

# Supporting Intimate Partner Violence Survivors and Their Children in Pediatric Healthcare Settings



Maya I. Ragavan, MD, MPH, MS<sup>a,\*</sup>, Ashlee Murray, MD, MPH<sup>b</sup>

## KEYWORDS

- Intimate partner violence • Domestic violence • Pediatric health care
- Healing-centered engagement • Victim services agencies
- Community-medical partnerships

## KEY POINTS

- Intimate partner violence (IPV) is a pervasive public health epidemic that influences child health and thriving. In this article, we discuss how pediatric health-care providers and systems can create healing-centered spaces to support IPV survivors and their children.
- We review the use of universal education and resource provision to share information about IPV during all clinical encounters as a healing-centered alternative to screening.
- We also review how to support survivors who may share experiences of IPV, focused on validation, affirmation, and connection to resources. Community-medical partnership development to collaborate with victim services agencies is discussed as are evidenced-based IPV training.

In April 2021, as coronavirus disease 2019 (COVID-19) vaccination efforts were underway, a parent and her 2 children came to a pediatric primary care clinic for worsening enuresis. Privately, the parent shared that they were experiencing compounding stressors since the pandemic began, due to her expartner and coparent. He tried to keep her children away from her, stating that her job as a nursing assistant put her at high risk of being infected with COVID-19 and intermittently shut off her cell-phone service. She was hesitant to reach out to services because she was not sure if what was happening constituted as “abuse” and did not know to whom to turn. Together, we called a local victim services agency, who provided legal services and

---

<sup>a</sup> Division of General Academic Pediatrics, University of Pittsburgh and UPMC Children’s Hospital of Pittsburgh, 3414 Fifth Avenue, Pittsburgh, PA 15213, USA; <sup>b</sup> Division of Pediatric Emergency Medicine, Children’s Hospital of Pennsylvania, 3401 Civic Center Boulevard, Philadelphia, PA 19104, USA

\* Corresponding author.

E-mail address: [ragavanm@chp.edu](mailto:ragavanm@chp.edu)

Pediatr Clin N Am 70 (2023) 1069–1086  
<https://doi.org/10.1016/j.pcl.2023.06.016>

[pediatric.theclinics.com](http://pediatric.theclinics.com)

0031-3955/23/© 2023 Elsevier Inc. All rights reserved.

supports, as well as helped her procure her own cellular phone. At a follow-up visit, she noted that her partner was now trying to use her diagnosis of depression to get custody of her children but felt well supported by the victim services agency.

Intimate partner violence (IPV) is a pervasive public health epidemic causing health impacts across the life span. The National Intimate Partner and Sexual Violence Survey found that nearly 47% of women and 44% of men have experienced sexual violence, physical violence, and/or stalking at some point in their lives.<sup>1</sup> For women, 27% first experienced IPV before the age of 18, and of those reporting IPV, 1 in 3 was injured and 1 in 8 needed medical care.<sup>1</sup> Historically, IPV research has been gender binary; important emerging work is showing that gender diverse people (sex assigned at birth does not match gender, such as transgender and gender nonbinary) are more likely to experience IPV, rooted in transphobia, genderism, and homophobia.<sup>2,3</sup> Finally, data show that 1 in 5 children are exposed to IPV, and this number increases to 1 in 4 during adolescence<sup>4</sup> with even higher prevalence for youth experiencing marginalization.<sup>5</sup> Pediatric clinicians have a responsibility and opportunity to support IPV survivors and their children using healing-centered approaches.<sup>6,7</sup>

### INTIMATE PARTNER VIOLENCE IS ROOTED IN POWER AND CONTROL

Fundamentally, IPV is rooted in power and control, where an abusive partner uses different behaviors and tactics to control, discredit, manipulate, or assert power over their partner. Power and control behaviors may occur in a variety of ways including through isolation, threats, physical or sexual violence, economic or financial coercion (eg, ruining someone's credit), spiritual abuse, immigration-related abuse, among others.<sup>8–10</sup> For example, during the COVID-19 pandemic, IPV survivors reported that partners took their stimulus checks, tried to limit their health-care access, and would turn off Wi-Fi and cellular technology thereby isolating them during shelter-in-place orders.<sup>11–13</sup> Important to pediatrics is use of children (especially child custody) to manipulate or control IPV survivors.<sup>14,15</sup> IPV can also manifest *within* pediatric health-care settings, by abusive partners controlling medical decision, manipulating appointment times, or stalking through use of patient portals.<sup>16</sup>

### STRUCTURAL OPPRESSIONS INFLUENCING INTIMATE PARTNER VIOLENCE SURVIVORS FROM MARGINALIZED COMMUNITIES

IPV affects all communities; however, survivors from marginalized communities, including those identifying as people of color (Black, Indigenous, Latine [a gender-neutral alternative to Latino/a or Hispanic], Asian, Pacific Islander, and Multiracial), sexual and gender diverse, immigrants and refugees, non-English speaking, or survivors living in poverty or with disabilities may be uniquely affected by IPV.<sup>17</sup> The lived experiences of IPV survivors from marginalized communities can be situated within intersectionality theory, which describes that social category (ie, race, immigration status, language, and socioeconomic status) intersect at the microlevel to affect individual experiences (ie, IPV, help-seeking), which reflect multiple interlocking systems of oppression and privilege at the macrolevel (ie, racism, xenophobia, ableism, and classism).<sup>17–19</sup>

Abusive partners may use structural-level oppressive policies and practices as a way to control and cutoff survivors from resources. As an example, abusive partners may threaten to reveal a survivor's immigration status or refuse to sponsor permanent residency, thereby using xenophobic policies and practices against an IPV survivor.<sup>17,20</sup> Similarly, IPV survivors identifying as gender or sexual diverse may experience violence related to intersecting transphobia, genderism, and homophobia (eg,

discrimination in health-care settings, partner threatening to “out” them),<sup>21–23</sup> which may be particularly harmful in the context of an increase in anti-lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more (LGBTQIA) + laws occurring at the state level. Past studies has also shown that Black survivors are less likely to be believed and may not feel safe engaging law enforcement.<sup>24,25</sup> Survivors living in poverty are more likely to experience economic abuse and face housing insecurity<sup>26</sup> and experience abuse again after leaving a relationship.<sup>27</sup> Fundamentally, clinicians must work to disrupt the oppressive policies and practices that affect survivors’ ability to access resources and thrive.

## INTIMATE PARTNER VIOLENCE EXPOSURE INFLUENCES CHILD HEALTH

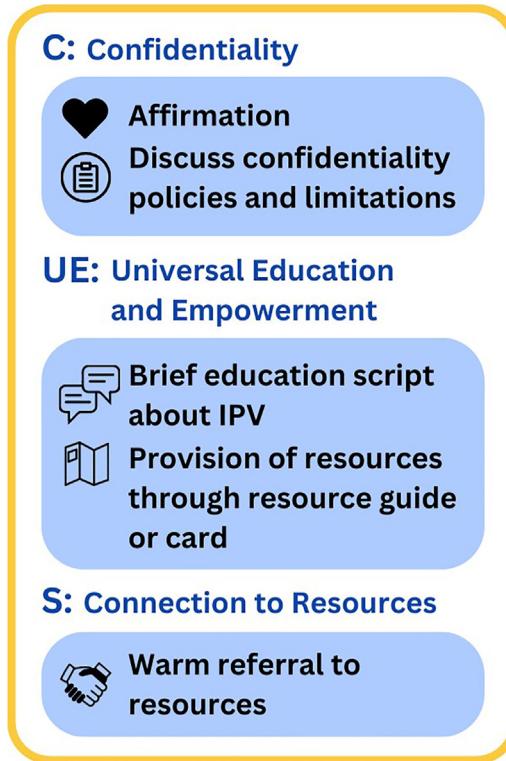
Decades of research have demonstrated that exposure to caregiver IPV influences child health, development, and thriving. Historically, articles have used a deficits-focused approach with long lists of negative child health outcomes; it is critical to shift to strengths-based approaches recognizing that IPV survivors do a remarkable job keeping their children safe and healthy. Further, children exposed to IPV are not “destined” to experience lifelong health impacts when they and their families are provided compassionate support and resources. With this framing in mind, IPV exposure has been associated with child mental health symptoms,<sup>28</sup> development delay,<sup>29</sup> chronic health concerns such as asthma,<sup>30</sup> and experiences of partner violence during adolescent relationships.<sup>5</sup> IPV is also associated with child abuse and neglect.<sup>31,32</sup> The impact of IPV on child and parent health further underscores the responsibility and opportunity for pediatric clinicians and systems in supporting IPV survivors.

## HEALING-CENTERED ENGAGEMENT: A STRENGTHS-BASED FRAMEWORK

When considering how best to support parents and caregivers experiencing IPV, we recommend the use of a healing-centered engagement framework. Healing-centered engagement is a strength-based, antiracist framework that prioritizes healing, connection to social supports, and referrals to victim services agencies.<sup>11,33–35</sup> Core to healing-centered engagement is the recognition that trauma *and* healing occur at the individual and collective levels, and that trauma and healing may occur concurrently. Healing-centered engagement is strength-based—rather than asking survivors to relive their trauma, it focuses on highlighting their strengths and understanding their priorities. This may be particularly important when considering the intersectional experiences of IPV survivors from marginalized communities, who understandably may not trust health-care systems due to historical and current day discrimination and may not feel comfortable sharing IPV experiences in health-care spaces. A healing-centered approach can be used to both universally discuss IPV and support IPV survivors who share their experiences during a clinical visit, as detailed below.

## UNIVERSAL EDUCATION AND RESOURCE PROVISION

Universal education and resource provision is an alternative to IPV screening, where *all* families are given brief education and resources around IPV rather than providing this information only to those who screen positive.<sup>11,36,37</sup> Such an approach shifts the paradigm away from disclosure-based strategies toward recognition that health-care settings must provide all families education and resources around this pervasive trauma. Providing resources to everyone also allows caregivers to share information with family and friends; even if they do not need resources, it is likely they will know someone experiencing IPV.



**Fig. 1.** CUES overview.

One universal education and resource provision framework is Confidentiality, University Education and Empowerment and Support (CUES)<sup>36,37</sup> whose steps are shown in **Fig. 1** and include discussing confidentiality, providing a brief script around IPV and resources to all families, and connecting families to more support if needed. CUES education scripts and resources can be IPV specific or part of a larger conversation about social and structural influences of health. Sample scripts are provided in an article by Ragavan and colleagues.<sup>11</sup> CUES approaches have been tested through cluster randomized clinical trials in other settings, including family planning clinics,<sup>38</sup> college health centers,<sup>39</sup> and school-based health centers.<sup>40</sup> These studies showed that the use of CUES is feasible and acceptable and increases self-efficacy to access resources, knowledge about IPV prevention, and, for adolescents, decreased violence victimization among those who reported IPV at baseline. Another similar universal education and resource provision approach is provide privacy, educate, ask, respect, and respond.<sup>41</sup> Passive materials such as handouts in bathrooms, posters on the walls, and easy access to helpline numbers can also be helpful to share information securely and privately around IPV.<sup>42</sup> Universal education and resource provision can be used in different pediatric health-care settings (eg, outpatient, inpatient, specialty, and emergency department) and during various types of health-care encounters. These approaches can also be used if the clinician has concern about IPV. Importantly, universal education and resource provision has not yet been tested in pediatric primary care clinics or with parent or caregiver IPV survivors, demonstrating an important area for future research.

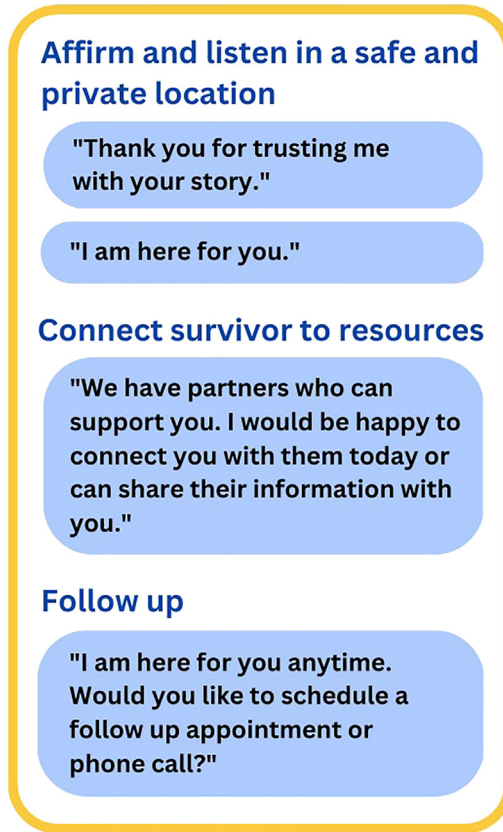
Pediatric clinicians or settings may also choose a screening approach, where all caregivers are asked about IPV at regular intervals through written or face-to-face inquiry. Limited evidence exists for how best to implement parental and caregiver IPV screening in pediatric health-care settings although the United States Preventive Services Task Force does recommend screening for reproductive age women in adult settings.<sup>43</sup> If screening is used, we recommend it is included as part of universal education and resources and several challenges must be considered, particularly in the context of pediatric health-care settings.

- IPV survivors may not feel safe disclosing, due to concern about escalating abuse, child protective services (CPS) reporting, lack of trust in the health-care systems due to structural racism and historical trauma, among others.<sup>44</sup> As an example, in a study of more than 2000 IPV survivors, 35% said they did not ask for help because they were concerned their information would be reported to authority figures.<sup>45</sup> This concern is similarly reflected in recent data on screening in primary care settings more broadly, which showed only 8.5% of patients reported IPV and 65% of IPV screens resulted in patient refusal.<sup>46</sup>
- Screening tools often focus on physical, sexual, and psychological IPV and may not be inclusive toward survivors experiencing other types of controlling and abusive behaviors.
- Screening may add data around trauma to the electronic medical record, which may be unsafe particularly if the abusive partner is a coparent or caregiver and has access to patient portals.
- Face-to-face inquiry around IPV *must occur confidentially*, without verbal children (3 years or older) or other family members present.<sup>47</sup> Screening through telemedicine is not advised because privacy cannot be guaranteed.<sup>11</sup>
- Screening without support is not sufficient; if screening is preferred, resources must be available for survivors.

## SUPPORTING INTIMATE PARTNER VIOLENCE SURVIVORS WHO DISCLOSE

In healing-centered engagement, disclosure is never the goal; however, when clinicians create healing spaces through universal education and resource provision, disclosures may happen. Disclosing IPV is a personal decision, and survivors may choose to disclose depending on their safety, supports, challenges, trust of the clinicians, and so forth. As described earlier, it is critical to remain survivor-centered; forcing a survivor to disclose may inadvertently perpetuate cycles of power and abuse.

**Fig. 2** describes steps to support a survivor after they disclose (the “S” step in CUES). After a survivor shares their experiences, the clinician should provide validation and empathy and then should listen to the survivor, collaborating with them to share what feels most comfortable.<sup>48</sup> *Important for the pediatric setting is to never discuss IPV in front of other family members, including a verbal child.*<sup>47</sup> We recommend having another team member sit with the child or scheduling a follow-up call with the survivor at a time, which is safe for them. We also recommend providing connection to victim service agencies or other individuals with expertise in IPV.<sup>49</sup> Some survivors may prefer calling the victim service agency during the clinical visit and others may prefer to take the information and call when they feel ready. Clinicians can schedule follow-up appointments if this is helpful to the survivor and begin supporting IPV survivors with safety planning in health-care settings, if it is safe and feasible. Here, we offer words of caution particularly that safety planning and IPV experiences should never be discussed in front of other family members or friends, including verbal children. We highly recommended collaborating with a victim services



**Fig. 2.** Supporting a parent or caregiver who discloses IPV.

agency to provide safety planning, as described in subsequent sections. **Table 1** includes a safety-planning template.

### ***Mandated Reporting to Child Protective Services***

An important consideration in supporting IPV survivors in pediatric settings is mandated reporting to CPS. Clinicians must know their state laws because the majority of states do not require mandated reporting for children whose parents or caregivers are experiencing IPV, although some do, and laws are not static.<sup>50</sup> Interestingly, there is little best practice consensus around this topic. In a Delphi study of pediatric IPV experts (which did not include survivors themselves), consensus was reached that reporters should not file with exposure to IPV alone but should file with co-occurring child abuse and neglect.<sup>51</sup> There are multiple concerns around CPS reporting including escalation of abuse, further trauma for the family, and CPS reporting not leading to increased support or resources. In a survey on mandated reporting (including to CPS) of more than 2000 IPV survivors, 50% said a mandated report made their situation much worse.<sup>45</sup> It is also critically important for clinicians to understand how historical and current structural racism embedded within CPS and health-care systems has led to racial disproportionality within the CPS system, with children of color (particularly Black and Indigenous children) being overrepresented.<sup>52,53</sup> Clinicians should consider a transformative justice approach;

Table 1 Resources for pediatric clinicians	
American Academy of Pediatrics Intimate Partner Violence website	<a href="https://www.aap.org/en/patient-care/intimate-partner-violence/">https://www.aap.org/en/patient-care/intimate-partner-violence/</a>
Futures Without Violence mandated reporting guidelines	<a href="https://promising.futureswithoutviolence.org/mandatory-reporting/">https://promising.futureswithoutviolence.org/mandatory-reporting/</a>
Futures Without Violence Issues Briefs	<a href="https://www.futureswithoutviolence.org/AAPIssueBriefs">https://www.futureswithoutviolence.org/AAPIssueBriefs</a>
Children's National Hospital Intimate Partner Violence training videos	<a href="https://www.aapdc.org/domestic-violence/">https://www.aapdc.org/domestic-violence/</a>
National Domestic Violence Hotline	<a href="https://www.thehotline.org/">https://www.thehotline.org/</a>
Futures Without Violence guidelines for developing community-medical partnership	<a href="https://ipvhealthpartners.org/">https://ipvhealthpartners.org/</a>
Children's Hospital of Philadelphia video training	<a href="https://injury.research.chop.edu/blog/posts/new-resource-alert-addressing-domestic-violence-healthcare-settings">https://injury.research.chop.edu/blog/posts/new-resource-alert-addressing-domestic-violence-healthcare-settings</a>
Healthy Children.org resource for parents	Stress and Violence at Home During Challenging Times— <a href="https://www.healthychildren.org/">HealthyChildren.org</a>

how can we prevent harm and violence without causing more harm and violence, and how do we hold the duality that we are mandated reporters but are reporting to (and from) systems rooted in racism, xenophobia, and other forms of oppression. Clinicians should review the work of Dorothy Roberts (and others; recent example is the book *Torn Apart*)<sup>54</sup> who share how to disrupt racial disproportionality within the CPS system and provide recommendations for grassroots, family-based, antiracist alternatives.

As we work to transform systems, we also recognize that clinicians may need to file CPS reports depending on state requirements and particularly in cases of co-occurring child abuse and neglect. In the Delphi study described above, consensus was reached around several best practices clinicians should consider when filing is indicated.<sup>51</sup>

- Survivors should be told why the report is needed.
- Survivors should be provided validation and affirmation that we are here to support them.
- Survivors be given the opportunity to file the report on their own (when possible, to allow them to control the situation).
- Clinicians should connect IPV survivors with resources and supports to develop safety plans.

*Considered together, these recommendations underscore the importance of prioritizing supporting over simply reporting.* Futures Without Violence has guidelines for pediatric clinicians about how best to support families in the context of mandated reporting (see [Table 1](#)).

### ***Documentation of Intimate Partner Violence in the Electronic Medical Record***

Documentation of parental or caregiver IPV in pediatric settings is unique because clinicians are documenting caregivers' experiences in the child's medical chart. Clinicians must be aware of potential implications of documentation, particularly in the context of the 21st Century Cures Act where patients have access to their and their

children's medical records.<sup>55,56</sup> Documentation should be brief, objective, and whenever possible use coded languages (eg, family described stress).<sup>57</sup> Clinicians should not share documentation with information around IPV; in fact, IPV is one of the reasons where it is allowable to not share a note. It is our practice to document IPV in a separate, unshared note rather than not sharing the full note. We also recommend carefully reviewing the full electronic medical record to ensure information around IPV is not inadvertently listed elsewhere (eg, problem list, social determinants of health screening, address, safe phone number, and so forth). Clinicians should always ask survivors how and where it is safe to document because they are the experts in their own safety and should be able to control how this information is documented in their child's medical chart.

## COLLABORATION WITH VICTIM SERVICES AGENCIES

### *Victim Services Agencies*

Victim services agencies support IPV survivors and are critical partners in the pediatric medical home and health-care infrastructure. Victim services agencies started as grassroots networks in the 1970s; now there are more than 1800 agencies serving 77,000 survivors daily.<sup>58,59</sup> Services exist at the national, state, and local levels. The national domestic violence hotline (<https://www.thehotline.org/>) has a 24/7 phone, text, and chat feature where survivors can connect with IPV advocates. Coalitions exist at the state level to provide coordination and collaboration among victim services providers. At the local level, most counties have at least one victim services agency, which offer a wide range of services as shown in **Fig. 3** (clinicians should check with their local agencies as services differ). Victim services agencies are staffed by IPV advocates, who are trained professionals specializing in confidential, healing-centered care and support survivors in various ways. As an example, they will often accompany survivors and their families to court hearings and medical visits. Pediatric clinicians should also be aware of culturally affirming agencies, defined as organizations centering the cultural experiences of their clients, which serve as important supports for IPV survivors with one or more marginalized identity.

### *Community-Medical Partnerships*

Community-medical partnerships are bidirectional, reciprocal collaborations between victim services agencies and health-care settings and are integral to addressing IPV in health-care spaces. Community-medical partnerships facilitate survivor-centered care and response, warm handoffs to trusted partners, streamlined resource provision, and established procedures for care coordination across systems. Principles underlying the development of community-medical partnerships are synergistic with community-based participatory research approaches and include creating relationships rooted in transparency and trust, addressing individual and structural power



**Fig. 3.** Potential services available at victim services agencies.



inequities, promoting shared ownership and dissemination, and supporting mutual accountability and reciprocity.<sup>17</sup>

Guidelines for developing community-medical partnerships are described below. Please note that this is an iterative rather than linear process.

1. *Connect with a local IPV agency.* We recommend taking time to explore the agency's website, learning about the agency's history, services they provide, and upcoming events. After learning more, connect directly with the agency to meet and develop a blueprint for partnership development. Many agencies have a community outreach director or medical advocate that can assist with making these connections. Hosting bidirectional trainings with the IPV agency can facilitate partnership formation.
2. *Create an IPV workgroup.* Key to building community-medical partnerships is establishing an IPV work group. When developing this group, it is important to consider size, leadership, and membership, aligned with partnership principles. The optimal size for working groups can be tailored for the practice size; we recommend 4 to 15 with at least one champion who can support the group's growth. Team members should be multidisciplinary and include nurses, physicians, social workers, administrative personnel, and IPV advocates. Inclusion of IPV survivors is also critical but it is important to ensure that IPV survivors' voices are amplified and not silenced in the space by applying a power and privilege analysis to the group. We suggest that the group either be majority IPV survivors or have time set aside where IPV survivors can meet together with a skilled facilitator in their own space. When including IPV advocates and survivors, it is critical to compensate them for their time, expertise, and trauma as a baseline measure of reciprocity. This group will lead practice and policy decisions related to forming and sustaining the community-medical partnerships.
3. *Develop strategies to connect families to victim services agencies using survivor-centered approaches.* The IPV workgroup should develop processes for how to connect families to services, considering that survivors may wish to connect to resources in different ways. Some survivors may prefer calling an agency themselves; others may prefer calling the agency with the clinician in the room or having an advocate speak with them in real time. Warm referral systems—processes that directly connect the survivor to a point person at the victim services agency—should be developed. Warm handoffs build a relationship between the IPV survivor and advocate, which help with trust building, confidentiality, and safety.
4. *Consider creating a memorandum of understanding (MOU).* As this relationship is strengthened over time, explore models of partnership and consider creating an MOU to define the partnership. Futures Without Violence provides an exemplar MOU template (see [Table 1](#)), which can be revised to meet the partnership's specific needs.
5. *Consider colocated services.* As the community-medical partnership expands and grows, you may consider having colocated services, where IPV advocates work directly in clinical spaces. Examples of community-medical partnerships include the following:
  - Boston Children's Hospital offers on-call social workers through the AWAKE (Advocacy for Women and Kids Emergencies) program that provides free and confidential services for patients, their caregivers, and employees.<sup>60</sup>
  - Children's Mercy in Kansas City uses a multilevel approach to support IPV survivors that includes a hospital-based IPV advocacy program, a universal education/screening intervention, and staff education.<sup>61</sup>

- Children's Hospital of Philadelphia (CHOP) offers a multicomponent, collaborative program called STOP IPV with a local victim services agency. Full-time IPV specialists work on-site to offer direct services and provide trainings and system level support.<sup>62</sup>

## TRAINING PEDIATRIC HEALTH-CARE PROVIDERS

Futures Without Violence, in collaboration with the American Academy of Pediatrics and UPMC Children's Hospital of Pittsburgh, published a recent brief prioritizing the need for clinician training to best support IPV survivors during and after the COVID-19 pandemic (see [Table 1](#)). Specifically, they recommend using a team-based approach that provides ongoing training to all clinicians, learners, and staff. In the subsequent sections, we review best practice recommendations for IPV training and strategies to incorporate IPV training into clinical practice.

### *Importance of Centering the Survivor's Voice*

---

Core to this work is including IPV survivors because far too often "expert-developed" training does not include the voices of those with lived experience. Nicolaidis and colleagues demonstrated the impact of the *Voices of Survivors* documentary, along with a complementary workshop, which improved clinicians' knowledge, attitudes, empathy, and behaviors around IPV.<sup>63</sup> More recently, CHOP in collaboration with Temple University and Lutheran Settlement House, created a 4-part video series during which 3 IPV survivors detail their stories with IPV disclosure and provide advice to health-care providers (see [Table 1](#)). When centering survivor voices, it is critical to compensate them, amplify their strengths, and be inclusive to survivors with one or more marginalized identities.

### *Best Practices for Intimate Partner Violence Education in Clinical Settings*

---

Despite recommendations around supporting IPV survivors in pediatric settings, there are limited data around IPV training content, delivery, or outcomes specific for pediatric settings. A scoping review of 56 published IPV curricula for medical trainees found that IPV was taught in medical school and residency; however, only 5 curricula were specific to pediatrics.<sup>64</sup> One example of a pediatric-based intervention for residents included education, screening prompts on patient medical forms, and hiring an on-site IPV counselor.<sup>65</sup> After implementation, pediatric residents demonstrate improved knowledge about IPV and how to access referral resources for survivors. In general, most curricula involved formal lectures and/or standardized patients. The most robust curriculum incorporated a didactic training during ethics class in first year, a small group session during a clinical rotation, and a small group session during students' outpatient clerkship. The review highlighted several commonly discussed topics including risk factors associated with IPV, screening and identification, physical examination concerns, barriers to disclosure, and legal protection and community resources. No study addressed universal education and/or the CUES intervention. Most studies reported subjective findings associated with provider attitudes, beliefs, and knowledge; few objectively measured clinical outcomes. The authors concluded that ideal IPV curriculum would use a multifaceted approach that includes didactic lectures, standardized patient encounters, case-based approaches, and group reflection.

### *Intimate Partner Violence Educational Resources*

---

Both Futures Without Violence and the AAP have several practical tools for supporting IPV survivors in pediatric health-care settings including sample scripts, patient

**Table 2**  
**MedEdPortal intimate partner violence training curricula**

Title	Author/Date	Participants	Mode of Delivery	Type of Curriculum	Content of Curriculum
Talking to Patients About Sensitive Topics: Communication and Screening Techniques for Increasing the Reliability of Patient Self-Report	McBride, <sup>68</sup> 2012	First year medical students	Multi-modal small and large group sessions that cover 3 sensitive topics	90-min interactive didactic session followed by a 2-h clinical skills practice session using standardized patients	Addresses physician discomfort when discussing sensitive topics with patients by providing communication techniques that can decrease provider anxiety, improve reliability and accuracy of patient reports
Novice Health Care Students Learn Intimate Partner Violence Communication Skills through Standardized Patient Encounters	Jung et al., <sup>69</sup> 2015	First-year and second-year medical students	Multimodal education as part of a 4-y longitudinal IPV curriculum	Year 1: 2 standardized patients during doctoring course Year 2: didactics, visit IPV shelter	IPV communication skills, mandatory reporting requirements, how to handle disclosure, and/or when a survivor is not ready for help
Health Education for Women and Children: A Community-Engaged Mutual Learning Curriculum for Health Trainees	Ragavan et al., <sup>70</sup> 2016	IPV survivors residing at a translational housing program and health trainees	Large group workshops facilitated by health trainees (premedical students)	Ten 90-min workshops + 2 optional workshops, include didactics, group-based activities, and open discussion	Exercise, healthy cooking, parenting, managing stress, and so forth. Two optional workshops were on sexual coercion and health access

*(continued on next page)*

**Table 2**  
**(continued)**

Title	Author/Date	Participants	Mode of Delivery	Type of Curriculum	Content of Curriculum
Addressing Interpersonal Violence as a Health Policy Question Using Interprofessional Community Educators	Clithero et al., <sup>71</sup> 2016	Family medicine residents	Small and large group session led by community interprofessional educator at a local family advocacy center	2-h case review	Examines a clinical encounter with a patient experiencing IPV and homelessness and the implications of existing policy on the delivery of health-care services
Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals	Schrier et al., 2017	Medical students	Flipped classroom model. Small groups of 8 students paired with one physician and on social-behavioral science faculty member	Prereading material, 3-h clinical skills course including role-plays and open discussion. Standardized patient 1-y posteducation	IPV screening and counseling using a checklist companion for tips on how to navigate the conversation, using a motivational interviewing framework
A Novel Intimate Partner Violence Curriculum for Internal Medicine Residents: Development, Implementation, and Evaluation	Insetta et al., <sup>72</sup> 2020	First-year internal medicine residents	Small and large group sessions in classroom setting led by several interprofessional educators	Part 1 (60 min): TEDtalk or in-person discussion with social worker from IPV shelter, didactics, and case review Part 2 (90 min): didactics, role-play	Part 1 focused on foundational information about IPV such as the prevalence, red flags, health consequences, recommendations for documenting, reporting, and access to local services. Part 2 focused on how to apply this information in clinical settings

**Box 1****Recommendations for creating healing-centered systems**

*Prioritize* development of comprehensive services and supports for IPV survivors (rather than just screening)

*Develop* and sustain funded programs to colocate IPV advocates in pediatric health-care settings to more easily facilitate warm handoffs

*Partner* with IPV survivors and advocates when developing service recommendations

*Invest* in community-medical partnerships and compensate victim services agencies who support patients

*Provide* survivor-centered training to all clinicians and staff

*Develop* systems for clinicians to privately speak with IPV survivors in pediatric health-care settings, without further traumatizing the child(ren). One potential option is a greater investment in child life specialists who can support children while the clinician is speaking with the parent or caregiver

*Reimburse* follow-up phone calls with IPV survivors so clinicians can further support them

*Invest* in healing for clinicians themselves, to address moral injury and vicarious trauma

*Continue* to interrogate institutional policies and practices to ensure they are strength-based, healing-centered, and rooted in principles of disrupting structural oppressions and making transformational change

vignettes, videos, and expert perspectives. Children's National Medical Center has developed online modules for pediatric clinicians that reviews specific cases of IPV, describes how best to respond to such cases, and identifies resources available to survivors in these situations (see [Table 1](#)). MedEdPortal, an open-access journal published by the Association of American Medical Colleges has several peer-reviewed IPV educational curricula available that one can implement within their pediatric clinical setting (synthesized in [Table 2](#)).

### ***Creating Healing-Centered Systems***

Much of what is offered above focuses on healing-centered providers or clinics, which are critically needed. However, to be truly transformative health-care systems also need to become more healing-centered and prioritize funding and resources toward supporting IPV survivors and their children.<sup>66</sup> There is a current priority being placed on systems-wide social determinants of health screening (which may include IPV) due to regulations from the Joint Commission, Centers for Medicare and Medicaid, and US News and World Reports.<sup>66</sup> This work has focused on screening, although more comprehensive systems-based programs to address SDOH are needed.<sup>67</sup> Leveraging this momentum, we now delineate several recommendations for health-care systems in [Text Box 1](#). Although not an exhaustive list, these recommendations demonstrate the need to invest money, time, and resources in IPV prevention rather than shifting the burden onto individual providers.

### **SUMMARY AND KEY TAKE HOME POINTS FOR PEDIATRIC CLINICIANS**

Pediatric clinicians and health-care settings have an urgent responsibility to support IPV survivors and their children. Key take home points are listed below.

1. IPV is pervasive and rooted in multilevel power and control, including through partners using structural-level oppressive policies and practices.

2. As an alternative to screening, we recommend the use of universal education and resource provision, with additional supports provided if a parent or caregiver discloses experiencing IPV.
3. Developing community-medical partnerships with victim services agencies can offer real-time support for IPV survivors.
4. Comprehensive, mandatory, yearly, strength-based, multidisciplinary, and inclusive training around IPV for pediatric trainees, clinicians, and staff is needed to ensure provision of healing-centered care within pediatric health-care settings.
5. Use of healing-centered approaches both as a framework for clinician–patient communication and to reimagine health systems more broadly is critical to amplify survivor strengths and support families.

### ACKNOWLEDGMENTS

The authors would like to thank Erin Mickievicz, BA for her assistance in creating the figures for this article.

### FUNDING

Dr Ragavan is supported by a K23 from the National Institute on Child Health and Human Development (K23HD104925).

### DISCLOSURE

Drs M.I. Ragavan and A. Murray have no conflicts of interest to disclose.

### REFERENCES

1. Leemis RW, Friar N, Khatiwada S, Chen MS, Kresnow M, Smith SG, Caslin S, & Basile KC. The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2022. Retrieved from: The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence (cdc.gov).
2. Garthe RC, Kaur A, Rieger A, et al. Dating violence and peer victimization among male, female, transgender, and gender-expansive youth. *Pediatrics* 2021;147(4). e2020004317.
3. Dank M, Lachman P, Zweig JM, et al. Dating violence experiences of lesbian, gay, bisexual, and transgender youth. *J Youth Adolesc* 2014;43(5):846–57.
4. Hamby S, Finkelhor D, Turner H, et al. Children's exposure to intimate partner violence and other family violence. US Department of Justice; 2010.
5. Ragavan MI, Culyba AJ, Shaw D, et al. Social support, exposure to parental intimate partner violence, and relationship abuse among marginalized youth. *J Adolesc Health* 2020;67(1):127–30.
6. Randell KA, Ragavan MI. Intimate partner violence: identification and response in pediatric health care settings. *Clin Pediatr (Phila)* 2020;59(2):109–15.
7. Thackeray JD, Hibbard R, Dowd MD. Committee on child abuse and neglect; committee on injury, violence, and poison prevention. Intimate partner violence: the role of the pediatrician. *Pediatrics* 2010;125(5):1094–100.
8. Domestic Abuse Intervention Program. Understanding the Power and Control Wheel. Available at: <https://www.theduluthmodel.org/wheels/>. Accessed November 18, 2019.

9. Stylianou AM. Economic abuse within intimate partner violence: a review of the literature. *Violence Vict* 2018;33(1):3–22.
10. Miller SL, Smolter NL. "Paper abuse": when all else fails, batterers use procedural stalking. *Violence Against Women* 2011;17(5):637–50.
11. Ragavan MI, Garcia R, Berger RP, et al. Supporting intimate partner violence survivors and their children during the COVID-19 pandemic. *Pediatrics* 2020;146(3):e20201276.
12. Ragavan MI, Risser L, Duplessis V, et al. The impact of the COVID-19 pandemic on the needs and lived experiences of intimate partner violence survivors in the united states: advocate perspectives. *Violence Against Women* 2022;28(12–13): 3114–34.
13. Wyckoff KG, Narasimhan S, Stephenson K, et al. "COVID gave him an opportunity to tighten the reins around my throat": perceptions of COVID-19 movement restrictions among survivors of intimate partner violence. *BMC Publ Health* 2023; 23(1):199.
14. Beeble ML, Bybee D, Sullivan CM. Abusive men's use of children to control their partners and ex-partners. *Eur Psychol* 2007;12(1).
15. Risser L, Berger RP, Renov V, et al. Supporting children experiencing family violence during the COVID-19 pandemic: IPV and CPS provider perspectives. *Acad Pediatr* 2022;22(5):842–9.
16. Ragavan MI, Query LA, Bair-Merritt M, et al. Expert perspectives on intimate partner violence power and control in pediatric healthcare settings. *Acad Pediatr* 2021;21(3):548–56.
17. Ragavan MI, Thomas KA, Fulambarker A, et al. Exploring the needs and lived experiences of racial and ethnic minority domestic violence survivors through community-based participatory research: a systematic review. *Trauma Violence Abuse* 2020;21(5):946–63.
18. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev* 1991;43:1241–99, 29.
19. Sokoloff NJ, Dupont I. Domestic violence at the intersections of race, class, and gender: challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women* 2005;11(1): 38–64.
20. Hulley J, Bailey L, Kirkman G, et al. Intimate partner violence and barriers to help-seeking among black, asian, minority ethnic and immigrant women: a qualitative metasynthesis of global research [published online ahead of print, 2022 Feb 2]. *Trauma Violence Abuse* 2022. <https://doi.org/10.1177/15248380211050590>. 15248380211050590.
21. Rogers M. Breaking down barriers: exploring the potential for social care practice with trans survivors of domestic abuse. *Health Soc Care Community* 2016;24(1): 68–76.
22. Kattari SK, Kattari L, Lacombe-Duncan A, et al. Differential experiences of sexual, physical, and emotional intimate partner violence among transgender and gender diverse adults. *J Interpers Violence* 2022;37(23–24):NP23281–305.
23. Gamarel KE, Jadwin-Cakmak L, King WM, et al. Stigma experienced by transgender women of color in their dating and romantic relationships: implications for gender-based violence prevention programs. *J Interpers Violence* 2022; 37(9–10):NP8161–89.
24. Monterrosa AE. How race and gender stereotypes influence help-seeking for intimate partner violence. *J Interpers Violence* 2021;36(17–18):NP9153–74.

25. Decker MR, Holliday CN, Hameeduddin Z, et al. "You do not think of me as a human being": Race and gender inequities intersect to discourage police reporting of violence against women. *J Urban Health* 2019;96(5):772–83.
26. Goodman LA, Smyth KF, Borges AM, et al. When crises collide: how intimate partner violence and poverty intersect to shape women's mental health and coping? *Trauma Violence Abuse* 2009;10(4):306–29.
27. Bybee D, Sullivan CM. Predicting re-victimization of battered women 3 years after exiting a shelter program. *Am J Community Psychol* 2005;36(1–2):85–96.
28. Holt S, Buckley H, Whelan S. The impact of exposure to domestic violence on children and young people: a review of the literature. *Child Abuse Negl* 2008;32(8):797–810.
29. Neamah HH, Sudfeld C, McCoy DC, et al. Intimate partner violence, depression, and child growth and development. *Pediatrics* 2018;142(1):e20173457.
30. Wang E, Zahid S, Moudgal AN, et al. Intimate partner violence and asthma in pediatric and adult populations. *Ann Allergy Asthma Immunol* 2022;128(4):361–78.
31. Hamby S, Finkelhor D, Turner H, et al. The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse Negl* 2010;34(10):734–41.
32. Tullberg E, Vaughn W. Revisiting the co-occurrence of intimate partner violence and child maltreatment. *J Interpers Violence* 2023;38(3–4):2957–82.
33. Miller E. Healing-centered engagement: fostering connections rather than forcing disclosures. In: Ginsburg KR, Brett Z, McClain R, editors. *Reaching Teens: strength-based, trauma-sensitive, Resilience-building communication strategies rooted in positive youth development*. Elk Grove Village, IL: American Academy of Pediatrics; 2020.
34. Ginwright S. The future of healing: Shifting from trauma informed care to healing centered engagement. 2018; <https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c>. Accessed date 21 May 2021.
35. Ragavan MI, Miller E. Healing-Centered Care for Intimate Partner Violence Survivors and Their Children. *Pediatrics* 2022;149(6).
36. Miller E, McCaw B. Intimate Partner Violence. *N Engl J Med* 2019;380(9):850–7.
37. Futures Without Violence. CUES: Addressing domestic and sexual violence in health settings Retrieved from: [CUES.pdf](https://www.futureswithoutviolence.org/CUES.pdf) (futureswithoutviolence.org). Accessed date 3 March 2023.
38. Miller E, McCauley HL, Decker MR, et al. Implementation of a family planning clinic-based partner violence and reproductive coercion intervention: provider and patient perspectives. *Perspect Sex Reprod Health* 2017;49(2):85–93.
39. Miller E, Jones KA, McCauley HL, et al. Cluster randomized trial of a college health center sexual violence intervention. *Am J Prev Med* 2020;59(1):98–108.
40. Miller E, Goldstein S, McCauley HL, et al. A school health center intervention for abusive adolescent relationships: a cluster RCT. *Pediatrics* 2015;135(1):76–85.
41. CommonSpirit Health, HEAL Trafficking, Pacific Survivor Center. PEARR Tool: Trauma-Informed Approach to Victim Assistance in Health Care Settings. 2020. Available at: [PEARR-Tool-2020.pdf](https://www.healtrafficking.org/PEARR-Tool-2020.pdf) (healtrafficking.org). Last Accessed June 2, 2021.
42. Randell KA, Sherman A, Walsh I, et al. Intimate partner violence educational materials in the acute care setting: acceptability and impact on female caregiver attitudes toward screening. *Pediatr Emerg Care* 2021;37(1):e37–41.
43. US Preventive Services Task Force, Curry SJ, Krist AH, Owens DK, et al. Screening for intimate partner violence, elder abuse, and abuse of vulnerable



- adults: US preventive services task force final recommendation statement. *JAMA* 2018;320(16):1678–87.
44. Othman S, Goddard C, Piterman L. Victims' barriers to discussing domestic violence in clinical consultations: a qualitative enquiry. *J Interpers Violence* 2014;29(8):1497–513.
  45. Lippy C, Jumarali SN, Nnawulezi NA, et al. The impact of mandatory reporting laws on survivors of intimate partner violence: intersectionality, help-seeking and the need for change. *J Fam Violence* 2019;35:255–67.
  46. Perone HR, Dietz NA, Belkowitz J, et al. Intimate partner violence: analysis of current screening practices in the primary care setting. *Fam Pract* 2022;39(1):6–11.
  47. Zink T, Levin L, Wollan P, et al. Mothers' comfort with screening questions about sensitive issues, including domestic violence. *J Am Board Fam Med* 2006;19(4):358–67.
  48. Chang JC, Decker MR, Moracco KE, et al. Asking about intimate partner violence: advice from female survivors to health care providers. *Patient Educ Counsel* 2005;59(2):141–7.
  49. Dichter ME, Ogden SN, Tuepker A, et al. Survivors' input on health care-connected services for intimate partner violence. *J Womens Health (Larchmt)* 2021;30(12):1744–50.
  50. Mandatory reporters of child abuse and neglect. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau; 2019.
  51. Ragavan MI, Skinner CM, Killough EF, et al. Child protective services reports in the context of intimate partner violence: a delphi process examining best practices. *Acad Pediatr* 2022;22(5):833–41.
  52. Cenat JM, McIntee S-E, Mukunzi JN, et al. Overrepresentation of Black children in the child welfare system: a systematic review to understand and better act. *Child Youth Serv Rev* 2021;120:105714.
  53. Cross TL. Racial disproportionality and disparities among American Indian and Alaska Native populations. In: Dettlaff, editor. *Racial disproportionality and Disparities in the Child Welfare system*. Cham: Springer International Publishing; 2021. p. 99–124.
  54. Roberts D. *Torn Apart: how the child Welfare system Destroys Black families and how Abolition can build a safer World*. New York, NY: Basic Books; 2022.
  55. Congress.gov. HR 34—21st Century Cures Act. Accessed on 3/3/2023. Available at: <https://www.congress.gov/bill/114th-congress/house-bill/34/>.
  56. Shum M, Asnes AG, Jubanyik K, et al. The 21st century cures act: affecting the safety of intimate partner violence survivors and their children. *Ann Emerg Med* 2022;79(5):503–4.
  57. Randell KA, Ragavan MI, Query LA, et al. Intimate partner violence and the pediatric electronic health record: a qualitative study. *Acad Pediatr* 2022;22(5):824–32.
  58. Macy RJ, Giattina M, Sangster TH, et al. Domestic violence and sexual assault services: Inside the black box. *Aggress Violent Behav* 2009;14(5):359–73.
  59. National Network to End Domestic Violence (NNEDV). (2020, March 10). 14th Annual Domestic Violence Counts Report. Retrieved March 17, 2021, Available at: [https://nnedv.org/wp-content/uploads/2020/03/Library\\_Census-2019\\_Report\\_web.pdf](https://nnedv.org/wp-content/uploads/2020/03/Library_Census-2019_Report_web.pdf). Accessed July 1, 2021.
  60. Rahman R, Huysman C, Ross AM, et al. Intimate partner violence and the COVID-19 pandemic. *Pediatrics* 2022;149(6). e2021055792.
  61. CHILDREN'S MERCY NEED TO ADD.

62. Children's Hospital of Philadelphia. Center for Violence Prevention. Available at: <https://violence.chop.edu/research-and-programs/intimate-partner-violence-prevention>. Accessed date 03 March 2023.
63. Nicolaidis C, Curry M, Gerrity M. Measuring the impact of the Voices of Survivors program on health care workers' attitudes toward survivors of intimate partner violence. *J Gen Intern Med* 2005;20(8):731–7.
64. Ghaith S, Voleti SS, Ginsberg Z, et al. A scoping review of published intimate partner violence curricula for medical trainees. *J Womens Health (Larchmt)* 2022;31(11):1596–613.
65. McColgan MD, Cruz M, McKee J, et al. Results of a multifaceted Intimate Partner Violence training program for pediatric residents. *Child Abuse Negl* 2010;34(4):275–83.
66. Toccalino D, Haag HL, Estrella MJ, et al. The intersection of intimate partner violence and traumatic brain injury: findings from an emergency summit addressing system-level changes to better support women survivors. *J Head Trauma Rehabil* 2022;37(1):E20–9.
67. Ragavan MI, Garg A, Raphael JL. Creating healing-centered health systems by reimagining social needs screening and supports. *JAMA Pediatr* 2023;77(6):555–6.
68. McBride R. Talking to patients about sensitive topics: Communication and screening techniques for increasing the reliability of patient self-report. *MedEd-Portal* 2012. [https://doi.org/10.15766/mep\\_2374-8265.9089](https://doi.org/10.15766/mep_2374-8265.9089).
69. Jung D, Kavanagh M, Joyce B, et al. Novice health care students learn intimate partner violence communication skills through standardized patient encounters. *MedEdPortal* 2015. [https://doi.org/10.15766/mep\\_2374-8265.9977](https://doi.org/10.15766/mep_2374-8265.9977).
70. Ragavan M, Karpel H, Bogetz A, et al. Health Education for Women and Children: A Community-Engaged Mutual Learning Curriculum for Health Trainees. *MedEd-PORTAL* 2016;12:10492. [https://doi.org/10.15766/mep\\_2374-8265.10492](https://doi.org/10.15766/mep_2374-8265.10492).
71. Clithero A, Albright D, Bissell E, et al. Addressing Interpersonal Violence as a Health Policy Question Using Interprofessional Community Educators. *MedEd-PORTAL* 2016;12:10516. [https://doi.org/10.15766/mep\\_2374-8265.10516](https://doi.org/10.15766/mep_2374-8265.10516).
72. Insetta ER, Christmas C. A Novel Intimate Partner Violence Curriculum for Internal Medicine Residents: Development, Implementation, and Evaluation. *MedEdPORTAL* 2020;16:10905. [https://doi.org/10.15766/mep\\_2374-8265.10905](https://doi.org/10.15766/mep_2374-8265.10905).