The Effects of Domestic Violence on Child Witnesses

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In recent years, awareness about domestic violence has dramatically increased in the medical community and in our broader communities. Domestic violence is recognized by public health officials as a health care issue of epidemic proportions, occurring in one in four American families [1]. The family physician has a unique opportunity to help break the cycle of violence inherent in domestic violence relationships by recognizing and intervening to help victims of the violence (ie, the abused woman) and the silent witnesses (ie, the children). A large gap continues to exist between what is well recognized as a public health epidemic and how domestic violence is managed in clinical practice. For example, although domestic violence affects at least one third of the patients cared for by family physicians, it is estimated that only 10% of family physicians routinely screen for domestic violence [2,3]. In addition, only 1 in 35 cases of domestic violence is correctly identified by health care providers [4].

Domestic violence is usually defined as a pattern of intentional violent, coercive, or controlling behaviors perpetrated by someone who is currently, or was previously, in an intimate relationship with the victim [5]. In the majority of cases, the victims of domestic violence are women, and the batterers are men. In 1998, the Bureau of Justice estimated that more than half of female victims of intimate violence lived in households with children under 12 years of age. Given that such violence occurs in the home, the children in these families are involved as victims or, more often, as witnesses.

The effects on children of witnessing violence are many and depend on the child’s age and gender and on the severity and duration of the violence. Research suggests that witnessing violence in the home may be as traumatic for children as being physically abused and may have more severe long-term consequences than physical abuse [6,7]. Because of the
many variables involved, child witnesses of domestic violence may present to the family physician in many different ways, including such common presentations as a routine well child-check or a visit to discuss new enuresis in an 8-year-old boy. Therefore, the family physician must be aware of the issue and the magnitude of the problem to recognize and intervene to help keep these children safe. This article reviews the epidemiology of domestic violence in childhood and the effects of domestic violence on children witnessing abuse at home and provides strategies for intervention, including a rationale for routine screening for domestic violence as part of well-child visits and anticipatory guidance.

**EPIDEMIOLOGY**

Much of the epidemiology of domestic violence underestimates the true scope of the problem because most estimates are based on reports to police and child welfare agencies and on medical records. Many cases are not reported. It has been estimated that 2 to 4 million women each year are victims of domestic violence [5]. Children living in violent homes are at increased risk of being victims of physical violence. It is estimated that children of battered women are 6 to 15 times more likely to be abused [8,9]. Researchers have found that 50% to 70% of men who frequently abuse their wives also frequently abuse their children [4,10]. Batterers may intentionally threaten or injure children as a way of threatening and controlling the abused partner. Children are often inadvertently injured during a violent episode or while trying to protect their mother [4]. In the United States, 17% of all homicides occur within the family, with 50% of these murders taking place within the home of the victim [1]. A child is killed, injured, or a witness to the murder 25% of the time [11].

In 1996, the Department of Health and Human Services and the National Committee to Prevent Child Abuse estimated more than 3 million cases of child abuse were reported. One million children were found to be victims of substantiated cases [1]. However, child witnesses to violence in the home represent a larger and less well-recognized group than child victims of abuse. Between 3.3 and 10 million children witness domestic violence each year [1,12].

It is important to understand the violent social context in which children today are living. Children are increasingly witnesses to violence in the media and in their communities. One study estimates that between the ages of 2 and 7, a child in the United States will witness 7000 murders on television; children will be exposed to more than 100,000 acts of interpersonal violence by high school graduation [13]. A 1993 study of Washington, DC schoolchildren found that 61% to 72% of children aged 6 to 10 years had witnessed violence, whereas 19% to 32% had been victimized themselves [14]. In Los Angeles, 10% to 20% of homicides are estimated to be witnessed by children [15]. The increase in youth violence over the last decade is a growing societal and health care issue. Homicide is now the second leading cause of death for young adults aged 15 to 24 and is the
leading cause of death among African American boys [16]. However, research suggests that domestic violence is more traumatic for children than street violence. This may be due to the child’s proximity to the violence and the fact that the victim and batterer are the child’s parents, people they know intimately and depend on for love and protection [17].

THE IMPACT ON CHILDREN OF WITNESSING DOMESTIC VIOLENCE

Children who witness domestic violence are affected in many different ways. A child’s response to domestic violence depends on their age, gender, coping skills, support system, and the duration and severity of violence witnessed. The specific effects of domestic violence on children can be grouped into three particular areas: (i) The family dynamic, in which these children live and grow, is significantly altered; (ii) each developmental stage throughout childhood may be profoundly affected by domestic violence; and (iii) children of all ages witnessing domestic violence are at risk for suffering from post-traumatic stress disorder (PTSD).

Family Dynamics

Family dynamics in violent homes are abnormal. The dysfunctional foundation is often in place before a child is born. Abuse of women often begins or escalates during pregnancy: One in six pregnant women are abused [18]. Pregnant women who are abused may get little or no prenatal care and may have poor maternal nutrition, an increase in substance abuse, preterm labor or premature births, low-birth-weight babies, damage to fetal organs, miscarriage, or fetal demise [4]. One in five unintended pregnancies are associated with a history of abuse or witnessing abuse in childhood [19]. Therefore, exposure to violence in the home as a child may influence a woman’s feeling of power in sexual relationships and her ability to negotiate around contraception or safe sex.

Children living in violent homes learn that violence is an appropriate means of conflict resolution and may be an integral part of relationships. As adults, these children are more likely to be victims of abuse or to abuse their partners and children. Although domestic violence can affect any family regardless of socioeconomic level, race, age, ethnicity, or sexual orientation, the one clear risk factor for becoming a perpetrator of domestic violence is having witnessed abuse in the home as a child [4,10]. Boys are at high risk: Sons who observe abuse of their mothers by their fathers have a 10-fold increased risk of being abusive toward their future spouses [12].

The form of discipline used and learned in the home is influenced by domestic violence. Women reported using physical discipline with their children eight times more often when living in a violent relationship than when living alone or in a nonviolent relationship [20]. A survey of more
than 6000 American families suggests that women who are abused are twice as likely to physically abuse their children compared with women who were not abused [21]. Battered women often get labeled as neglectful or even abusive mothers, charged with a “failure to protect” their children from the violence of an abusive partner. Children are often removed from their care for this reason [22]. Given the nature of violent relationships, a battered woman may not have the resources to keep her children safe. Leaving an abusive relationship may create new problems for a woman and her children. Fifty percent of homeless women and children are fleeing domestic violence. Research shows that the risk of violence or even death increases when a woman tries to leave [4]. However, 40% to 70% of battered women eventually leave an abusive relationship, and many do so for the sake of the children [23,24].

Parents may deny or minimize the effect violence has on their children, believing that children do not understand or know what they witnessed at home, or even denying the child’s presence during a violent episode. However, researchers have found that children witnessing violence are at risk for the same long-term developmental, cognitive, emotional, and psychological sequelae as children who are victims of physical or sexual abuse [1,15,25]. Even if they do not directly witness the assault, children are directly exposed to the violence by hearing violent fights, their mother’s cries, and the cursing or threatening of the batterer or by seeing the aftermath of a fight in punched-out walls, broken glass, or their mother’s bruises [17,26].

Living in a violent relationship may lead parents to neglect their children for a variety of reasons. Many battered women continue to strive to be good parents in spite of their own fears, depression, anxiety, and injuries [23]. However, they may be unable to differentiate a safe from an unsafe environment. Because of the fear and immobilizing psychological effects of a violent relationship, battered mothers may be unresponsive to their children and incapable of meeting their needs. These children may have physical signs of neglect, including failure to thrive and developmental delay. They also may exhibit behavioral problems, including poor social relationships; poor school performance and attendance; and delinquent acts such as stealing, vandalism, and alcohol and drug use [27]. Children may be victimized further by being abused: 60% of children who witness domestic violence are also physically or sexually abused [10,21,28].

**Developmental Stages**

The impact of domestic violence is different for each child, and children of battered women do not exhibit any particular form of behavioral or emotional disturbance. However, certain patterns of behavior and psychological sequelae of witnessing domestic violence can be further described based on a child’s developmental stage [29].
Infancy

The crucial developmental task of infancy is to develop emotional attachment. In violent families, the basic needs for infant attachment may be significantly disturbed, and bonding may not be permitted. This may alter the ability to form future relationships and may block development of age-appropriate skills. These infants may therefore show signs of developmental delay. Normal sleeping and feeding routines may also be disrupted. A mother living in fear of her partner may be unable to meet the demands of an infant. They may be emotionally inaccessible, less supportive, or less nurturing. Infants of battered women exhibit poor health, weight problems, difficulty eating and sleeping, and excessive irritability and screaming [25,29–31].

Pre-school and Early School Age

The central developmental tasks for preschoolers are to develop connections with caregivers and to learn age-appropriate behaviors, including discipline. In cases of children living with violence, preschool-aged children exhibit high levels of distress and adjustment problems. They may show signs of terror with nightmares, yelling, and irritability. Alternatively, they may be withdrawn, subdued, or even mute. They may have vague somatic complaints and may regress to earlier stages of functioning. They may re-enact violent events through play. They live with a significant amount of fear and anxiety, feeling unsafe in their own home, yet they are too young to seek alternatives or help [29,30].

School Age

For school-aged children, the primary developmental tasks are to develop roles and cognitive development. School-aged children who witness domestic violence may have learning difficulties and significant emotional difficulties. Their behavior changes, and school performance declines. Children may have poor self-esteem and less confidence in themselves and their future. Violent fights between parents often arise from arguments about child-rearing, and this may cause children to blame themselves for the violence. They may also feel guilty that perhaps they could have prevented the violence. Such self-blaming and guilt plays a significant role in children’s emotional reaction to the violence at home [29]. They may have vague somatic complaints, prompting visits to a physician. These children are caught between a desire to keep quiet to lessen shame about the violence at home and a hope that if someone finds out, they might be rescued. Because of the isolation often imposed on families living with domestic violence, these children may have few opportunities to develop friendships or extra-curricular interests [25,29,30].

Gender differences in how children respond to violence at home begin to emerge during school age. Boys tend to be more aggressive and more disruptive and tend to have severe temper tantrums. Boys may also show...
clinically significant internalizing problems, with frequent crying, withdrawal, and somatic complaints, suggesting emotional distress [29]. Girls are more withdrawn and passive and exhibit more dependent behaviors. They may have multiple somatic complaints. Studies suggest that girls have fewer adjustment problems than boys, with only subtle changes in peer relationships and school performance [32,33]. Girls are at increased risk of becoming victims of violence in dating relationships [29,30], and boys are at increased risk of becoming batterers in adulthood [10].

**Adolescence**

For adolescents, the primary developmental task is to develop autonomy. As part of accomplishing this task, teenagers develop intimate and peer relationships outside the family. In these relationships, they practice the communication patterns and sex roles they have learned. If these skills and roles have been learned in a violent home, without any positive role model for healthy adult relationships, the abusive family dynamics may be replicated. Adolescent boys may become violent in dating relationships, and adolescent girls may accept threats or violence from boyfriends [29].

Adolescents who witness violence at home express rage, shame, and betrayal. They may manifest these emotions by rebelliousness or delinquency, running away from home, sexual promiscuity, dropping out of school, or by using drugs and alcohol [30]. Adolescents exposed to violence in the home have more feelings of fear, loneliness, and isolation. They exhibit higher degrees of depression and anxiety and increased suicidality [25]. Because these children have been exposed to many years of violence, the abusive nature of relationships at home may seem commonplace or acceptable. Therefore, these children may deny the violence and work to preserve the family secret. Teenagers may also play a larger role in the abusive family dynamic. They often side with one parent, usually the more powerful abuser, depersonalizing or blaming the mother for the family problems. They may even participate in beating their mothers [25,29].

**PTSD**

Many child witnesses show signs of PTSD. PTSD was redefined in 1987 in the Diagnostic and Statistical Manual of Mental Disorders to include children [34]. Children who witness domestic violence are more likely to develop PTSD if they witness violence that is severe or chronic (ie, occurring over a longer period of time) rather than if they witness a single incident. PTSD is more likely to develop in younger children, in children in close proximity to the violence, and in children experiencing frequent violence in the home. Evidence suggests that a child’s psychological response to trauma is intensified if they know the perpetrator or victim. Children who witness violence against a parent exhibit stronger negative emotional reactions than when witnessing violence against a stranger [35,36].
Symptoms of PTSD common in children include sleep disturbances, hypervigilance, attachment disorders, decreased ability to concentrate in school, and difficulty forming close relationships. Children with PTSD may have a hopeless, fatalistic attitude about people, life, and their future, which may lead to an increase in risk-taking behaviors [37]. The symptoms children persistently display include flashbacks or the re-seeing of memories of the trauma. This often manifests in dreams and nightmares, especially younger children. Children may also exhibit repetitive play with re-enactments of the trauma, and they may have trauma-specific fears [38]. Although symptoms of PTSD may vary with age, sleep disturbances, nightmares, and increased levels of anxiety are common at all ages [39].

Long-term Effects on Children

Exposure to domestic violence at any developmental stage may cause long-term patterns of developmental or psychological problems that last into adulthood. These include antisocial, aggressive, or self-injurious behaviors; mood disorders; substance abuse; impulse control problems; and conduct disorder. Of children witnessing the abuse of their mothers by her male partner, 40% suffer anxiety, 48% suffer depression, 53% act out with parents, and 60% act out with siblings [40]. They may have somatic complaints, nightmares, behavioral problems, or impaired social skills [1]. In general, children witnessing violence at home have increased risk of poor health, low self-esteem, eating and sleeping difficulties, and poor impulse control. Because learning may be disrupted and interpersonal skills never or poorly learned, the ability to maintain relationships and jobs may be affected [25,29].

The following case, as told by a child’s mother, illustrates the concepts reviewed above regarding the profound effect witnessing domestic violence can have on children.

One morning after my husband left for work, my sons were in their room and as I cleaned the kitchen, I realized that they were role-playing one of our fights … and I wanted to die. Over the years the imitation continued. The older one wanted to beat up his dad for me and tried on a few occasions. But the younger one walked around the house calling me a fat pig. Eventually he started to hit me. That was too much. It opened my eyes. I wouldn’t tolerate this behavior from an eight-year-old, so why was I tolerating it from my husband? I realized that my kids were growing up with a totally distorted image of what a family is, what a normal mom is, what a normal dad is, what love is. They’d already learned to disrespect victims, to disrespect me. [41]

IMPLICATIONS FOR FAMILY PRACTICE

Although children living in violent homes may not be able to seek help on their own or even know how to talk about the violence they are experiencing, they will be seen by family physicians, where they should be given an opportunity to discuss the violence in their lives. Children witnessing domestic violence present to the family physician in many
different ways. Given that domestic violence occurs in one in four American families, these children will be seen frequently by family physicians. The following partial list of presentations reflect the numerous and almost daily ways in which a child witness or victim of domestic violence may present to a family practice office:

- An infant with failure to thrive or weight loss
- A young child with night terrors, stomachaches, enuresis, or headaches
- A child with a history of hitting other children in school or truancy
- An emergency room visit accompanying an injured mother or as a victim of abuse
- An adolescent engaging in dangerous behaviors or with a history of depression or suicide attempts

Any of these presentations should raise red flags and compel the family physician to investigate the presence of domestic violence. However, given the magnitude of domestic violence and the fact that only 1 in 35 cases is correctly identified by health care providers, it is not sufficient to ask about domestic violence only on a case-by-case basis. In addition to interventions that occur as direct questioning when a child presents with symptoms suggestive of exposure to violence in the home, interventions to help child witnesses of domestic violence should begin with strategies for primary prevention. This includes routine screening and violence anticipatory guidance. Studies have shown that the incorporation of a few screening questions into routine visits can detect a large number of patients with a history of family violence [42,43]. For example, in a community pediatric practice, mothers were asked three domestic violence screening questions. More than 30% of all of the mothers reported a history of having experienced violence from a partner, and 50% of these women had been abused in the preceding 24 months. The incidence of domestic violence was 60% in the mothers of children with a history of child abuse. In the 4 years preceding this study, only one case of domestic violence had been reported in this practice [44]. Accordingly, multiple specialty organizations, including the American Academy of Family Physicians, the American Medical Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists, recommend that universal screening for domestic violence be a part of routine visits and anticipatory guidance for women and children [5,45–47].

**INTERVENTIONS**

The family physician has the opportunity to reduce the isolation and stigma families living with domestic violence experience and can support their ability to end the violence by providing children and families with a safe, confidential place to discuss issues of family violence. Interventions for children living with domestic violence can be approached using the framework of routine well-child visits. With age-appropriate screening
questions, interviewing strategies, anticipatory guidance, and specific interventions as needed, the family physician can play a significant role in the prevention and management of domestic violence.

Discussing domestic violence is not an easy task. Interviewing child witnesses presents a special challenge and certain barriers to the identification of domestic violence. After a violent incident, children may be afraid, anxious, or confused. They may be blaming themselves for the violence and struggling with how to behave to prevent further violence. After living with years of violence, they may not see the abusive behavior as abnormal and may not be able to identify it as such to disclose the abuse. Children have loyalties to parents and the family, and they may find it impossible to discuss family matters with an outsider, such as a physician. They also may be fearful of what will happen if they reveal the truth about abuse at home, preferring to preserve the family in the face of fears about separation from and destruction of the family if they disclose [29]. Therefore, the establishment of trust between family physician and patient—even when the patient is a young child—is paramount to an effective intervention in cases of child witnesses of domestic violence.

Barriers to identifying domestic violence also exist for physicians. Physicians most commonly cite a lack of training, time, or knowledge about resources as reasons for not discussing or identifying domestic violence [3]. Rosenberg et al suggest the following six steps to building family violence intervention skills that can be applied to intervening to help child witnesses [48]:

1. Understand background information about the magnitude of domestic violence, the nature of violent relationships, the role physicians can play, and barriers to identification that may exist.
2. Physicians must learn definitions of family violence.
3. Routine screening for domestic violence must be implemented for all adult and well child visits.
4. Physicians must understand issues of safety, that any intervention requires keeping women and children safe as a priority.
5. Obtain information about legal options and reporting requirements, including state laws about reporting child abuse and domestic violence.
6. Know your local community resources and referral information.

Some helpful national resources include the National Coalition Against Domestic Violence at www.ncadv.org, the Family Violence Prevention Fund at www.endabuse.org and 1-800-END-ABUSE, and the National Domestic Violence Hotline at 1-800-799-SAFE.

**Age-Appropriate Interventions**

Screening for the presence of domestic violence in the homes of children as primary prevention or intervention can be accomplished with violence anticipatory guidance. Certain age-specific questions incorporated
into well-child visits can elicit a history of domestic violence and provide information to parents and children about creating a healthy nonviolent environment.

Newborn/2-Week Visit

During infancy, children need appropriate bonding and attachment to develop skills for healthy, nonviolent relationships later in life. Physicians can help parents by encouraging nurturing, caring relationships and educating and supporting parents around appropriate parenting skills. Ask parents about what kind of support they have at home with questions like “Who will help you with the baby?” Encourage parents to build a good support system, and help them identify friends, family, or other community resources who may be able to help. Acknowledge how stressful taking care of a newborn can be and encourage parents to create a little space for themselves (eg, have a family member watch the baby for 2 hours so they can rest or have some time alone) [49,50].

It is also important to identify factors that may threaten adequate bonding and attachment, such as post-partum depression and domestic violence. The newborn visit presents an ideal opportunity to screen women for domestic violence, as long as this can be done in a confidential setting. With the father or other family members out of the room, ask mothers:

- How are you and your partner getting along?
- Do you feel safe at home?
- Have you been in a relationship in which you were threatened, hit, kicked, or sexually assaulted in any way?
- Has your partner ever hurt you or any of your children? [42,50]

If you identify a family at risk, provide the mother with support. Let her know that she is not alone; that you are worried about her and want to help; and that if she is not safe, her children are not safe. The goal in any intervention is to keep the abused woman, and therefore her children, safe. Find out if she knows what her options are and try to help her with safety planning. Refer her to local domestic violence resources or law enforcement as necessary. If child abuse or neglect is suspected, report as required to local authorities. It is important to document abuse or suspected abuse of the child. However, documentation of abuse of the mother should not be placed in the child’s chart because both parents have legal access to this chart. A batterer’s discovery of disclosure of abuse in the child’s chart may put the abused mother in greater danger [51]. If the family does not seem to be at risk, advise parents that the stress and responsibility of raising a child may create more conflict in the home. Encourage parents to talk about their feelings, and support them in finding nonviolent ways to handle their stress and anger [49,50].

It is also important to screen for a child’s safety in the newborn visit, as physicians do when asking about car seats or smoke detectors. Another
important question to further assess safety and the risk for violence in the home is whether there are guns in the house. Ask parents of newborns, “Is there a gun in the home? If so, how is it stored?” Advise parents about the curiosity of children that increases the danger of having guns at home. Guns in the home also increase the lethality of violence. Encourage parents with guns to keep guns unloaded and stored in a locked place that children cannot access [50].

**Toddler/Preschool Visits**

During the toddler stages, children need to connect with caregivers and begin to learn about discipline. It has been reported that children who connect with other people are less likely to be violent [50]. In addition, children who are disciplined violently learn that violence is a normal and appropriate response. Therefore, it is important for the family physician to ask about what forms of discipline are used in the home. Advise parents to use consistent discipline with clear rules and messages. Redirecting or using time out are good examples. Other ways to support the development of close personal connections and encourage nonviolence are to advise parents to read to their children and limit television exposure [49,50].

At toddler visits, it is important to ask about parental support and conflict at home. Screening for domestic violence should also be done, as long as it can be done in a confidential way. If a child presents with symptoms suggestive of violence in the home, it is appropriate to directly question the mother, in a confidential and nonjudgmental way, about domestic violence. In domestic violence screening protocols, it is usually recommended to interview women alone [5,22,52]. This usually includes having no potentially verbal children (over age 2 to 3) present. These children could report what was discussed between their mother and the doctor to their father—the batterer—thereby increasing a woman's danger. Safety is always the key in dealing with screening and interventions in domestic violence. Asking about violence in front of a child who is witnessing violence at home and having the battered mother relay accounts in front of that child may serve to further victimize the child [51]. This makes the issue of screening for domestic violence as a part of routine well-child visits, as recommended by the American Academy of Pediatrics, somewhat challenging [46]. Many women bring their children to a physician’s office alone, with no one to help watch them outside the room if the physician wishes to speak with the mother privately. One solution is to ask the mother’s permission to ask questions about violence in front of the children: “I have a few routine questions I ask all of my families about violence in the home. May I ask these questions in front of your child?” [51]. If the answer is no, or domestic violence is suspected, offer a follow-up visit in 1 to 2 weeks, requesting that the mother bring someone who can help watch the child outside of the room. Tell the mother “There are some issues regarding the health and safety of you and your child that I would
like to discuss with you more privately.” For the family physician, it may also be possible to schedule a visit with the mother alone because she may be your patient as well.

Always assess for the possibility of child abuse when domestic violence is identified or suspected. Ask:

- Has your partner ever hurt your children?
- Are the children ever hurt during violent episodes?
- Has your partner threatened to hurt the children?
- Are you afraid that your child may be hurt? [51]

If violence is discovered, provide support and make appropriate reports and referrals.

**School-Age Visits**

School-aged children are developing communication and problem-solving skills. Physicians can help parents teach their children conflict resolution skills by encouraging them to model nonviolent behavior and anger management. Ask parents “Has your child been in any pushing/shoving fights?” Ask parents how they would advise their child to handle a potentially violent conflict, like a run-in with a bully. Ask about the safety of the school and neighborhood. Discuss the type of discipline used at home and limits on television viewing. Encourage parents to identify positive activities for their children, such as organized sports, music, or other after-school activities [49,50].

It is important to again screen for domestic violence. If domestic violence is identified, provide support and make appropriate referrals. The primary goal of any intervention is safety. Other goals of interventions for children living with domestic violence include encouraging them to talk about their feelings and experiences; this helps to decrease their sense of isolation and confusion. Acknowledge the child’s fears and worries about their family [57]. Let them know that their physician is an adult they can trust and who will try to keep them safe, and find out who else they can talk to. Ensure that the child has adequate safety skills and resources available [29]. Mental health referrals are essential in any intervention for child witnesses. Many different programs and therapeutic techniques are used to help children who witness violence. A few examples include the Child Witness to Violence Project at Boston City Hospital (www.bostonchildhealth.org or 617-414-4244), play therapy, art therapy, and storytelling [15,30,53,54].

**Adolescent Visits**

During adolescence, children are becoming more independent, assuming more adult responsibilities, and beginning to experience more intimate relationships. They are also at the greatest risk of experiencing violence, as victims or perpetrators. The family physician may be the only adult to have regular, confidential interactions with an adolescent
throughout development, providing an important opportunity for violence risk assessment, prevention, or intervention [55]. Therefore, it is essential to ask adolescents, in a confidential manner, about their experience of violence. In doing so, the physician can help model healthy, nonviolent relationships, provide strategies for conflict resolution, and encourage the teenager to talk about any violence they are witnessing or experiencing. Questions about violence can be easily incorporated into a well-child visit by using the FISTS acronym:

- **Fights:** “Everybody fights, what happens when there are fights at home? What happens at school/away from home? How many fights have you had in the last month/year? When was your last pushing/shoving fight?”
- **Injuries:** “Have you ever been injured in a fight? Have you been hit at home in the past year? Has anyone you know ever been injured or killed in a fight?”
- **Sexual violence:** “What happens when you and your boyfriend/girlfriend/partner fight? Have you ever been in a pushing or shoving fight in your dating relationship? Have you ever been forced to have sex against your will?”
- **Threats:** “Have you ever been threatened with a knife or gun?”
- **Self-defense:** “How do you avoid getting in a fight? Do you ever carry a weapon for self-defense?” [50,56]

The above questions help to begin a discussion of violence with the adolescent. If exposure to violence in the home is discovered, encourage the child to talk about their feelings and experiences and make appropriate mental health referrals. Refer the child to any local resources that may be available for child witnesses because primary prevention can help stop the intergenerational transmission of violence. In addition, as part of routine well-adolescent visits, assess for substance abuse. This is particularly important for child witnesses to domestic violence because they are at higher risk of substance abuse, often turning to drugs and alcohol as ways to self-medicate and numb their pain.

Discuss dating violence with adolescent witnesses to domestic violence because they may replicate their experience of violence in their own dating relationships. If an adolescent girl is a victim of violence in her relationship, assess the seriousness of the violence and the girl’s safety. Give her the same supportive messages you would give to an adult victim of domestic violence, and express your concern for her safety. Let her know that she is not alone, that she does not deserve to be treated this way, and that help is available to her. Provide her with information and help her with safety planning. Make referrals to local domestic violence resources or law enforcement as necessary. If an adolescent boy reveals a history of violent fights in his relationships, acknowledge the problem and your disapproval of the violent behavior. However, also try to support him, and encourage him to talk about his experiences. Refer him to available local resources for child witnesses, batterers, anger management, or mental health [50].
SUMMARY

Domestic violence is a problem of significant magnitude and complexity that often remains undetected by physicians, especially in the case of the children witnessing violence at home. Further training of family physicians and residents is required to incorporate domestic violence screening and violence anticipatory guidance into all routine well-child visits. Specific training regarding the effects of witnessing domestic violence on children and appropriate interventions should be included.

In addition to training and intervention, political advocacy is an important responsibility for family physicians working with child witnesses and victims of domestic violence. As stated in the American Academy of Family Physicians (AAFP) position paper of family violence, AAFP initiatives to decrease family violence include “participating in public policy initiatives and legislative reform to protect victims and rehabilitate batterers.” The family physician can play an important role in improving resources to help reduce all forms of family violence and protect all its victims, including the vulnerable child victims and witnesses.

For more information about the effects of domestic violence on children, some helpful web sites are the National Clearinghouse on Child Abuse and Neglect Information at www.calib.com/nccanrch/pubs/otherpubs/harmsway.cfm and the Minnesota Center Against Violence and Abuse, which features a comprehensive bibliography about children witnessing violence and examples of art by child witnesses, at www.mincava.umn.edu.

By screening for the abuse of women during routine pediatric visits, the family physician can intervene to keep women and children safe. As the American Academy of Pediatrics June 1998 policy states, “Identifying and intervening on behalf of battered women may be one of the most effective means of preventing child abuse” [46]. In addition, early intervention for children witnessing domestic violence is an essential form of primary prevention, which reduces the likelihood of violence in future generations.

References


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