JONATHAN THACKERAY, MD

INTIMATE PARTNER VIOLENCE
WHY ABUSE OF WOMEN IS A PEDIATRIC ISSUE

As a medical student, my education on intimate partner violence (IPV) was limited to resources available in the community (which were few) and reasons why physicians don't talk to their patients about IPV (which were many). As a resident, IPV was presented almost exclusively as an adult issue that affected grown women.

I trained in a combined internal medicine/pediatrics program and early on developed an interest in the various aspects of family violence. With my internal medicine hat on, I planned a rotation at our community shelter to learn more about the "adult issues" of IPV.

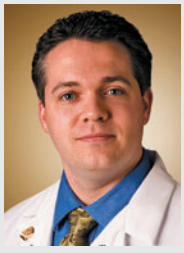
I remember my first day vividly. Within my first few minutes there, I turned the corner and was greeted by a child running full speed with an armful of books. The collision was harmless, and as we shared a laugh and started to collect the books strewn across the floor, I still recall my first thought—a naïve one at that: "What is a child doing in a shelter for victims of IPV? They never taught us that victims have children."

But they do, of course—15 million children by recent estimates. The American Academy of Pediatrics (AAP) advises pediatricians that "the abuse of women is a pediatric issue." I applaud the authors of this month's cover article "Screening and intervention for intimate partner violence: A practical apprach," for reminding us of this and for presenting an excellent summary of IPV to an audience of pediatricians who provide care to these children.

Rates of IPV are disproportionately higher in homes with young children. The magnitude of childhood exposure to IPV described in this article (twice as common as childhood asthma!) should make pediatricians sit up and take notice.

I often wonder how many children who present to the pediatrician with "bad behavior" are being raised in homes with violence. I wonder how many caregivers confide in their pediatricians about a child's school difficulties and then return home only to scream and throw punches at each other over some disagreement. I suspect many of us evaluating these children unfortunately "spin our wheels" diagnosing various disorders and providing various treatments without ever identifying the true heart of the issue in many of our patients' homes.

Once rarely ever mentioned as a consequence of IPV, the effects of childhood exposure to IPV (and other toxic stressors) are now a foremost area of medical and behavioral health research. We now know that the infant brain exposed to IPV develops with a different architecture than the infant not exposed to violence. This abnormal brain development is the



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nidus for a cascade of cognitive and developmental problems that can ultimately lead to early mortality, with a host of social, medical, and behavioral health consequences in between.

It is important to acknowledge with colleagues that IPV is not an inherently easy subject to discuss. In fact, I suspect it is nearly impossible for pediatricians to generate an acceptable level of comfort with the topic unless they practice having this discussion with caregivers regularly.

As pediatricians, however, we discuss the most sensitive of other subjects with our patients and their families, from delivering a diagnosis of cancer in a child to his or her parents, to obtaining the most personal of sexual histories from teenagers, to routinely discussing issues related to drug and alcohol use. Why then should the issue of IPV be any more difficult?

We can approach these conversations armed with the support of the AAP, the Institute of Medicine, and other major medical organizations. We can feel confident that we are practicing evidence-based medicine in accordance with the US Preventive Services Task Force, which endorses screening women of childbearing age for IPV.

I think it is equally important to recognize that screening is not a one-time discrete event but rather an ongoing conversation between the pediatrician and the caregiver. "Caregivers lie to me," I'm often told. Perhaps, but by initiating a discussion on IPV, you have told the caregiver that your office is a safe place to discuss the topic if and when she is comfortable doing so. Remember that with our relatively frequent contacts in the context of well-child and sick visits, we are in a unique position to having ongoing discussions with the caregiver.

If we know that IPV is frighteningly common and we know that the adverse effects on the child are innumerable and undeniable, I will argue then that it is no longer acceptable for pediatricians to simply ignore the issue. When discussing IPV screening by pediatricians, it is time for the conversation to shift from "why don't I ask?" to "how could I not ask?" cp

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