider-specific personal and behavioral barriers, interpersonal barriers between the provider and caregiver, and practical system-based barriers inherent to the ED environment (Table 2). It is important that these barriers are recognized and discussed before any effort to include IPV screening and assessment in the ED.

Examples of personal and behavioral barriers include a lack of knowledge of and/or confidence in how to ask about IPV or what to do when IPV is identified.^{23,24} Specifically, pediatric health care providers have self-reported feelings of inadequate training and lack of confidence that limit their ability to screen. Teaching methods and strategies for IPV screening during residency can overcome these personal barriers. However, confidence in one's ability (self-efficacy) is the best predictor of screen-

TABLE 2. Perceived barriers to IPV screening and solutions.

Barrier	Solutions
Lack of training	Development of strong residency curriculum; annual retraining for care providers, including nurses, physicians, and social workers
Lack of confidence	Adequate training and availability of resources
Fear of positive screen—not knowing what to do	Readily available support systems and resources; social workers or counselors available to address immediate concerns
Fear of offending the caregiver/IPV victim	Teach techniques for sensitive practice; establish environment where IPV screening is universal and expected
Perception that IPV has no impact on child well-being	Annual education and focus groups discussing impact of IPV on children
Overcrowded rooms	Self-administered, confidential IPV screens in waiting rooms and individual rooms
Time constraints on nurses and doctors	Incorporate IPV screening into ED workflow; remove sole responsibility from clinicians; utilize technology for readily available, self-administered IPV screen establish automated social work paging system when positive screen identified

ing behavior. Despite adequate training and resource availability, some clinicians continue to lack assurance that they know how to react appropriately to a positive screen.²⁵ Immediate access to resources and support is of particular importance to help overcome such perceived barriers.

In addition, in the setting of pediatric care, because the IPV victim is not the patient, clinicians may opt not to screen because of concern for offending the caregiver and negatively impacting the care of the pediatric patient. Learning to interact appropriately when it comes to a sensitive subject, especially in a busy ED setting, requires sufficient practice, or these interaction-related barriers can be difficult to overcome. Lack of a preestablished provider-caregiver relationship may be addressed by creating a supportive environment in which compassionate screening and assistance coexist within the rapidly paced ED.²⁵ Furthermore, it is important that parental concerns about the

child's health take priority before addressing any identified IPV.²⁶ Another perceived barrier is that attempting an intervention may be ineffective. For instance, when compared with a control group, women randomized to IPV screening did not report decreased IPV or increased health or quality of life overtime.²⁷

Many providers fail to appreciate the impact of IPV on child well-being and therefore do not see the use of IPV screening in a pediatric setting.²³ Some even believe that there is a risk to screening. However, among ED patients identified as IPV victims on an electronic screen, no adverse events related to screening were reported, and furthermore, a significant number of women who screened positive for IPV contacted community resources after discharge.²⁸

Opportunity for screening may be limited when multiple children and/or family members are present. Furthermore, caregivers may have attitudes that make them reluctant to disclose IPV, such as shame or fear that disclosure may escalate abuse or result in a report to CPS.^{23,26,29} There may also be unidentified intrinsic characteristics of the provider-caregiver dynamic, such as race and gender, that negatively impact the screening process. Many of these barriers can and have been overcome with self-administered assessments, which will be discussed below.²⁶

Finally, practical system-based barriers such as time constraints and multiple demands on health care providers also exist in a hectic ED environment.²⁹ Although these barriers may seem the most overwhelming, it is actually the behavioral barriers that are most challenging to change. Unfortunately, clinicians may adopt a mindset that the outcome of a child living in a violent home cannot be influenced from the efforts in a health care visit and therefore avoid thinking about IPV exposure altogether.

ENDORSEMENT OF IPV SCREENING

Despite barriers to family violence diagnosis and treatment most major medical organizations including the AAP,³⁰ the American College of Obstetrician-Gynecologists,³¹ the American Academy of Family Physicians,³² the American College of Emergency Physicians,³³ and the American Medical Association,³⁴ recognize the influence of family violence on health and endorse IPV screening in the health care setting. The AAP recommends routine IPV screening during all health care supervision visits and encourages screening in all pediatric settings, stating that "identifying and intervening

on behalf of battered women may be one of the most effective means of preventing child abuse."¹ Parents also endorse routine IPV screening, identifying family violence as common in their communities and recognizing that exposure to IPV is harmful to children.²⁶

Pediatricians are in a unique position to screen for family violence, given the inherent risks IPV poses to child well-being. Abused women may be more likely to seek health care for their children than for themselves, and these women may feel more comfortable discussing family violence with their children's medical provider rather than their own physician. Screening caregivers for IPV is an important component of the social history and may not only improve the clinician's understanding of the child's home environment, but also give insight to a patient's current illness as well as the family's ability to adhere to treatment recommendations.³⁵ Routine screening communicates to families that IPV is a common problem. It reduces the isolation associated with IPV, conveys that IPV exposure affects children, and creates an opportunity to support a safe home environment through initial disclosure of the problem.

Despite the medical communities' overwhelming endorsement for routine IPV screening, some dispute that screening is not indicated because of lack of support from the US Preventative Services Task Force (USPSTF). In 2004, the USPSTF published guidelines stating that there was insufficient empiric evidence to recommend either for or against routine IPV screening.³⁶ This recommendation is based on a paucity of evidence that screening "leads to decreased disability or premature death" among patients with no presenting symptoms. Because only studies of asymptomatic patients were included, those involving patients in EDs, in high-risk social circumstances, or with provider-elicited signs of violence were not evaluated. By only measuring the impact of screening on disability or premature death, other benefits of assessment and intervention for IPV, such as improved safety or health behaviors, were overlooked. Futures Without Violence suggests that screening for IPV should be considered a psychosocial assessment and counseling practice rather than a medical procedure as reviewed by the USPSTF.² This distinction is important because the USPSTF uses a different analytic framework to assess the 2 types of interventions. Intimate partner violence is viewed by experts as a chronic, recurrent, and usually escalating problem that is not easily divided into symptomatic and asymptomatic patients. Thus, IPV screening would better

fit in the behavioral and counseling services framework in future evaluations.² In a recent systematic review³⁷ to update the 2004 USPSTF recommendation, new evidence on the effectiveness of IPV screening was evaluated and demonstrated improved birth outcomes in pregnant women, and a reduction in pregnancy coercion and unsafe relationships for women in family planning clinics. Multiple studies showed minimal adverse effects with screening and included emotional discomfort, loss of privacy, and concerns about future abuse. From this review, it was determined that screening instruments designed for use in health care settings can accurately identify women experiencing IPV. Intervention studies have adequately demonstrated that screening women for IPV could reduce IPV and improve health outcomes.

FRAMEWORK AND APPROACHES TO IPV SCREENING

The transtheoretical model, known as “stages of change,” is a framework for the process of behavioral changes that may occur in women experiencing IPV.^{38,39} This model highlights the importance of recognizing that an individual experiencing IPV may not initially recognize the behavior as unacceptable or as a problem (Table 3). Although the proposed stages of change do not necessarily occur in a sequential fashion and there is not necessarily forward movement through the steps, this framework provides clinicians with a contextual understanding of how to offer assistance, support, and protection for these women and their children. This model makes it apparent that ending IPV, even on an individual basis, is a process that occurs over time.³⁵

Because of the harmful effects of family violence on children, IPV screening tools have been incorporated into both the pediatric office and ED clinical environments.⁴⁰⁻⁴³ Considerable IPV screening research has focused on both the instrument and method used for screening. There is an exhaustive list of instruments that can be used to assess IPV.^{43,44} When comparing face-to-face interview, written self-report questionnaire, and computer self-report questionnaire, more anonymous screening methods (written or computer) were favored by women.^{44,45} In addition to patient preference, the use of a brief, validated IPV measure that is self-administered through a computer provides optimal detection rates with the greatest time efficiency, privacy, and provider preference.^{45,46} Computer-

TABLE 3. Stages of change for IPV.

Stages of Change	Definition
Precontemplation	The woman does not recognize the abusive behavior as a problem and is not interested in change.
Contemplation	The woman recognizes the abusive behavior as a problem and has an increasing awareness of the pros and cons of change.
Preparation	The woman recognizes the abusive behavior as a problem, intends to change, and has developed a plan.
Action	The woman is actively engaged in making changes related to ending the abusive behavior.
Maintenance	The abusive behavior has ended, and the woman is taking steps to prevent relapse.

Data from Burke et al.³⁹

ized questionnaires optimize confidentiality because the computer screen can change to a new item immediately after a response, reducing the potential of nearby observers overseeing answers to these sensitive questions. From a health systems perspective, direct patient entry of responses into a computer prevents hospital personnel from spending time to distribute and score questionnaires.^{42,43}

Although incorporating IPV screening into a hectic ED may seem daunting, development and implementation of a self-administered computerized screen is feasible when the clinical team prioritizes family violence as an important facet of care to support within their practice (Table 4).^{42,43} Although many cite time constraints as a barrier to IPV screening in the ED, in fact, the most time-consuming aspect should be the process of developing an effective screening program, as opposed to the process of screening once underway.³⁵ Most important is gaining support and “buy-in” from the ED staff and administrators, so that everyone shares a common goal when initiating the new screening process.^{43,47} Choosing an appropriate screening instrument, educating personnel, implementing a protocol, identifying and addressing potential challenges and perceived barriers, and arranging a follow-up plan for positive screens are important aspects of instituting an IPV screening program.³⁵ Once established, an effective IPV screening process is a first step toward a shared effort by EDs to reduce violence and its negative influence on children and families.

TABLE 4. Tool box to address IPV in the ED setting.

Background	Appreciate the magnitude of IPV, the dynamics of family violence, and the negative impact on children.
Culture	Engage all ED staff and administrators in trauma-informed care: IPV is an important family issue to be addressed.
Screening	Initiate universal self-initiated computerized screening tool.
Safety	Recognize potential dangers for victims and children. Learn to develop effective safety plans with them. <ul style="list-style-type: none"> • Call shelters, know legal options, and find local resources ahead of time. • Prepare emergency bag ahead of time. • Have plan of where to go and when. • Involve friends in developing safety plan, and use code words for help. • Educate children on how to call for help.
Legal issues	Become familiar with how your institution documents positive screens, confirm documentation strategy with caregiver, and determine what types of abuse necessitate mandated reporting.
Resources	Collect list of community resources and be able to distribute to patients. Integrate efforts with community. Provide education to families.
Follow-up	Have a plan for informing primary care physician of positive screens and establishing follow-up in the medical home.

Data from Tscholl and Scribano.³⁵

IPV SCREENING IN THE PEDIATRIC ED: WHY IT MAKES SENSE

The ED has been identified as an important venue to screen for IPV.⁴⁷ Young, low-income, single-parent families frequently seek care in the ED, making the ED visit an ideal opportunity to screen this vulnerable population.^{48,49} Families already predisposed to injury and violence present to the ED with “teachable moments” that may foster greater willingness to address unsafe behaviors.^{49,50} Abused caregivers may be more likely to access care for their children in an ED than in an ambulatory care office because EDs provide relatively “anonymous” health care.^{50,51} In extreme circumstances, this relatively obscure provision of health care may attract frightened victims such as those that are only able to have unscheduled care for themselves and their children because their abusers prevent access to regular primary care.

Gathering information about family violence during every pediatric emergency medical evaluation can help providers identify many children experiencing family violence, as studies have found that 10% to 20% of women screened at adult and pediatric emergency visits report being victims of IPV currently or in the past.⁵² Such high prevalence of partner violence disclosure in EDs suggests that closer examination of the general health of children of IPV victims is warranted, as to not overlook children presenting with complaints related to underlying IPV or even child maltreatment.

EXISTING IPV SCREENING TOOLS IN PEDIATRIC EDS

Several ED screening tools to identify victims of IPV have been piloted and/or implemented. Most have incorporated the partner violence screen, which is a 3-question tool shown to be sensitive and specific in detecting women who have a history of partner violence (Figure 1).⁵⁰ Newman and colleagues⁴¹ used a written survey that included the partner violence screen as well as an additional question about sexual assault. They found that socioeconomic and visit characteristics were imprecise in identifying women at risk for IPV, thus supporting universal rather than targeted screening efforts. Caregivers in their study felt that IPV screening in the ED was acceptable, and most were willing to participate. Bair-Merritt and colleagues⁴² compared an audiotape questionnaire to a written questionnaire and found that women felt that the audiotape method was more private and safer. Both groups preferred self-administered screens compared with direct verbal ED provider screening.

Compared with usual care (face-to-face screening at the discretion of the clinician), Trautman and colleagues⁵³ found that computer-based partner violence screening resulted in more women screened and increased IPV detection. Although most caregivers preferred using a computer and few had difficulty with the technology, significant effort and coordination were involved in administering the computerized screen. Clinical staff members were required to log in and set up the screen for each patient, requiring the provider to remember to administer the screen as well as take time to initiate the screen. Modifications to the computerized screening process have been successfully implemented by Scribano and colleagues,⁴³ who executed a caregiver-initiated computerized questionnaire using kiosks located in the ED waiting room. As an effort to address home safety, the IPV screen was

Every year, millions of women are abused by a partner. The safety of mothers can affect the health and safety of children. In order for us to figure out how to best provide women with help if they are in an abusive relationship with a partner, we would like to ask you some personal safety questions.

1. Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?
 - a. If so, by whom? (person in current relationship, person from previous relationship, someone else)
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe *now*?
4. Within the past year, has a partner repeatedly used words, yelled, or screamed at you in a way that frightened you, threatened you, put you down, or made you feel rejected?
5. Have you had unwanted, forced sexual contact with someone in the past year?

(Data from Scribano,⁴³ and Bair-Merritt²⁵)

Figure 1. Sample IPV screening tool.

included among other non-IPV issues such as car safety restraint, accidental poisonings, smoke detector and fire safety, bike helmet use, and safe navigation of the Internet. This screening program overcame previously identified barriers by streamlining the process into the natural workflow of the ED. The computerized kiosks were private and limited the number of ED personnel required to administer the screen. Only the initial triage desk was required to give brief instructions to the caregivers on how to complete the screen when they registered for a visit. The initiation, administration, and scoring of the screen were automated. A positive screen prompted an automated page to the ED social worker who received a summary of the screening results on a dedicated printer and conducted a safety assessment and offered assistance before discharge.

RESPONSE TO A POSITIVE IPV SCREEN

Adequate clinician training and education will provide the skills and confidence required to work with patients, colleagues, and health care systems to lessen violence and abuse.⁵⁴ Optimal care for the caregiver in an abusive relationship depends on the physician's working knowledge of community resources that can provide safety, advocacy, and support. Any assessment and intervention on behalf of caregivers struggling with IPV should include an understanding of the need to respect their autonomy and should be offered in the context of advocating and demonstrating concern for their own health and safety as well as that of their children.⁵⁵

The following responses to a positive IPV screen are recommended and summarized in Table 4: (1) questions about escalation of violence, weapons,

and comfort in going home to assess the caregiver and child's immediate safety; (2) if violence is escalating or the family is in immediate danger, safe housing must be established; if no other temporary housing options are identified, IPV hotlines can help to facilitate this need; (3) detailed history and physical examination to evaluate for potential child maltreatment; (4) provision of social work assistance or national and local IPV resources; (5) and planning for ongoing safety.¹³ Clinicians should recognize that advising the woman to leave the relationship may not be the safest solution for her or her children. The risk of homicide for women increases by 75% around the time of leaving an abusive relationship.³⁹

Health care providers should be aware that if the abuser is also a parent of the pediatric patient, he will have access to the child's medical record and may obtain documentation regarding the abusive relationship that could place the mother at risk.³⁵ In contrast, it may be legally beneficial (in restraining orders or child custody cases) to document IPV in the child's medical record. Although the risks of documentation are more theoretical than evidence based, it is important to establish a process in your department in which this potential confidentiality issue is addressed.

With any disclosure of IPV, a careful assessment of the child's well-being and safety is essential. Clinicians are obligated to report any suspicion of child abuse or neglect or any concern that the child is in imminent danger to CPS. Some states require mandated reporting of IPV exposure, and clinicians should know their specific state's reporting requirements before screening and inform the caregiver accordingly. Web sites such as www.endabuse.org or <http://www.childwelfare.gov> provide information on state-specific laws about mandated reporting.

Once resources have been provided and safety plans established, communication to the child's medical home is essential to ensure follow-up of positive screens and continued support. As an example to illustrate the importance of the clinical care handoff, when a child presents to the ED in respiratory distress, is identified to be in status asthmaticus, improves with steroids and β -agonists, and is discharged, communicating and establishing follow-up with his primary pediatrician are expected and crucial aspects of care. Although the ED is instrumental in identifying an asthma exacerbation and providing emergent care, the core asthma management takes place in the medical home where follow-up from ED visits is essential. Likewise, when family violence is identified in the ED, emergent care, if needed, is provided, and communication with the medical home and a follow-up visit must also be established for optimal management.


Given the ever-growing evidence that children exposed to IPV are at significant risk for child maltreatment and short- and long-term medical, behavioral, and mental health problems, efforts to improve IPV detection are necessary to effectively promote violence prevention. In addition, the Institute of Medicine recommends several core competencies on family violence for health care professionals.⁵⁶ These core competencies include training on the identification, assessment, and documentation of abuse; knowledge of interventions to ensure victim safety; recognition of culture and values as factors that affect IPV; understanding of applicable legal responsibilities; and violence prevention. Emergency department clinicians who possess knowledge and skills in these areas will be in a position to most effectively intervene when IPV is present and provide more optimal and appropriate health care to children and their families.

ILLUSTRATIVE CASE FOLLOW-UP

After a period of observation, the child was discharged home in the care of his mother. The child protection team social worker met with the patient's mother, and together, they identified supportive family members and possible safe housing options for the future. Arrangements were made through the state's victim assistance program to assist with paying medical bills, loss of wages, and counseling services. Contact information for 2 local domestic violence centers and the 24-hour domestic violence hotline were provided. Counseling services were arranged for the patient's 6-year-old brother

who had witnessed violence in the home, although history and physical examination showed no physical injuries.

SUMMARY

Intimate partner violence is a public health issue that is not simply an adult problem. The negative effects of IPV exposure on the health and well-being of children are substantial, including significant risks for nonaccidental trauma. Intimate partner violence screening is an important facet of addressing these public health risks, and some innovative tools may offer promise to incorporating IPV surveillance and initial intervention in the ED setting. 

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