Witnessing Domestic Violence: The Effect on Children

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Domestic violence is an ongoing experience of physical, psychologic, and/or sexual abuse in the home that is used to establish power and control over another person.[1] Although awareness about the rate of domestic violence in our society is increasing, the public health ramifications have only recently been recognized in the medical community. The majority of the medical literature to date has focused on the effect of domestic violence on the primary victim. What effect does witnessing domestic violence have on secondary victims, such as children who live in homes where partner abuse occurs? It is estimated that 3.2 million American children witness incidents of domestic violence annually.[2]

Witnessing domestic violence can lead children to develop an array of age-dependent negative effects. Research in this area has focused on the cognitive, behavioral, and emotional effects of domestic violence. Children who witness violence in the home and children who are abused may display many similar psychologic effects.[3,4] These children are at greater risk for internalized behaviors such as anxiety and depression, and for externalized behaviors such as fighting, bullying, lying, or cheating. They also are more disobedient at home and at school, and are more likely to have social competence problems, such as poor school performance and difficulty in relationships with others.[5-9] Child witnesses display inappropriate attitudes about violence as a means of resolving conflict and indicate a greater willingness to use violence themselves.[3,4,10]

Although there is general agreement that children from violent homes have more emotional and behavioral problems than those from nonviolent homes, the research in this area has a number of limitations. The sample sizes are generally small, usually composed of shelter participants, and the studies generally have a retrospective design. A number of variables are not well controlled, such as gender, socioeconomic status, intelligence, cultural background, and social support. Many of these children also experience abrupt school and home changes and parental separation that can have a significant effect on their development.

Another potential confounding variable is that many of these children undergo direct abuse. How can the effects of witnessing violence be distinguished from the effects of direct abuse? Research in this area has focused on the cognitive, behavioral, and emotional effects of witnessing domestic violence. More research is needed to develop appropriate screening tools and intervention strategies for children who are at risk.[7,8]

Age Span Differences

The potential negative effects vary across the age span *(Table 1)*.[3,5] In infants from homes with partner abuse, the child's needs for attachment may be disrupted. More than 50 percent of these infants cry excessively and have eating and sleeping problems. Infants are also at a significantly increased risk for physical injury.

Preschool-aged children who witness intimate violence may develop a range of problems, including psychosomatic complaints such as headaches and abdominal pain. They also can display regressive behaviors such as enuresis, thumb sucking, and sleep disturbances. During the preschool years, children turn to their parents for protection and stability, but these needs are often disrupted in families with partner abuse. Increased anxiety around strangers and behaviors such as ▸

whining, crying, and clinging may occur. Nighttime problems such as insomnia and parasomnias are more frequent in this age group. Children in this age group who have witnessed domestic violence also may show signs of terror, manifested by yelling, irritability, hiding, and stuttering.[5,8,11]

School-aged children also can develop a range of problems including psychosomatic complaints, such as headaches or abdominal pain, as well as poor school performance. They are less likely to have many friends or participate in outside activities. Witnessing partner abuse can undermine their sense of self-esteem and their confidence in the future. School-aged children also are more likely to experience guilt and shame about the abuse, and they tend to blame themselves.[4,5]

Adolescent witnesses have higher rates of interpersonal problems with other family members, especially interparental (parent-child) conflict. They are more likely to have a fatalistic view of the future resulting in an increased rate of risk taking and antisocial behavior, such as school truancy, early sexual activity, substance abuse, and delinquency.[5,10,12,13]

TABLE 1
Potential Effects in Children Who Witness Violence*

Age	*Potential effects*
Infants	Needs for attachment disrupted Poor sleeping habits Eating problems Higher risk of physical injury
Preschool children	Lack feelings of safety Separation/stranger anxiety Regressive behaviors Insomnia/parasomnias
School-aged children	Self-blame Somatic complaints Aggressive behaviors Regressive behaviors
Adolescents	School truancy Delinquency Substance abuse Early sexual activity

*—*Effects categorized according to age.*

Information adapted from references 3 and 5.

Resilience

It is important to note that many children who witness domestic violence do not have adverse cognitive, behavioral, and emotional effects. Several variables may lessen the effects of witnessing violence. These variables include female gender, intellectual ability, higher levels of socioeconomic status, and social support for the children. The studies on resilience also have been limited by small sample sizes but show promise in identifying potential protective factors that mediate the negative effects of witnessing domestic violence.[14]

Prevention and Screening

Primary care physicians can address the issue of domestic violence on multiple levels. Medical schools should educate physicians about the potential negative effects in children who witness domestic violence. Although a recent effort has been made to educate physicians about domestic violence, the focus has been on the primary victim. Medical education must broaden the view of domestic violence to include effects on silent witnesses and to encourage physicians to screen for and help prevent violence.

Physicians can begin violence prevention measures in the clinic. Because violence is, in large part, a learned behavior, physicians should assess the parents' methods of resolving conflict and their responses to anger.[15] Optimally, this discussion should begin when a couple is contemplating having a child or during prenatal examinations. Couples should be educated about the negative effects that arguments and fights have on children. They should be encouraged to be consistent with discipline and to keep children out of

TABLE 2
Steps to Discourage Domestic Violence

Counsel parents about developmentally appropriate means of disciplining their children.
Counsel parents about nonviolent ways to resolve conflict.
Educate parents about the negative consequences of arguments on children and each other.
Ask about the presence of guns or other weapons in the home.
Advise parents to limit their children's television viewing.
Screen for domestic violence.
Display resource materials in the office.

Information from references 15, 16, and 20 through 22.

their disagreements. Physicians can also discuss nonviolent forms of discipline, such as time-outs and removal of privileges.[16,17]

Parents should be educated about the negative consequences of watching violence on television and should be encouraged to limit their children's television viewing to no more than two hours per day. In addition, because the presence of guns and other weapons in the home is associated with an increased risk of homicide and suicide among family members, parents should be asked if weapons are kept in the home.[18,19] If so, parents should be advised to store guns unloaded in a locked case. Children should be told that if they see a gun they must not touch it and should leave the area immediately and tell an adult.[20-22]

Posters and information about family violence issues and resources can be displayed in waiting rooms, examination rooms, and office restrooms (*Table 2*).[15,16,20-22]

During well-child and adult health maintenance examinations, physicians should routinely screen for family violence by asking open, nonjudgmental questions. The discussion should begin with a statement regarding the importance of the topic, such as, "Because I am concerned about the health effects of domestic violence, I ask all patients about violence in the home." Specific questions that address the various forms of domestic abuse should follow (*Table 3*).[1] According to experts, screening during well-child examinations should be performed privately with the mother.[23]

If a child presents with emotional or behavioral problems, an inquiry about family violence should be made. Because such symptoms are not specific for witnessing domestic violence, the physician also should inquire about other etiologies, such as child abuse, marital discord, peer relationships, sexual vio-

TABLE 3
Questions for Screening Intimate Partner Violence

Do you ever feel afraid of your partner?
Has your partner ever threatened or abused your children?
We all have disagreements at home. What happens when you and your partner disagree?
Has your partner ever forced you to have sex when you didn't want to? Does your partner ever force you to engage in sex that makes you feel uncomfortable?
Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
Has your partner prevented you from leaving the house, seeking friends, getting a job, or continuing your education?
You mentioned that your partner uses drugs or alcohol. How does your partner act when drinking or taking drugs? Is your partner ever verbally or physically abusive?
Do you have guns or other weapons in your home? Has your partner ever threatened to use them?

Adapted with permission from Flitcraft AH, Hadley SM, Hendricks-Matthews MK, McLeer SV, Warshaw C. Diagnostic and treatment guidelines on domestic violence. Chicago, Ill.: American Medical Association, 1992.

TABLE 4
Age-Specific Screening Questions for Adolescents and Young Adults (FISTS)

Fighting	When was your last pushing-shoving fight? How many fights have you been in during the past month? The past year?
Injuries	Have you ever been injured in a fight? Do you know anyone who has been injured or killed?
Sexual violence	What happens when you and your boyfriend (or girlfriend) have an argument? Have you ever been forced to have sex against your will?
Threats	Have you ever been threatened with a knife? A gun?
Self-defense	How do you avoid getting in fights? Do you carry a weapon for self-defense?

Information from references 15 through 20.

lence, and community violence. Depression and alcohol and drug abuse also should be considered. Age-specific screening questions can be incorporated into well-child examinations and sports physicals *(Table 4)*.[1,15-20,24,25]

Identification of Domestic Violence

If domestic violence is identified, a number of actions may be taken by the primary care physician. First, the patient should be assured that confidentiality will be maintained. It is also important to express concern for the patient's safety and to acknowledge that violence is not an appropriate behavior. Physicians should avoid expressing outrage toward the perpetrator, implying that the patient is responsible for the abuse, or directing the patient to leave the relationship. In addition, medical records must be accurate and thorough because they may become an important element in any legal action.

Of note, a mother's disclosure during a well-child examination should not be recorded in the child's medical record, because the perpetrator may have access to that record. Rather, documentation should be placed in the mother's medical record. Because child abuse is often present in homes where partner abuse occurs, the risk for both types of violence should be assessed.

State laws require physicians to report a diagnosis or impression of probable child abuse or neglect to the authorities. Witnessing domestic violence is not defined as a mandatory reportable form of child abuse. Reporting requirements for domestic violence vary by state, so physicians should be aware of their own state laws. Five states have mandatory reporting (California, Kentucky, New Hampshire, New Mexico, and Rhode Island). Community and national resources for victims of domestic violence should be offered to the patient *(Table 5)*. Many shelters also provide services for children who have witnessed violence. Safety assessment and planning for patients and children are para-

TABLE 5
National Resources for the Prevention of Domestic Violence

National Domestic Violence Hotline: 800-799-SAFE (7233)
National Resource Center on Domestic Violence: 800-537-2238
Family Violence Prevention Fund: www.fvpf.org
American Medical Association: www.ama-assn.org
American Academy of Pediatrics: www.aap.org
American Academy of Family Physicians: www.familydoctor.org
Minnesota Center Against Violence and Abuse: www.mincava.umn.edu

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TABLE 6
Helping Patients Plan for Safety

Do you feel safe going home? If not, where could you go?
Are you aware of your local resources?
Can you keep money, important papers, and telephone numbers in a safe place?
Are there weapons in the home? Can they be removed or placed in a safe, locked area?
Do you have a friend or family member with whom you can stay?
Where would you go in an emergency? How would you get there?

Information from references 1 and 23.

mount *(Table 6)*.[1,23] A follow-up appointment or telephone call should be scheduled to ensure that the patient will have access to a primary care provider.[1,23-26]

Community Advocacy

Physicians can be community advocates and leaders with regard to violence prevention issues. Many communities have formed coordinated community response teams for cases of domestic violence that require physician input. Physicians may serve as consultants to schools on issues such as conflict resolution and anger management programs. Physicians also may foster links between physician societies and local community groups to develop programs for the management and prevention of domestic violence.[27]

Witnessing domestic violence can have significant short- and long-term effects on a child. Primary care physicians should be aware of the possible cognitive, behavioral, and emotional effects of witnessing domestic violence. Physicians can play a key role by developing curricula for medical schools, screening in the office, and serving as advocates for their community on this important public health topic.

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Levels of Evidence in *AFP*

American Family Physician recently has introduced guidelines for preparing evidence-based clinical review articles.[1] (also available online through *AFP*'s "Authors Guide" at www.aafp.org/afp). Select articles now contain labels identifying the strength of evidence supporting key recommendations. *AFP* has adopted the following convention for labeling the strength of evidence, using an ABC rating scale:

Level A (randomized controlled trial/meta-analysis): High-quality randomized controlled trial (RCT) that considers all important outcomes. High-quality systematic review of randomized controlled trials. High-quality meta-analysis (quantitative systematic review) using comprehensive search strategies.

Level B (other evidence): A well-designed, nonrandomized clinical trial. A systematic review of studies other than RCTs with appropriate search strategies and well-substantiated conclusions. Lower quality RCTs, clinical cohort studies, and case-control studies with nonbiased selection of study participants and consistent findings. Other evidence, such as high-quality retrospective studies, certain uncontrolled studies, or cross-sectional studies, is also included.

Level C (consensus/expert guidelines): Consensus viewpoint or expert guidelines. This category refers to official consensus statements, such as NIH Consensus Development Conference Statements or expert guidelines issued by major medical organizations, such as the NIH, CDC, American Heart Association, or American Academy of Pediatrics. They do not refer to the personal opinion of individual authors or to clinical review articles.

Each rating is applied to a single reference in the article, not to the entire body of evidence on a topic. Authors will directly cite original research studies rather than citing evidence that is presented within a clinical review article. Clinical review articles will not be assigned evidence ratings. Each label will include a letter rating (A, B, C), followed by the specific type of study for that reference. For example, a level B rating will be followed by one of these descriptors: (1) nonrandomized clinical trial; (2) systematic review of studies other than RCTs; (3) lower quality RCT; (4) clinical cohort study; (5) case control study; (6) retrospective study; (7) uncontrolled study; (8) cross-sectional study. Here are some examples that demonstrate how levels of evidence appear in text:

- To improve morbidity and mortality, most patients in congestive heart failure should be treated with an ACE inhibitor. [Evidence level A, systematic review of RCTs]
- The USPSTF recommends that clinicians routinely screen asymptomatic pregnant women 25 years and younger for chlamydial infection. [Evidence level B, nonrandomized clinical trial]
- The American Diabetes Association recommends screening for diabetes every three years in all patients at high risk of the disease, including all adults 45 years and older. [Evidence level C, consensus/expert guidelines]

Authors should consult the "Authors Guide" on the *AFP* Web site (www.aafp.org/afp) for additional information about levels of evidence, including a sample article with evidence labels.

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