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Helping Young Children Affected by Domestic Violence: The Role of Pediatric Health Settings

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Helping Young Children Affected by Domestic Violence:

The Role of Pediatric Health Settings

Paper #1 in the Series

Early Childhood, Domestic Violence, and Poverty: Helping Young Children and Their Families

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The University of Iowa

Early Childhood, Domestic Violence, and Poverty: Helping Young Children and Their Families

Series Introduction, by Susan Schechter and Jane Knitzer.

Series Paper #1: *Helping Young Children Affected by Domestic Violence: The Role of Pediatric Health Settings,* by Betsy McAlister Groves and Ken Fox.

Series Paper #2: *Young Children Living with Domestic Violence: The Role of Early Childhood Programs*, by Elena Cohen and Jane Knitzer.

Series Paper #3: *Domestic Violence and Family Support Programs: Creating Opportunities to Help Young Children and Their Families*, by Nilofer Ahsan.

Series Paper #4: *Police in the Lives of Young Children Exposed to Domestic Violence*, by Miriam Berkman and Dean Esserman.

Series Paper #5: *Working with Young Children and Their Families: Recommendations for Domestic Violence Agencies and Batterer Intervention Programs*, by Abigail Gewirtz and Resmaa Menakem.

Series Paper #6: *Young Children's Exposure to Adult Domestic Violence: Toward a Developmental Risk and Resilience Framework for Research and Intervention,* by Abigail Gewirtz and Jeffrey L. Edleson.

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Dedication

This series is dedicated to the memory of Susan Schechter (1946-2004).

Susan Schechter was a visionary leader in the movement to end violence against women and children. Her work and influence were national in scope, though her home base in recent years was Iowa City, Iowa, where she served as Clinical Professor at The University of Iowa School of Social Work. Susan was a founder of the battered women's movement, and throughout her career was a respected leader and thinker in the field. She was the author or co-author of several pioneering books and monographs, including the widely cited *Women and Male Violence*, which was an early history of the battered women's movement, and the *Greenbook* that is currently the guide for many reform efforts around the country.

Perhaps Susan's most significant and enduring contribution was her path breaking and persistent effort to help the children of battered women. This work began in 1986, when Susan developed AWAKE, (Advocacy for Women and Kids in Emergencies) at Children's Hospital, Boston, which was the first program in a pediatric hospital for battered women with abused children. She also served as a consultant to several national domestic violence and child welfare initiatives and as a member of the National Advisory Council on Violence Against Women. Her analysis, writing, advocacy, and speeches played a major role in shaping current policy and practice regarding family violence and children. On a less public but no less significant stage, the positive way in which Susan touched the lives of those around her was among her greatest gifts. Susan was a remarkable person, thoughtful and good-hearted; many individuals from diverse fields were fortunate to call her a mentor and friend. Her leadership, warmth, humor, wisdom, and passionate advocacy will be missed.

This series of papers reflects the integrity of Susan's work and is a fitting tribute to her intellect and her unique skills, which bridged the fields of child advocacy and domestic violence in ways that encouraged multi-disciplinary approaches to evolve. It was her hope that this series would be a catalyst for change that would bring safety and stability to young children and families affected by domestic violence, racism and poverty.

Early Childhood, Domestic Violence, and Poverty: Helping Young Children and Their Families

Series Introduction

This paper is part of a series that addresses a widespread but often hidden challenge: how to mobilize community and programmatic resources to provide responsive help to young children and families affected by both domestic violence and poverty. Although these children and families come into contact with many helping systems, their problems with violence are often invisible, and the assistance that they need is therefore unavailable, uncoordinated, or unresponsive to specific family or cultural contexts.

The series aims to knit together two agendas, addressing domestic violence and promoting healthy development in young children affected by it. The aim is to offer practical guidance to community-based agencies that work with families confronting multiple difficulties linked to poverty. It proposes a common practice framework for the multiple agencies and systems—health clinics, early childhood programs, family support programs, police, and domestic violence services—that families use as they seek safety and stability. It also sends a message that, in many instances, there are alternative, safe ways of helping young children and families without resorting to out-of-home placement or the involvement of more coercive systems.

Establishing a Common Practice Framework

All low-income families struggle with limited material resources and related hardships. But families struggling with domestic violence and poverty are likely to have more needs than other families: battered women and their children may require protection; men who batter may find themselves facing legal and social service interventions; families will need increased economic resources to survive, and children will require financial stability and emotional comfort. All those who work directly with children and families affected by poverty and domestic violence need to be responsive to these circumstances as well as to the cultural ways in which family members define and most comfortably solve problems. Further, although no single community agency can provide

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a comprehensive array of the needed responses, collectively, communities can embrace a common vision and work together, across institutional boundaries, to implement this vision as fully as possible. This vision includes the following five elements of a common practice framework.

1. Young children and their caregivers need to be safe.

Domestic violence is a pattern of assaultive and coercive behaviors—including physical, sexual, and psychological attacks, and economic coercion—that an adult uses against an intimate partner. This pattern of serious assault is most typically exercised by men against a female partner and sometimes against their children.[1] These assaults are often repetitive and continuous and may leave women and children feeling dazed and bereft.

In the face of abuse and assaults, a battered woman with children often confronts two kinds of difficult decisions. First, how will she protect herself and her children from the physical dangers posed by her partner? Second, how will she provide for her children? This second set of social and economic risks are central in each battered woman's calculation of her children's safety. If, for example, a woman decides to leave her partner to protect herself and her children, where will she find housing and money to feed her family? Who will take care of the children if she must work and her partner is no longer there (Davies, Lyon, & Monti-Catania, 1998)? How will she manage the complex, and for many families enduring relationship with the batterer over time? For women who have immigrated to the United States, these risks are often further complicated. What will they do if they have no access to governmental benefits such as welfare or food stamps? What if they cannot speak English, are without money, and in physical danger (National Council of Juvenile and Family Court Judges, 1999)? Creating safety requires that communities also try to eliminate the two sets of risks—physical and material—that children and their mothers face.

2. Young children need to experience warm, supportive, nurturing relationships with their parents and with other caregivers.

According to a recent and remarkable synthesis of developmental and neuroscientific literature, the earliest relationships between young children and those who are closest to them have an especially potent influence on their early development (Shonkoff & Phillips, 2000). Childcare providers, pediatricians, family workers, and children's advocates are all in a position to help parents and others understand how important they are to their children, how best to support them, and how to help parents build healthy relationships with their young children. Community providers also are key to ensuring that young children have age-appropriate opportunities outside the family. Research suggests that quality early care and learning experiences can help all low-income children succeed in school. For young

[1] Because the most serious forms of adult domestic violence are carried out by husbands and male partners, the term "battered woman" is used in this series to refer to the adult victim. However, lesbians and heterosexual and homosexual males are also victims of the kind of abuse described in this series.

children exposed to domestic violence, such experiences can provide a safe haven through which they can thrive.

3. Young children and their families need to have their basic needs met.

Common sense tells us that poverty and economic hardship (e.g., being hungry or homeless) are not good for people in general and children in particular. Research tells an even more compelling story. Poverty in early childhood appears to be more harmful than poverty at other ages, particularly in terms of cognitive development (Duncan, Yeung, Brooks-Dunn, & Smith, 1998), while increases in income seem to be associated with improvements in indicators of cognitive, social, and emotional competencies (Dearing, McCartney, & Taylor, 2001). Those working with young children and families cannot solve the problems of poverty, but they are in a position to ensure that both caregiving and non-caregiving parents have access to all benefits to which they are entitled, as well as to local opportunities that will promote their economic security. Focusing on financial strategies can help ensure that women and children are not trapped in violence because of their economic circumstances. Similarly, focusing on economic issues with men who batter may also have a positive impact, particularly on domestic violence recidivism rates, which are highest among those who are unemployed.

4. Young children and families need to encounter service systems that are welcoming and culturally respectful, and service providers with the cultural knowledge, skills, and attitudes to help them.

Although the majority of poor families in the United States are white, the United States is now a country with many diverse communities of color. According to the U.S. Census 2000,[2] more than 12% of respondents reported their race as Black or African American; an additional 12% reported themselves as Hispanic; 1% described themselves as American Indian or Alaskan Native; and almost 4% categorized themselves as Asian or Pacific Islander. Over 40 ethnic groups are represented in the Asian and Pacific Islander population with, many of them—Chinese, Japanese, and Filipino populations, for example—having lived in this country for generations, and others, such as the Hmong, Laotian, and Vietnamese, arriving more recently and bearing burdens due to displacement and war (Yoshihama, 2003). Although the psychological consequences of domestic violence seem to be similar for all women (Jenkins, 2003), victims from different races and ethnic groups may explain and experience battering in very different ways. For example, some Southeast Asian women may be abused not only by their husbands but also by their in-laws and other extended family members. These women may need help to deal with multiple abusers.

From a community provider perspective, the ethnic and cultural diversity of families facing poverty and domestic violence poses significant challenges. Staff that look like the families,

[2] The U.S. Census 2000 used revised standards for collecting data on race and ethnicity wherein respondents could record more than one race.

speak their language, understand their spiritual and cultural background, and can talk about safety with an appreciation for the complexities of those conversations can make a big difference, but even agencies that do not have this can become more responsive. However, it requires a commitment. To do this multicultural work well, agencies must carry out a careful assessment of their mission, policies, hiring procedures, services, staff supervision, budgets, and resources that are provided for training in cultural competence. Above all, they must be prepared to learn from their resourceful clients.

5. **Young children and their families should be able to receive early, strengths-based interventions to help them avoid the harmful consequences of domestic violence and to reduce the likelihood of entry into the child protection and, ultimately, juvenile court systems.**

Emerging developmental knowledge makes a strong case for targeting intentional supports, services, and specialized early interventions to young children and families experiencing multiple risk factors. For parents, this may mean not just attention to safety and basic needs, but help to repair or prevent damaged parent-child relationships and to promote positive parenting. For children, it means ensuring they have access to health care, developmental screening, high-quality early childhood programs, and, if necessary, specialized services (Knitzer, 2000). A review of findings from 15 projects which focused on children experiencing domestic violence, for example, suggested that participating in either groups or in mother-child dyadic interventions resulted in reduced aggression, decreased anxious and depressive behaviors, and improved social relationships with peers (Graham-Bermann, 2001).

Strengthening the focus on early intervention for young vulnerable children and their families is especially critical because, in the absence of specific attention to early intervention services, community providers are more likely to believe that their only alternative, and/or obligation, is to refer a family experiencing domestic violence to Child Protective Services (CPS) or to the police. Indeed, rates of foster care placement, especially for young children, are escalating. Such referrals become the default option. CPS certainly has an important role to play for those children at serious risk of harm. If Child Protective Services, however, is the only assistance available, many families will avoid seeking services, fearful that their disclosure of violence will lead to removal of their children.

Summary

The papers in this series were designed to offer practical guidance to organizations that encounter and help low-income families. Their vision is to engage the intervention network of pediatric health care professionals, childcare providers, family support workers, community police officers, and domestic violence advocates, in order to help families find safety and stability before repeated trauma takes its toll. By effectively mobilizing the resources of community agencies, concerned neighbors, and kin, and by building on

the strengths and carefully crafted survival strategies of battered women, this intervention network can promote children's healthy development and literally save lives.

About the Authors

Susan Schechter is a Clinical Professor at The University of Iowa School of Social Work and the author or co-author of several books and monographs about domestic violence, including *Women and Male Violence: The Visions and Struggles of the Battered Women's Movement; When Love Goes Wrong; Domestic Violence: A National Curriculum for Children's Protective Services;* and *Domestic Violence and Children: Creating a Public Response.* She has also directed or founded several clinical and advocacy programs, including AWAKE (Advocacy for Women and Kids in Emergencies), at Children's Hospital, Boston, which is the first program in a pediatric hospital for battered women with abused children. She also has served as a member of the National Advisory Council on Violence Against Women.

Dr. Jane Knitzer is the Acting Director of The National Center for Children in Poverty at the Mailman School of Public Health, Columbia University. She is a psychologist whose career has been spent in policy research and analysis of issues affecting children and families, including mental health, child welfare, and early childhood. She has been on the faculty at Cornell University, New York University, and Bank Street College for Education. Prior to that, she worked for many years at the Children's Defense Fund.

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Helping Young Children Affected By Domestic Violence: The Role of Pediatric Health Settings

Series Paper #1

Introduction

A pediatrician in a busy community health center in Boston reported the following case:

> A six-year-old Puerto Rican boy came to the clinic with his mother, whose chief concern was that his medication for Attention Deficit Disorder "doesn't seem to work anymore." According to the mother, Juanito was a good student last year, but is doing poorly now. He fails to complete schoolwork and is disruptive in class. The family has moved frequently in the past two years. Recent chart notes indicate that the Department of Social Services investigated the family three months ago. When the pediatrician asks if the mother feels safe in her current living situation, she replies that she "feels safe now," but her eyes fill with tears.
>
> She then asked if Juanito could wait in another room and told the pediatrician the following story:
>
> *"Four years ago, when Juanito was two and I was about to have the new baby, I had finally decided to leave his father. I had told my mother-in-law. That was a mistake. I thought she was on my side, but she said it was my responsibility as a wife to stay. 'You think life is supposed to be easy for a woman?' She cussed me out. Bad.*
>
> *"So on the day I was going to go to the shelter, Juanito's father came home early from work. He said he was hungry, could I fix his plate? He was watching TV, lit a blunt (marijuana), and then I heard this crash. I tell you it was like hell busted loose, like a dam burst all through my house.*
>
> *"Juanito's father came in the kitchen and started kissing me real hard. Then he bit my tongue and wouldn't let it go. It started bleeding. The pot boiled over. Soup splashed on the floor. Juanito started crying. I put Juanito in his room and closed the door.*
>
> *"My husband broke everything that night. He said he didn't think I would be needing this and that anymore. He broke the front room window with*

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the dining room chairs I had just got out of lay-away. He cut up the curtains and pulled the stuffing out of the couch and the tape out of every cassette. He broke all the dishes and glasses in the cabinets, the baby's bassinet, the bathroom mirror, and the hands on the kitchen clock. He ripped open the bird cage and broke the parakeet's wing with a broom when it tried to fly. He knocked it all up against the wall.

"Then he said it was all my fault because I had burnt his food. That he doesn't have money to throw away food like that. That I better clean it up. That I was a 'dinner-burning whore' and all that. He dumped everything out of my purse on the floor and crushed it. He broke my red lipstick. Then he said he was going out for Chinese food. Did I want something?

"Juanito didn't see all that, and anyway he was only two, and I had closed his bedroom door. But when I went in his room that night, he was in the closet. When I tried to get him out, he slapped me dead in the face. That hurt even though his hand was small. Later, we left his dad."

The pediatrician replied, *"I'm so glad you made it here today. Children who see too much react in many different ways. It sounds like you might be worried that this has affected Juanito as he has gotten older. You are a very strong person and you've taken some big steps to put your life back together again. If you'd like me to, I will refer you and Juanito to a special counselor in a program that works with young children who have witnessed violence in their home. But I have two questions for you:*

"Are you safe? How can we keep you and Juanito safe? I'm asking you these questions because there may be other resources—social, economic, and legal—we can use to support the important steps you've already taken."

After a soft knock, Juanito slipped in and sat on his mother's lap. *"Did you color this house for me?"* his mother asked. He nodded yes.

"Que linda! Mommy loves you, too. I need to talk to the doctor to make a plan. I will be out in a minute, Juanito. Promise." She wiped her eyes and hugged him tight.

This case demonstrates the importance of routine inquiry about safety and domestic violence in a pediatric setting. Had this doctor failed to ask about safety, one wonders if he would have learned this powerful and important information about his patient's history. Because the mother trusted her pediatrician, she could tell him about her experiences, and the doctor could connect the dots and voice his concern about the long-term impact of this traumatic violence on her son. The pediatrician's role was to make certain that this boy's history of trauma was recognized and that he received adequate support. As is evident in this case, pediatric health settings play a crucial role in identifying and supporting families affected by domestic violence.

In 1998, the American Academy of Pediatrics recognized the significance of domestic violence by publishing a position statement entitled *The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women* (American Academy of Pediatrics, 1998). The first

sentence of that statement was, "The abuse of women is a pediatric issue." One of the Academy's recommendations was that "pediatricians should attempt to recognize evidence of family or intimate partner violence in the office setting" (see http://www.aap.org/policy/re9748.html). Although the statement made a strong case for identifying domestic violence, it stopped short of offering specific guidelines for screening and did not provide discussion about the policy and practice dilemmas that arise when pediatric providers implement screening protocols for family violence. Since then, a number of studies have focused on screening in pediatric settings. In 2001, the Family Violence Prevention Fund convened national experts to develop additional guidance for screening in pediatric and family practice settings. These recommendations were published in 2002 (Groves, Augustyn, Lee, & Sawires, 2002).

This paper will highlight the importance of the pediatric health setting in working with young children affected by domestic violence and will provide a review of research on screening in pediatric settings. It will elaborate on the practice and policy dilemmas that pediatric health providers face. A specific emphasis will be placed on mental health services as resources for pediatric providers, clarifying when to refer young children for mental health care; the characteristics of good mental health services; and the limitations of the current response. Finally, the paper will propose policy recommendations for improved practice in pediatric health and mental health settings.

Children, Domestic Violence, and Health Settings

There are over 100 studies that have explored the effects of domestic violence on children (Edleson, 1999a). Most of these studies have focused on latency age children or adolescents. These studies generally have not examined race or culture as a protective or risk factor. In addition, there is little systematic research on the effects of exposure to domestic violence on infants, toddlers, and pre-schoolers. (For a discussion on the gaps in the research, see Series Paper #6—*Young Children's Exposure to Adult Domestic Violence: Toward a Developmental Risk and Resilience Framework for Research and Intervention*, by Abigail Gewirtz and Jeffrey L. Edleson.) However, clinical findings from the Child Witness to Violence Project at Boston Medical Center, described later in this paper, suggest that young children are profoundly affected by growing up in homes where there is domestic violence (Groves, Acker, & Hennessey, 2002). As early as age two, these children may suffer from symptoms of increased arousal as evidenced by sleep problems, impulsivity, exaggerated startle responses, and hypervigilance (Scheeringa & Zeanah, 1995). Many of these children are aggressive and highly active. Children who grow up in homes where there is domestic violence are also more likely to be victimized or to experience child abuse and neglect. In 30 to 60 percent of families affected by domestic violence (depending on the study), children are directly abused (Edleson, 1999b). Young children are more likely to be abused than older children, often because they cannot get out of harm's way.

Pediatric health settings are perhaps the only institutions that see virtually all children at some point in their early years. As such, these settings provide a critical opportunity to screen families

for social and health risks. In addition, pediatricians are viewed by most parents as important and respected authority figures. Their inquiry about family violence communicates a strong message about their concern for this problem. Pediatricians can use their positive authority to educate parents about the impact of exposure to violence.

Several studies make a strong case for the importance of providing screening for domestic violence in pediatric settings, especially in low-income communities. The Adverse Childhood Experiences Study, conducted on a sample of 30,000 members of the Kaiser Health Plan in California, selected exposure to violence against a mother as one of seven risk factors to be investigated for later adult health problems (Felitti et al., 1998). In this study, 12.5% of respondents reported childhood exposure to domestic violence, and 10.8% indicated a history of child abuse. This study underscored the prevalence of exposure to domestic violence in a large non-clinical sample, and linked this exposure to adverse adult health outcomes. Another study, conducted in five major US cities, found that young children—ages five and under—were disproportionately represented in households where there was substantiated domestic violence, and that a sizable number of children were directly involved with the abuse incident by either calling for help, being identified as the cause of the dispute that led to violence, or being directly physically abused by the perpetrator (Fantuzzo, Boruch, & Beriama, 1997). A third study, sampling families who used outpatient pediatric health services in an urban hospital serving low income families, focused on prevalence of exposure to violence in children age six and under, using reports from parents (Taylor, Zuckerman, Harik, & Groves, 1994). Researchers found that 10% of the children had witnessed a knifing or shooting by the age of six, and an additional 18% had witnessed "pushing, kicking, hitting, or shoving." Parents reported that nearly half the violence their children had witnessed occurred in the home. A fourth study, conducted in an urban outpatient pediatric clinic serving low-income families, found that 40% of a sample of 160 mothers had filed a restraining order against a boyfriend or husband (Lenares et al., 1999).

Two studies have drawn from samples of patients in middle class or affluent areas and found lower rates of domestic violence disclosures. One study focused on a pediatric practice in which the majority of mothers had private insurance and found that 17% of mothers reported domestic abuse (Parkinson, Adams, & Emerling, 2001). Another study, involving multiple sites, implemented a standardized set of screening questions for four practice groups. It found a range of rates of reported current abuse: 6% in a practice with Medicaid or uninsured patients; no disclosures in a more affluent private practice (Siegel et al., 2001).

Together, these studies lead to several conclusions: first, that domestic violence is present in many families; second, that domestic violence is more likely in communities that are characterized by impoverishment and high crime; and third, that young children are disproportionately represented in families where there is domestic violence. These conclusions point to a compelling opportunity within pediatric practice to identify and assist young children who may be living with domestic violence.

Domestic violence is one among many threats to child health and development, particularly in contexts marked by poverty and economic inequity. Poverty, at the start of the 21st century, remains the single most powerful predictor of child health outcomes (Wise & Fox, in press). Poverty may act as an independent force in the generation of poor health outcomes or combine with other large-scale social forces like social marginalization (unjust exclusion from essential resources on the basis, for example, of racial, ethnic, linguistic, or gender identity) to achieve its health-harming consequences (Evans, Whitehead, Diderichsen, Bhuiya, & Wirth, 2001).

Poverty represents more than inevitable misfortune randomly distributed among a luckless few. Its effects on health, now well-documented, are cumulative, pervasive, and persistent at points all along the life course. Poverty places children in an awful position called "double jeopardy"—they suffer both elevated risk that health problems will occur and greater likelihood of harm once these problems do occur (Parker, Greer, & Zuckerman, 1988).

Insurance status in the U.S. is a critical predictor of whether health care happens at all (Newacheck, Hughes, & Cisternas, 1995), and almost 11 million U.S. children are uninsured (Children's Defense Fund, 2001). Poor children are less likely to be insured than non-poor children. In addition, racial/ethnic inequities in insurance coverage are stark: one of six Black children and one of four Latino children is uninsured, compared with one of eleven White children. For these reasons, poor and minority children are also less likely to have a medical home—a regular source of primary medical care (Cornelius, 1993). These social facts have profound impact on pediatric health and care among the poor. Discontinuities in care entailed by the absence of a medical home also exacerbate poor kids' double jeopardy (Halfon & Newacheck, 1993) and lower the quality of care they receive. Moreover, poor families may not be able to afford co-payments for medications, medical equipment, or doctor's office visits. Poor children have less preventive care, anticipatory guidance, safety information, and phone consultation. Unfortunately, those at greatest risk for poor health outcomes also have the least access to high quality health care (Wise and Fox, in press).

In sum, inadequate material and social resources, diminished access to care, and disruptions in continuity of care heighten poor children's risks for harm from domestic violence. Existing vulnerabilities thus cluster to enhance the threats posed by domestic violence.

Practice in Pediatric Settings

Currently, there are no guidelines that have been endorsed by the major professional medical associations for screening for domestic violence in a pediatric health setting. In practice there are a number of protocols for screening, although their use is erratic. In some settings, questions about safety and domestic violence may be asked on written forms. In others, providers use computer-based prompts to question patients. In still others, the provider screens patients with a short series of questions about safety and exposure to community and domestic violence. Finally, some practices fail to screen for domestic violence.

Both research and direct information from providers reveal obstacles to implementing a screening protocol for domestic violence (Sugg & Inui, 1992; Groves & Augustyn, 2001). Some of these barriers are common to all medical practice; others represent dilemmas that are unique to pediatric settings.

The first and most frequently mentioned barrier is that of time. There are demands on providers to see large numbers of patients, and at the same time there are increased expectations about what is to be covered in anticipatory guidance. The challenges of high volume, high acuity, and inadequate time may be especially difficult in primary care clinic settings committed to serving low income populations, particularly among Medicaid enrollees under capitated managed care arrangements (Szilagyi, 1998). Providers are always pressed for time and may avoid topics that lead to lengthy discussion or extensive demands for follow-up.

A second barrier is inadequate training. In a study of general violence prevention counseling, researchers found that 76% of pediatric residents and 83% of practitioners rated their training as inadequate in this area. In this same group, it was reported that 68% of residents and 73% of practitioners never or rarely screen for domestic violence (Borowsky & Ireland, 1999). In addition to being poorly trained, providers may lack knowledge about resources and local specialists in the area of domestic violence. They may be unaware of the local services for families affected by domestic violence, and they may not know how to find appropriate mental health resources for the child.

A third barrier is the provider's sense of powerlessness. Domestic violence is not a simple problem, nor do many patients want to talk about it. It is well known that women stay in relationships that are dangerous for them and their children because of economic constraints, lack of housing, or emotional reasons. Physicians are unlikely to be able to address any of these issues easily. For professionals whose success depends on efficiently diagnosing and effectively treating problems, domestic violence may represent a failure or a frustration that leaves the provider feeling helpless.

A fourth barrier is the concern that patients and their families will be offended if asked about domestic violence. Providers worry that patients will feel singled out by this line of questioning and resent it. However, a study done in 1999 showed that many women appreciated the questioning and revealed domestic violence when screened in the pediatric office setting (Siegel, Hill, & Henderson, 1999). Of the 154 women screened in this study, 31% disclosed domestic violence at some time in their lives, and 17% reported violence within the past two years.

A fifth barrier is that of language and cultural sensitivity. Providers may not speak the language of the patient; institutions may not provide adequate interpreter services. In addition, providers may lack sensitivity or knowledge about what it means within a particular culture to inquire about family issues or personal relationships. Thus, screening is less effective, and patient responses may be misunderstood.

Recommendations for Identifying and Assisting, in Pediatric Settings, Families Affected by Domestic Violence

All women in pediatric settings should be screened for domestic violence. There is considerable evidence to show that universal and regular screening of adult women by skilled health care providers, when conducted face-to-face in adult health settings, increases the identification of victims (McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991; Koziol-McLain, Coates, & Lowenstein, 2001). There is reason to believe that universal screening in pediatric settings would provide similar opportunities for identification and intervention within families. When child witnesses of domestic violence and adult victims are identified early, providers are able to intervene to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions may lead to reduced morbidity and mortality (Saltzman, Salmi, Branche, & Bolen, 1997).

Screening provides women a valuable opportunity to tell their providers about their experiences with abuse. Battered women report that one of the most important parts of their interactions with their physicians was being listened to about the abuse (Hamberger, Ambuel, Marbella, & Donze, 1998). The pediatric or family practice provider's direct discussion about safety at home tells the patient that this is an important topic and one that belongs in the realm of pediatric and family practice care.

The question about screening men in pediatric settings for domestic violence (either as perpetrator or victim) is largely unexplored in the literature. In its deliberations about screening guidelines for pediatric and family health settings, the advisory committee to the Family Violence Prevention Fund's publication on this topic debated including men in its guidelines, but ultimately decided against it, citing several reasons for their decision (Groves, Augustyn, et al., 2002). First, the majority of child visits are conducted with women as the parent who accompanies the child. The majority of victims of domestic violence are women. Second, it is unlikely that perpetrators of partner violence would acknowledge their behavior in such a setting. Third, there was a concern by some that asking a perpetrator questions about domestic violence may have negative consequences for the victim and children.

However, we believe that every parent should be asked about safety in the home and community, and about their children's exposure to violence. We therefore recommend screening men who accompany their children to pediatric visits about safety in the home and community, and about their children's exposure to violence in the home or community. If a man discloses that he is abusive toward his partner, the provider should refer the man to a batterer intervention program, offer educational information, and arrange for follow-up visits.

Screening Questions

Screening for domestic violence should be conducted as part of routine pediatric health screening and within the context of questions about child safety and well-being that are a part

of anticipatory guidance provided by pediatric providers. For example, providers typically ask about car seat or seat belt use, or home safety. Embedding questions about personal safety in this context gives the message that concern about domestic violence is a logical and important topic to include, and that the provider has resources to suggest, if necessary. Screening may be done by a physician, nurse practitioner, or nurse assistant, depending on the specifics of that particular health practice. The guidelines from the Family Violence Prevention Fund recommend screening at all newborn baby visits, several times throughout the first year, and once a year afterward. Women should not be screened if their partners are in the room. Providers may ask 2-3 questions, beginning with a general statement, such as the following:

> *"I have begun to ask all of the women/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?"*

Introductory statements such as this one reassure parents that these questions are a routine and standard part of health care interventions. Providers may prefer to begin with indirect questions and then focus on direct questions.

Indirect questions may include the following:

- *"Do you feel safe in your home and community?"*
- *"How do you resolve conflict with your partner/husband/boyfriend or other adults in your home?"*

Direct questions would include the following:

- *"Have you ever been hurt or threatened by your partner/husband/boyfriend?"*
- *"Do you ever feel afraid of (controlled or isolated by) your partner/husband/boyfriend?"*
- *"Has your child witnessed a violent or frightening event in your neighborhood or home?"*

When a health provider asks about domestic violence in families with young children, it is generally preferable to ask the parent directly, rather than ask the child about his/her exposure to violence. Young children (usually those under the age of four) may lack the cognitive maturity to understand the substance of the questions. Therefore, they may answer the question incorrectly or unreliably. If children are living with domestic violence, they may be confused or afraid to disclose this information for fear of reprisal or out of loyalty to their parents. Direct inquiry of a young child may present an uncomfortable dilemma for the child: either tell a lie, or disclose the truth and be punished or suffer guilt at having disclosed a family secret. The provider has thus created more problems than he/she may solve by such questioning.

This is not the case for older children, who have greater psychological independence from their parents, and increased cognitive capacity to understand the question and respond accurately. Pediatric providers generally begin to ask older children directly about peer relationships, sexual activity, drug and alcohol use, and school safety in pre-teen pediatric visits. Questions about witnessing violent events in the home or community would be appropriate as well.

Asking Sensitive Questions with Children in the Examining Room

In most pediatric visits, the parent and child are together throughout the visit. Providers differ in their practice of addressing sensitive questions to the mother when the child is present (Zink, 2000). If the child is under the age of three, providers generally agree that asking these questions in the child's presence is acceptable. However, some providers are concerned about these queries when older children are in the room. They assert that the child's presence will be a barrier to parental disclosure. Some say that it would be upsetting for children to hear such conversation. Other providers believe that the screening questions about domestic violence should be asked regardless of the age of the child. They assert that children generally are aware of the domestic violence and that mothers will indicate if they are uncomfortable with the subject, thus giving the provider the opportunity to schedule a more private conversation with the parent. In their view, the discomfort of asking these questions in front of a child is out-weighed by the importance of communicating the practitioner's concern for the family's safety and well-being.

Recent guidelines suggest that screening should occur with the child in the room, regardless of his/her age (Groves, Augustyn, et al., 2002). If the parent is uncomfortable with the subject, or if the parent begins to describe situations that are obviously upsetting for the child, the provider can offer other options for talking more privately. In some cultures, it is particularly inappropriate to bring up family issues for discussion in front of children. For example, in many Asian cultures this inquiry may make parents quite uncomfortable, because family problems are not talked about with outsiders or in front of children. In some practices, the child can stay in a waiting area or under the supervision of another staff member. In other practices, this is impossible, and a follow-up telephone call or separate visit may be necessary.

If the parent and provider do not speak the same language, an interpreter should be used. Under no circumstances should a child be asked to translate these questions or facilitate this discussion.

Responding to Disclosures of Domestic Violence: The Pediatric Provider's Role

If the woman discloses that she has been a victim of abuse, the pediatrician's first duty is to assess the safety of the mother and her children. The provider should articulate concern about the woman's safety and ask questions to ascertain the current danger to the woman and child (see Appendix A). If the provider hears information that raises questions about safety, he should give the woman feedback such as the following:

> *"When I hear that your husband has made threats toward you, it makes me think that you and your children are in danger. What can we do to make this situation less dangerous for you? What do you need right now?"*

The provider should offer information about resources and options for help. These resources should be culturally and linguistically appropriate, and may include community resources as well as a local battered women's advocates' support group or shelter. In some settings there are social workers, domestic violence resource advocates, or child development specialists on staff who

could provide information, advocacy, and support to the parent. (See information below about model domestic violence programs in pediatric settings.) The provider should also offer to help the woman make a plan for safety and should schedule a follow-up appointment within a short period of time. If the mother does not wish to seek services, it is important that the provider recognize her right to make her own decisions about what is best for her and her children, and provide follow-up by scheduling a prompt return visit. The pediatrician should also assess the child's emotional adjustment (see box on Symptoms/Signs of Distress in Young Children, below) and safety.

The following might be the pediatric response to the visit by Juanito and his mother:

> As the pediatrician is making notes in Juanito's chart, the mother says, *"Doctor, I saw you writing when we were talking. Does that mean you're going to report me to DSS? I know I sure don't need them in my life."*
>
> *"Oh, I'm glad you asked! I'm writing these notes so I don't forget the most important things we talk about and so that if there's a time I'm not here when you come in, the doctor caring for you will know what happened without your having to go through the whole story. I am not thinking about making a report because Juanito is safe, and you are taking good care of him. Is that okay?"*
>
> *"Yes, it is, and thank you. Now I understand. But my main concern, Doc, is that I heard Juanito's father just got out of jail. I got called to the phone at work twice last week. But the person on the line was just breathing. He wouldn't say nothing. He just kept holding on, not saying a word. I thought it was him. And I started buggin' out, so I just hung up. You know, I got scared. Real scared. I almost fell apart right there. We were starting to do okay, me and my boys, and I just want to keep us safe. But we ain't got no phone. I think I need to find a lawyer. And I need to let my family know I'm okay, and to remind them that they shouldn't tell Juanito's father anything about where we live now. But I don't want people at work all up in my business. So could I use the phone here at the clinic?"*
>
> *"Of course. That's a good idea. There's a lot we can do. We have a social worker who could help get that restraining order back in place. And maybe you should let Juanito's school know to be on the watch and not to give out your contact information. We'll put a special label on the medical record here so that it's not released to Juanito's father. Maybe there's even a way to get emergency phone services in place at your apartment."*
>
> *"And what about Juanito's medicine?"*
>
> *"Well, that may take some figuring out. We could talk to his teacher, and have a psychiatrist re-evaluate Juanito and see about the choice and dosing of his medicine. I wonder if we could also get a counselor for him at school. We can coordinate these things from here at the clinic."*
>
> *"When do we come back?"*

"You can come back anytime you think you need to. But, at the very least, I think we should plan to see Juanito here on a regular basis to follow things closely. Sorting out his troubles is complicated, but I'm confident we can do it if we work together. Let's make an appointment in a week just to check in about where things stand then."

"Thanks for your time, Doc."

"No, thank you. Helping you keep yourself safe is time well spent."

"Gracias, Doctor."

"De nada."

Role of Child Protection Services

If the parent discloses domestic violence, providers must inquire about risk or injury to the child. The provider may be required to make a report to child protective services (CPS) about the child's exposure to domestic violence. Each state has its own definition of child abuse and neglect, and there are widely divergent laws, policies, and guidelines that address the question of whether a child's exposure to domestic violence (without direct injury) is a form of child neglect. In some states, there are laws for mandated reporters requiring them to notify child protection services whenever a child is in the home and has been exposed to a parent's violence, whether or not the child has been directly abused. In most states, a child's exposure to domestic violence does not require a mandatory child protection report. There is wider discretion left to the provider to assess whether a child has been directly involved and what other factors may exist to put the child at serious risk. In these states, before deciding whether to notify CPS, a provider would take into account the existence of direct injury to a child, the potential danger of the situation, and the capacity of the mother and father to keep their children safe. Because the state's guidelines may be vague, providers may be unsure about what to do; they may avoid asking the questions, or they may make reports in situations that are unwarranted, thus unnecessarily subjecting the non-abusing parent and child to state intervention. In fact, battered women's advocacy groups in New York City have legally challenged the Children's Protective Services agency in that city over indiscriminate removal of children of battered women (Sengupta, 2000).

Pediatric providers must know their state's child abuse reporting laws, including specific policies on defining child exposure to domestic violence as child maltreatment. In a state that requires mandated reporting in all cases of domestic violence, the provider should inform the non-offending parent of the obligation to file a report to CPS, assess the safety needs of the adult victim, and inform CPS about the specifics of the perpetrator, his anticipated response, and the potential for serious harm. In states where exposure to domestic violence does not automatically require a mandatory child protection report, it is preferable to make the decision—about filing a report—based on the specifics of the case and the provider's clinical judgment about whether or not the child is at risk for injury or abuse, and how imminent this risk may be. If the situation is not currently dangerous, the provider can refer the victim to voluntary services: community-based

services, battered women's services, counseling (preferably with a provider who has worked with victims of domestic violence), or child-focused services. Reporting decisions are often difficult for the provider and may require consultation with colleagues or mental health clinicians who are knowledgeable about domestic violence.

If a report is filed, the provider should discuss this action with the parent to obtain information about the anticipated response of the perpetrator, the safety of the victim and children, and how and where to safely interview the parent. In some instances, the victim may prefer to be interviewed outside the home. The health provider should ensure that the protective services worker is aware of the potential safety issues and the victim's preferences for how the investigation might best proceed.

Documentation

Practice guidelines and recommendations about documenting the existence of domestic violence in the child's chart are contradictory and inconsistent. One recommendation is for the provider to document in the child's chart that a screening for domestic violence was conducted (King & Strauss, 2000). This type of routine documentation is recommended for tracking and quality assurance purposes. If possible, the documentation (if positive for abuse) should be placed in the woman's health chart or in social work notes where there is more protection of confidentiality. Some practices use non-specific terms or a code word to indicate the presence of domestic violence in a child's chart: for example, "family problems," "difficult home situation." Other practices maintain a section of the child's chart that is confidential and is not released when there is a request for medical records. A brief notation of domestic violence in this section is appropriate.

The dilemmas about documentation raise the basic question about who the patient is. In pediatric settings, the patient is the child. A parent can read anything written in the child's chart. If the batterer is the biological or custodial parent, he may have access to the chart. Therefore, putting information about domestic violence disclosures in the child's chart may be endangering or inadvisable. On the other hand, the information is important because other providers working with the family should know about this risk factor.

Model Domestic Violence Programs in Pediatric Settings

The AWAKE (Advocacy for Women and Kids in Emergencies) Program at Children's Hospital, Boston

AWAKE is an innovative program that provides advocacy to battered women in conjunction with pediatric services for children. In the mid-1980's, staff at Children's Hospital realized that interventions which focused exclusively on abused or neglected children missed the larger context of violence within the home. Knowing that they could better protect children by helping their mothers, staff designed a hospital-based outreach and intervention model to assist battered women. Services include individual counseling, risk assessment and safety planning, assistance

in securing emergency shelter and legal representation, and a walk-in support group. AWAKE works regularly with health care professionals and social workers in the hospital and in its affiliated neighborhood health centers, both on individual cases and on training and policy development.

The Community Advocacy Program (CAP)/ Center for Community Health Education, Research, and Services

The CAP program, a collaboration of six community health centers located in Boston, expands health and social services for domestic violence victims. A family advocate at each health center provides adult victims with case management services, support groups, and referrals for services. The advocate is generally from the community, reflecting the culture and language of the population that uses the health center. The family advocate works closely with adult and pediatric health providers to ensure that screening occurs and to provide on-site direct counseling services, linkage with legal or housing assistance, and victim compensation services. This program is based on the premise that community-based health services for women and their children are the ideal setting for identification of families experiencing domestic violence and for long-term intervention. This model of locating an advocate directly within a community health practice is praised by health providers; it increases their comfort with screening for domestic violence because they have immediate access to resources such as advocates who offer help to families.

Healthy Steps for Young Children

Healthy Steps is a national pediatric initiative which seeks to transform primary care for young children by infusing child development information and family support into pediatric well child visits. The approach involves the addition of a new member to the healthcare team—a Healthy Steps Specialist who brings training in child development and mental health to enhance information and services to families. Healthy Steps Specialists work alongside the primary care clinician to enhance well child care by providing information on behavioral and developmental issues for the baby and by addressing those adult risk factors which impact child behavior and development, such as parental depression and domestic violence. Healthy Steps practices ask families about their relationships and provide referral services for those who report concerns about their safety and the safety of their children. Healthy Steps Specialists provide home visits, conduct developmental "check-ups" for the child and the family, facilitate appropriate referrals, and staff a child development telephone information line. Healthy Steps is unique among early childhood interventions in that it is based in a healthcare setting, offers a "universal" approach to addressing the needs of all families, and introduces a new professional into the health care system. More information can be obtained at their website: http://www.healthysteps.org

Responding to Child Witnesses to Domestic Violence

The six-year-old boy, Juanito, mentioned in the earlier case study, provides a dramatic example of how children may be psychologically affected by domestic violence and its aftermath of homelessness, frequent moves, and poverty. This case also raises the importance of early

identification and intervention; if Juanito's needs had been recognized at age two and he had received appropriate intervention—including counseling, parent guidance, and high-quality day care—he might have avoided some of the risks he now carries.

If a pediatric provider determines that a child has witnessed domestic violence, the practitioner should assess the child's emotional status and functioning. Children react in different ways to trauma, and they have a range of strengths and vulnerabilities which affect their coping with this stress. Some children appear to be resilient; others may be deeply affected. In addition, there are responses from the caregiving environment that are more or less supportive of the child.

Symptoms/Signs of Distress in Young Children *

- Sleep difficulties, nightmares, fear of falling asleep
- Separation anxiety, persistent worries about a parent
- Vague or diffuse somatic complaints
- Increased aggressive behavior or angry feelings
- Loss of previously acquired developmental skills
- Distractibility, difficulties with concentration
- Repetitive play or talk about upsetting events

*These symptoms may be associated with many stressors in early childhood. Exposure to violence should be considered as a possible cause.

A child who has witnessed domestic violence should not automatically be referred to counseling. The pediatric provider should inquire about the child's reactions and symptoms and listen carefully to the parent's concerns. There are several options for support and assistance, depending on the resources in the community, the comfort and ability of the parent to access services, and the severity of the child's distress. Referrals should be made to services with cultural sensitivity and language appropriate to the family. There is a continuum of supports for young children's social and emotional development that effectively addresses stressors such as exposure to domestic violence. In some communities, early child care services provide mental health consultation and support to parents as part of child care. There are also parent support groups, family resource centers, or community agencies that can offer support to young children and parents. If the abuser is still in the home, it would be important to address basic safety issues before making a referral. The mother may worry that the father would not support a referral for the child.

In some instances, the level of distress of the child, or the concern of the parent, may warrant a referral to a mental health professional. In one report of symptomatology of children age six and under who had been exposed to domestic violence, the symptoms most frequently mentioned by parents were aggression, oppositional behavior, and sleep disturbances (Groves, Acker, et al., 2002). These symptoms can be intense and should be regarded as a clear indicator of distress.

Health providers might discuss such a referral with a parent in the following circumstances:

- If the parent is concerned about the child's behaviors or symptoms.
- If the child witnessed severe violence, resulting in injury or hospitalization of either the child or the parent.
- If the child's symptoms have persisted for more than three months. (See box on the Symptoms/Signs of Distress in Young Children.)
- If the violence resulted in the death of a parent.
- If the caretaker is unable to be emotionally attuned to the child's needs.

In these circumstances, and if it is safe to do so, a referral should be made for counseling. The goal of counseling is to help the child manage his/her intense emotional reactions to the trauma, to assist the parent with accessing safety and other concrete supports, and to assist the child and parent to develop strategies to reduce symptoms so that the child is better able to function at home and in childcare settings.

The health provider should be sensitive to the parent's receptiveness to such a referral. In some instances, a parent may worry about the stigma of seeking mental health services, or she may experience guilt or shame that she has not been able to protect her child from the effects of domestic violence. In many cultures, mental health intervention carries a particular stigma; it is not acceptable to talk with "outsiders" about family problems; it is not accepted that young children may suffer from trauma. The provider should acknowledge the parent's ambivalence about seeking help, and reassure her that seeking assistance is important for her child. It is also essential to be able to make referrals to mental health clinicians who understand and, if possible, offer services from multicultural and multilingual perspectives.

Referrals to Mental Health Services

It is best to refer the child to a mental health clinician who has experience working with families affected by domestic violence and who is knowledgeable about young children and trauma. However, the referring pediatrician may encounter a lack of appropriate mental health resources for children, particularly young ones. In part, this shortage reflects a denial of the reality that young children can suffer from psychological distress that is similar to that experienced by adults. There is a widespread belief that their age protects young children against trauma and that young children will "grow out of their problems." Another myth is that it is unhelpful for young children to talk about their problems, because they will probably forget them. The case of Juanito serves as grim testimony to the enduring power of trauma in a young child's life.

Unfortunately, there are relatively few mental health professionals who are experienced in working with families affected by domestic violence and trained to work with pre-school children. Graduate schools of psychology and social work generally do not offer specializations in early childhood. A well-meaning and knowledgeable therapist who does not know about the dynamics

of domestic violence can inadvertently make the situation more dangerous for the child and the non-abusing parent. (See "Recommendations for Practice in Mental Health Settings," below, for suggestions about how to strengthen mental health services for families affected by domestic violence.)

The constraints of the managed health care system offer a final obstacle to finding adequate mental health services for young children. Managed care health insurers may limit the number of sessions a family can have, and they dictate the nature of the sessions in ways that overlook the needs of young children. For example, mental health consultation to a day care center may be an essential component of intervention for a young, traumatized child, in order to help him stabilize. However, insurance will not pay for a therapist to visit the day care center.

Recommendations for Practice in Mental Health Settings

The following recommendations would improve mental health services for young children affected by domestic violence.

1. ***Train child mental health clinicians to use a model of mental health assessment and treatment that combines a thorough knowledge of early childhood development, trauma, and the effects of domestic violence on all family members.***

2. ***Implement the recommendations in the U.S. Surgeon General's report of 2001, to ensure that mental health providers acquire cultural competence and sensitivity in understanding child development, family relationships, and the meaning of seeking mental health services across cultures (U.S. Public Health Service, 2001).***

3. ***Increase the number of providers who can offer mental health services to children by training a broad range of professionals to recognize and intervene with children exposed to domestic violence, including family support workers, outreach workers, and advocates.***

4. ***Offer a range of services to children and non-abusing parents, recognizing that children are affected differently by exposure to violence. Services might include individual assessment and treatment, groups for children and for mothers, and educational material made available to the families.***

5. ***Offer referrals for batterer intervention programs for abusers; when it is appropriate and safe, involve abusing parents in parent guidance or parent education about the impact of domestic violence on children.***

6. ***Incorporate an ecological/advocacy perspective into clinical mental health treatment, working collaboratively with domestic violence advocates; community-based, culturally-specific services; the courts; and other agencies on behalf of children and families. Many low-income families experiencing domestic abuse require help with meeting their basic needs for housing, income, and food. Many abused women will find it difficult to protect their children without these basic supports.***

7. *Because of the overlap between child maltreatment and domestic violence, develop policies that are within the state's guidelines for reporting suspected abuse or neglect and that also take into consideration the special circumstances of domestic violence within families. Develop protocols for making reports that ensure the safety of family members and avoid blaming the victim for acts that were beyond her control.*

The Child Witness to Violence Project at Boston Medical Center: A Mental Health Program for Young Children Who Witness Domestic Violence

The Child Witness to Violence Project is located in the Department of Pediatrics at Boston Medical Center and provides outpatient counseling services to children age eight and under (and their families) who have witnessed significant violence. Through state and federal funding, services are offered at no cost to the families. Approximately 80% of referrals are for children who have witnessed domestic violence. Families are referred to the project from a wide range of sources: courts, domestic violence shelters, health centers, early childhood programs, and schools. Approximately 25% of referrals come from victims of domestic violence who are concerned about their children. The staff of the project are mental health clinicians with training in early childhood development, trauma, and domestic violence.

Children are usually evaluated with the non-offending parent and are seen in individual treatment. Parents are closely involved in the treatment; sometimes they are seen directly with the child, or they meet separately with the child's therapist. The general goal of intervention is to restore equilibrium for the child and family, to allow the child a safe place to talk about what has happened, to help the child gain a better perspective on the traumatic event, to help the parent better understand the child's behavior, and to equip her with strategies to help the child. The Project uses an ecological model of intervention, working actively with the child and family's network of caregivers: schools, child care centers, health providers, the courts, and child protective services.

The Child Witness to Violence Project has published a curriculum to train child mental health clinicians. The curriculum includes information about providing intervention that is sensitive to issues of race, class, and culture. In addition, staff have trained pediatric providers, court personnel, police, and child protective services staff throughout the country.

Policy Recommendations from a Pediatric Perspective

This paper has focused on the role of pediatric and mental health clinics in identifying and supporting young children and families affected by domestic violence. The following recommendations would strengthen the capacity of these systems to respond more effectively to families:

1. *The American Academy of Pediatrics and other professional medical associations should support and promote guidelines for universal screening for domestic violence in pediatric*

settings. Endorsements from professional associations are essential in setting policy and practice guidelines in health settings.

2. *Graduate programs for mental health clinicians should offer courses on working with adults and children affected by domestic violence. This training should include information about the developmental impact of trauma on children and how to provide clinical services in a culturally sensitive manner to children and families.*

3. *Early childhood professional associations, government agencies, and medical professional associations should promote and publicize the importance of early identification and intervention with young children who witness domestic violence. This increased recognition would justify better funding for mental health services. Important work has been done in this area by the National Academy of Sciences in its book* From Neurons to Neighborhoods, *which provides a comprehensive overview of early child development and the role of genetics and environmental influences on early child development (National Research Council and Institute of Medicine, 2000). If children are identified early in life, services can be put into place that assist them before they suffer chronic or more acute emotional difficulties. Health settings are uniquely situated to provide this early identification.*

4. *Stronger and more comprehensive collaborations should be promoted between pediatric providers, legal advocates, community-based providers, culturally-specific services, and women's health professionals. Such collaborations would ensure that pediatric providers could respond more effectively to women's unattended needs by linking patients to help with housing, economic supports, restraining orders, safety planning, and legal assistance.*

5. *More funding should be allocated for mental health services for young children and families affected by domestic violence. As health care screening for domestic violence improves, we should anticipate an increase in need for services. One example in this area is the new federally-funded network of services for children who are traumatized, the National Child Traumatic Stress Network, funded by the Substance Abuse and Mental Health Services Administration, DHHS. This grant supports the development of models of treatment for a wide range of traumatized children, including young children who are affected by family violence.*

6. *Medical and other professional settings should provide better training of pediatric and mental health clinicians to screen, assess, and intervene with young children and families affected by domestic violence. Health providers need specific training about how to screen, what to look for, and how to help families access resources. Mental health professionals need training on clinical intervention in families affected by domestic violence, with an emphasis on the specific dynamics of these families and ways to shape interventions that take into account the safety risks of family members. Both health and mental health providers need training in screening and intervening in a culturally sensitive manner.*

7. ***Government and private funding agencies should place more emphasis on prevention, particularly working with young fathers. This includes the recognition that gender inequality underlies violence against women; that the stressors of poverty, unemployment, and racism are breeding grounds for violent behavior; and that a comprehensive approach to domestic violence prevention must take into account these larger issues of social inequality and poverty.***

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Appendix A

Assessment of Danger in Domestic Violence Situations

Questions to Ask

- What kinds of threats has your partner made to you? To your children?
- Has your partner threatened to kill you or your children?
- Does your partner have access to weapons?
- Have you ever needed to seek medical treatment after a fight with your partner?
- What was the most serious injury he/she caused?
- Has the abuse gotten worse in recent months/weeks?
- Does your partner try to control or monitor your daily activities?
- Does your partner have a history of mental illness?
- Does your partner drink or use drugs?
- Have you tried to leave in the past? What happened?
- How dangerous do you think the situation is right now? What are you most worried about?

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Susan Schechter, Project Director

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