CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Intimate Partner Violence: Role of the Pediatrician

Jonathan Thackeray, MD, FAAP,[a] Nina Livingston, MD, FAAP,[b] Maya I. Ragavan, MD, MPH, FAAP,[c] Judy Schaechter, MD, MBA, FAAP,[d] Eric Sigel, MD, FAAP,[e] COUNCIL ON CHILD ABUSE AND NEGLECT, COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION

The American Academy of Pediatrics and its members recognize the importance of improving the physician's ability to recognize intimate partner violence (IPV) and understand its effects on child health and development and its role in the continuum of family violence. Pediatricians are in a unique position to identify IPV survivors in pediatric settings, to evaluate and treat children exposed to IPV, and to connect families with available local and national resources. Children exposed to IPV are at increased risk of being abused and neglected and are more likely to develop adverse health, behavioral, psychological, and social disorders later in life. Pediatricians should be aware of these profound effects of exposure to IPV on children and how best to support and advocate for IPV survivors and their children.

INTIMATE PARTNER VIOLENCE: OVERVIEW

The Centers for Disease Control and Prevention defines intimate partner violence (IPV) to include physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (ie, spouse, boyfriend or girlfriend, dating partner, or ongoing sexual partner).[1] IPV may also include other aspects of intimidation and control, including financial[2] (eg, ruining credit, taking money) and immigration-related abuse.[3] Traditionally, research has focused on the subset of IPV that is partner violence against cisgender women, although partner violence against cisgender men is a substantial concern as well. Importantly, transgender and gender-diverse people experience higher rates of IPV, rooted in transphobia and other intersecting inequities. In the United States, 36.4% of women and 33.6% of men report sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime.[4] In 2017, IPV resulted in 2237 deaths in the United States, approximately 70% of which were women. Since 2010, gun-related murders of intimate partners increased by 26%, with most of the increase occurring since 2014.[5]

The focus of this clinical report is children and adolescents who are exposed to IPV in the home—the issues associated with assessment of IPV, suggested

abstract

[a]*Division of Child Advocacy, Department of Pediatrics, Dayton Children's Hospital, Dayton, Ohio;* [b]*Division of Child Abuse Pediatrics, Department of Pediatrics, Connecticut Children's Medical Center, Hartford, Connecticut;* [c]*Department of Pediatrics, University of Pittsburgh Medical Center Children's Hospital of Pittsburgh, Pittsburgh, Pennsylvania;* [d]*The American Board of Pediatrics, Chapel Hill, North Carolina; and* [e]*Section of Adolescent Medicine, Children's Hospital Colorado, Department of Pediatrics, University of Colorado School of Medicine, Aurora, Colorado*

Drs Livingston, Ragavan, and Sigel conducted a literature review, conceptualized and designed the report, and drafted the initial manuscript; Drs Schaechter and Thackeray conducted a literature review and drafted the initial manuscript; and all authors critically reviewed and revised the manuscript.

DOI: https://doi.org/10.1542/peds.2023-062509

To cite: Thackeray J, Livingston N, Ragavan MI, et al; AAP Council on Child Abuse and Neglect, Council on Injury, Violence, and Poison Prevention. Intimate Partner Violence: Role of the Pediatrician. *Pediatrics*. 2023;152(1):e2023062509

approaches when IPV is identified, and the anticipated adverse effects of exposure. It is important to also briefly address adolescent relationship abuse (ARA), or IPV occurring between adolescent partners. These patterns of violence often start early, and young people are at particularly high risk of IPV. Among 12- to 18-year-old youth with current or past-year dating, 69% reported experiencing adolescent relationship abuse victimization in their lifetime.[6] The majority of the victimization is psychological, although sexual and physical abuse are common as well. Youth who identify as LGBTQ+ experience higher rates of sexual and physical dating violence than their cisgender and heterosexual peers. Additional information is available from the American Academy of Pediatrics (AAP),[7] and resources on violence within "tween" relationships and ARA are available from the Centers for Disease Control and Prevention[8] and Futures Without Violence.[9] Given the complexities and unique dynamics of ARA, however, further discussion is beyond the scope of this clinical report.

IPV AND INTERSECTING STRUCTURAL OPPRESSIONS

IPV survivors from communities experiencing marginalization may face unique challenges because of deeply rooted structural oppressions and inequities.[10] The needs and lived experiences of IPV survivors can be contextualized within an intersectionality framework, which describes how aspects of social identity (eg, gender identity, race and ethnicity) interact with systems of oppression (eg, sexism, racism, transphobia) to shape lived experiences and access to resources.[11]

Oppressive policies and practices impact IPV survivors in myriad ways, and survivors belonging to multiple marginalized groups may face compounding barriers. Rooted in racism, IPV survivors of color (particularly Black survivors) may be less believed when they disclose violence and may not be safe engaging law enforcement.[12–14] Immigrant IPV survivors, especially immigrant survivors of color, may face unique challenges as well, possibly including language barriers. Abusive partners may attempt to control their partners by threatening to reveal their immigration status or refusing to sponsor their partner's permanent residence (for survivors whose status is interlinked with their partners' status).[15] Practices and policies rooted in xenophobia may also limit immigrant IPV survivors from accessing resources. Poverty disproportionately impacts IPV survivors, and the negative effects of IPV and poverty compound one another.[2] IPV survivors experiencing poverty may also experience economic abuse and face unique challenges, such as housing insecurity, limiting their ability to heal from an abusive relationship. IPV survivors experiencing poverty are also more likely to be abused again after leaving an abusive relationship.[16]

IPV survivors identifying as LGBTQ+ may experience violence rooted in homophobia or transphobia (eg, their partner threatening to tell others about their sexuality or gender), may experience discrimination by health care providers,[17] and may face barriers accessing culturally sensitive resources.[18] As an example, a study examining implicit biases of prosecutors demonstrated that prosecutors were more likely to prosecute under the severest criminal penalty for female survivors in heterosexual relationships.[19] It is essential that pediatric health care professionals consider the way oppressive societal practices and policies impact IPV survivors' experiences and ability to access services. Additionally, further research is needed to determine how implicit and explicit biases impact the services and supports IPV survivors receive in health care settings.

IPV AND THE CHILD

IPV has profound, wide-ranging, and potentially long-lasting effects on children.[20] As children develop and grow in an environment in which they are exposed to IPV, they face not only a higher risk of suffering other forms of maltreatment but also the risk of significant adverse physical, psychological, and psychosocial effects from exposure to abusive events. Exposure to IPV should be considered a childhood adversity and a traumatic experience, similar to other adversities within the caregiving relationship such as neglect or abuse. The AAP clinical report on trauma-informed care[21] summarizes the cascade of physiologic changes experienced in the face of toxic stress, and pediatricians should expect a similar profile of short- and long-term outcomes for children experiencing IPV in the home. Despite the many adversities children may face, including IPV, pediatricians are encouraged to support children and their caregivers in leveraging resilience, fostering social connections, and advocating for best outcomes by creating safe and healing spaces focused on thriving.

The Child Exposed to IPV

Approximately 1 in 4 children have a lifetime exposure (witnessing, hearing, or otherwise being proximate) to caregiver IPV,[22] and pediatricians should be aware of the substantial effects on children who are exposed to such violence. Exposure to IPV as a child is associated with a multitude of physical and behavioral health consequences that vary based on violence severity and chronicity, developmental stage of the child, resiliency, social supports, and other factors.[23,24]

Infants and children exposed to IPV demonstrate significantly more internalizing behaviors, including anxiety, depression, withdrawal, and somatic complaints, as well as externalizing behaviors, including attention problems, aggressive behavior, and rule-breaking actions, than children who are not exposed to IPV.[25–28] Exposure to IPV is also associated with poor academic performance, developmental

delay,[29] underimmunization,[30] and an increased risk of chronic health problems such as asthma and allergies.[31]

Stress and anxiety can persist long after the trauma of IPV exposure, and many children exhibit symptoms consistent with posttraumatic stress disorder, including insomnia, irritability or angry outbursts, poor concentration, and feelings of detachment. Additionally, because of their histories of trauma, children exposed to IPV may struggle with social functioning and have trouble establishing and maintaining relationships with their peers. They may be more likely to be aggressive with peers and perpetrate bullying.[32–34] As adolescents or adults, they may adopt the same dynamic of violence in their own dating or peer relationships.[35] A clinical report from the AAP provides guidance to the pediatrician on understanding the behavioral and emotional consequences of child maltreatment, including exposure to IPV.[36]

Effects of IPV exposure and other childhood adversities may last into adulthood and include higher reported risks of mental health diagnoses, suicidal ideation, social dysfunction, and impaired parenting.[37–39] Ultimately, some of these children may experience IPV or use violence in their own adult relationships,[40,41] and it is estimated that 30% of children exposed to IPV become adult perpetrators of IPV.[42]

The psychological effects of exposure to IPV can be far-reaching, and the medical effects can be profound. Exposure to IPV, along with other adverse childhood experiences, has been shown to be associated significantly with many risk factors for the leading causes of death in adulthood, including smoking, severe obesity, physical inactivity, depression, and suicide attempts.[20] The consequences of IPV and other childhood traumas, including child abuse, parental substance use disorders, family mental illness, incarceration, housing insecurity, etc, are difficult to untangle as many adverse childhood experiences often occur in the same families, leading to what has been called the "adversity package."[43] These collective experiences increase the risk of child welfare involvement and early interventions are crucial in preventing generational trauma from repeating.

Co-Occurrence of IPV and Child Maltreatment

The co-occurrence of IPV and child maltreatment is well-documented, including physical abuse, sexual abuse, emotional abuse, and neglect.[44–47] The overlap between IPV and child physical abuse in published studies ranges from 45% to 70%.[24] Analysis of the National Survey of Children's Exposure to Violence found that more than 1 in 3 youth with a history of exposure to IPV had been maltreated within the past year and more than half (56.8%) of children exposed to IPV reported a history of maltreatment across their lifetime.[41] A subanalysis of the original Adverse Childhood Experiences study[48] by Dube et al[49] demonstrated that adults who were exposed to IPV as children were 6 times more likely to be emotionally abused, 4.8 times more likely to be physically abused, and 2.6 times more likely to be sexually abused than children not exposed to IPV.

It is also important to remember that even the youngest children may become collateral victims of IPV. IPV during pregnancy and the immediate neonatal period has been associated with poor health outcomes, including intracranial injury[50] and death.[51] Children may sustain injuries if they are being held while their caregiver is experiencing physical IPV.[52,53] Older children may be harmed while mediating a crisis or defending the abused caregiver. Identifying and intervening on behalf of a caregiver experiencing IPV, therefore, may be an effective means of reducing the risk of child maltreatment.

Assessment for IPV

The AAP recommends that pediatricians use healing-centered engagement as an approach to support IPV survivors. Healing-centered engagement is a trauma-informed approach that recognizes that trauma and healing are universal experiences and that pediatric health care settings can support survivors in their healing.[54–57] Through a healing-centered approach, pediatricians are encouraged to create a safe, secure, and nonjudgmental space for IPV survivors. Rather than asking for IPV survivors to disclose, healing-centered approaches prioritize relationship development and universal provision of resources and support. Healing-centered engagement uses a strength-based approach in which a pediatrician recognizes that survivors are experts about their own lived experiences and what solutions may work best for them. Core to this approach also is the support of medical staff in their own healing and wellness, recognizing that many providers and staff may have experienced IPV themselves and that supporting IPV survivors and their children can be emotional and challenging work.

Pediatricians need to be aware that most abused caregivers will seek care for their children but not for themselves, making the pediatric setting an ideal place to be alert to the presence of IPV.[58] Qualitative work examining the perspectives of pediatric IPV experts found that abusive partners may use behaviors during pediatric encounters to control, manipulate, or discredit IPV survivors in pediatric health care settings. Examples of these tactics include limiting health care access, dominating conversations during medical visits, controlling medical decision-making, and manipulating perceptions of the health care team.[59] Signs that IPV may be present in the home are often subtle—depression, anxiety, failure to keep medical appointments, reluctance to answer questions about discipline in the home, or frequent office visits for complaints not borne out by the medical evaluation of their child. In fact, most of the time, indicators of abuse are absent

altogether. Addressing IPV in the pediatric setting also gives pediatricians an important opportunity to educate caregivers about the impact of IPV on children[60] and, as described previously, to consider co-occurring child maltreatment when IPV is identified.

How to Address IPV in Practice?

One suggested approach to addressing IPV that differs from the traditional paradigm of screening is "universal education." Universal education is centered in the normalization of conversations about IPV in the clinical setting using inclusive and nonjudgmental language and the prioritization of social connection and resource provision over IPV disclosure. The CUES approach (Confidentiality, Universal education and Empowerment, and Support) is one example that provides a framework for universal education.[61] The approach is not a therapeutic interview, but rather incorporates use of brief scripting and encourages provision of resources. Another similar example is the Provide Privacy, Educate, Ask, Respect, and Respond (PEARR) model.[62] Through these approaches, parents and caregivers are routinely provided with brief education and resources on IPV followed by validation, support, and referral to services if a disclosure is made. Universal education and resource provision can occur in multiple different contexts (birth hospitalization, primary care, inpatient, subspecialty care) in the same way as IPV screening. This approach shares power between the pediatrician and the parent or caregiver, providing the opportunity to disclose only if the caregiver feels safe and comfortable, and encouraging the caregiver to share resources with friends and family. A universal education approach has been shown to be both feasible and acceptable in different health care settings, including school-based health centers addressing adolescent abusive relationships,[63] college-based health centers,[64] family planning clinics,[65] and the emergency department.[66]

Although parents and caregivers experiencing IPV view the health care setting as an ideal environment to disclose IPV,[67] many may have attitudes and beliefs that make them reluctant to disclose, including shame, fear that disclosure will escalate the abuse, or a desire to protect the abuser.[68] Other barriers that inhibit disclosure include the fear that a disclosure will result in a report to child protective services, concerns for the safety of the child or children, a perceived lack of provider empathy, or the concern that a child's health care needs are the priority over those of the caregiver.[69] Furthermore, mistrust of the health care system stemming from structural racism and historical trauma may impact the caregiver's trust of medical professionals and inhibit the ability to feel safe and secure to disclose. A universal education approach may offer important advantages in identification of IPV, including enabling a caregiver to access resources without requiring IPV disclosure to the health care team. This approach, therefore, helps build our health systems as trustworthy and creates health care environments that can focus on leveraging social and community resources.

Alternatively, if a more traditional screening approach is to be implemented, some investigators have found that women prefer self-completed screening (written or tablet-based) to face-to-face screening,[70] whereas others have found that both are acceptable and may best be used in combination.[69] Any direct face-to-face inquiry about IPV should be conducted with compassion and occur in a confidential setting without older, verbal children (eg, age 3 years or older), the intimate partner, or other family members present. Screening for patients with limited English proficiency should always be conducted with a professional medical interpreter and not someone known to the patient or family member. The US Preventive Services Task Force (USPSTF) identifies several validated brief screening instruments that can be incorporated into practice.[71] Links to these instruments are available in the resource table.

Although there is limited evidence demonstrating the benefits of routine screening for IPV in health care settings with respect to reduction in violence,[72,73] there is evidence that screening improves identification of women experiencing IPV[74–76] and that ongoing supportive services are of benefit, specifically in studies of pregnant or postpartum women. The USPSTF found inadequate evidence to determine the harms of screening or interventions for IPV and indicated that the limited evidence available showed no adverse effects of screening or interventions for IPV. The USPSTF currently recommends that providers screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[71] Accordingly, health insurance companies should pay physicians and health care providers appropriately for the time and effort involved in educating and screening caregivers for IPV. Given the significant impact of IPV on children and the potential for improved outcomes with ongoing supportive services, the AAP recommends supporting families through use of a universal education and resource provision approach. Alternatively, if a screening-driven approach is used, the AAP recommends health care professionals use validated tools and consider the potential challenges to effectively implementing such an approach. Further work is needed to understand when and how to provide universal education and/or screening to families around IPV. Regardless of the approach taken, pediatric health care settings should develop protocols to protect the safety and well-being of staff, IPV survivors, and children, particularly in the context of escalating controlling or manipulative behaviors by the abusive partner (or partner using violence).

SUPPORTING FAMILIES WHO ARE EXPERIENCING IPV

Choosing to disclose IPV is a personal decision, and survivors may choose to not discuss IPV with health care professionals for a variety of reasons, including safety, fear of repercussions, or mistrust, among others. If a parent or caregiver discloses IPV either through universal education or screening, use of a survivor-centered approach is helpful to support the family. IPV survivors are best positioned to assess their own safety, and it is essential to not force disclosure or use of resources. Instead, pediatric health care professionals can advocate for IPV survivors and leverage their own resilience and strengths. The health care professional should respond with messages of validation and empathy.[77] Examples of each are provided in the resource table. Providing resources and referrals to hospital or community-based IPV agencies (as described below) is important, if the survivor feels those services would be helpful. IPV survivors have experience keeping themselves and their children safe; thus, when providing resources, it is critical for providers to allow the survivor to guide the conversation and use whichever supports they believe will be safe and helpful.

Families who have experienced IPV can benefit from interventions to build resilience. The "Strengthening Families" Protective Factors Framework[78] developed and disseminated by the Center for the Study of Social Policy is one such resource. This research-informed approach focuses on building 5 key protective factors: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. The Web site (https://cssp.org) provides free downloadable action sheets for use in practice. Interested health care professionals can seek further training for themselves or their staff members to most effectively implement these strategies in practice.

Although IPV alone is not a situation for which health care professionals are mandated to report, individual states have differing requirements for reporting concerns of children exposed to IPV based on the age of the child, relationship of the child to the perpetrator of the violence, and physical proximity of the child to the violent act. Pediatricians should be aware of state laws regarding the mandated reporting of children exposed to IPV and how it may influence their practice of inquiry for IPV. An updated database of these laws is available through the Child Welfare Information Gateway (https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/witnessdv/).[79] When a report of suspected abuse or neglect related to IPV is mandated, the practitioner should inform the parent or caregiver of the practitioner's responsibility to report and provide support to survivors with referrals to an IPV agency that can create a safety plan with the family. There are also tools to create safety plans available online (https://www.thehotline.org/plan-for-safety/create-a-safety-plan/) that a pediatrician can provide to a parent or caregiver for consideration and adaptation.

Current limitations in federal and state firearm policies limit the impact of background check policies to prevent IPV perpetrators from acquiring and carrying firearms. Increasing numbers of states have extreme risk protection order laws, which empower citizens (and in some states, providers) to petition to have firearms removed temporarily from individuals deemed at high risk through a legal process.[80] This information is critical for survivors to know, and health care professionals should know whether their state has an extreme risk protection order law to convey this information to survivors and to become educated on how they may support reporting for the petitioning process. Additional information and assistance with state laws and related advocacy issues are available from the AAP State Advocacy team at E-mail: stgov@aap.org. Practitioners should be familiar with local violence advocacy resources to best support families identified as experiencing IPV. Practitioners caring for immigrant families can share recently enacted federal policy that allows noncitizens who have experienced IPV and cooperate with law enforcement to qualify for U Visas and work permits pending review of their U Visa application.[81] Additional resources available nationally are summarized in the resource table. Practitioners may also make direct referrals to mental health services for children and caregivers. Early evidence suggests that psychotherapeutic and group psychoeducational interventions for children exposed to IPV have positive effects on mental health and behavioral outcomes, and interventions for nonoffending caregivers improve behavioral outcomes.[82]

SYSTEMS-LEVEL PROCESSES IN HEALTH CARE TO ADDRESS IPV

In addition to the role of the pediatric health care professional, there are several other ways for a pediatric health care setting to support IPV survivors and their children. Use of hospital-based pediatric IPV advocates (individuals with advanced training in IPV) can provide support to survivors in a variety of clinical settings (eg, birth hospitalization) without requiring referral to outside agencies.[83] One example of an IPV-health care system collaboration is the Advocacy for Women and Kids Emergencies program, which is embedded within a pediatric academic medical center and provides an array of services, including support to survivors, referral to organizations, housing assistance, and legal resources.[84] Pediatric health care centers can also develop partnerships with community-based IPV agencies. IPV agencies are often equated with emergency shelters; however, many agencies provide services in addition to temporary housing, including counseling, youth programming, support groups, legal advocacy, economic empowerment, pet shelters, and transitional apartments. Each agency may provide slightly different services, so understanding the scope of available community-based resources is

important. Engaging with culturally specific agencies or programs, many of which serve marginalized groups of survivors facing unique structural barriers, may also be helpful. Health care systems may also consider developing longitudinal and bidirectional relationships with community-based IPV agencies to design community-specific health education programs and conduct on-site preventive or acute clinical visits. Such partnerships can also serve as mutual learning opportunities for trainees to learn from IPV agencies about how best to support IPV survivors.[13] Health care professionals and regulators should encourage payers to facilitate these visits by providing coverage and strengthening community resources.

Health care systems can also consider integrating IPV identification and referrals into the electronic health record (EHR) system. For example, a large insurance plan has integrated IPV screening tools into the EHR, including best practice alerts, progress note templates, and community resources.[85] Integration of IPV materials into the EHR requires plans to safeguard confidential information, especially in light of the 21st Century Cures Act and the statutory prohibition on "information blocking."[86] It is important to understand who has access to the medical record because an abusive partner may have access if he or she is also the child's parent or legal guardian. Blocking information related to a disclosure of IPV may align with the Cures Act exception related to withholding of information that will substantially reduce the risk of harm to the patient, although health care systems may interpret the statute differently.[87] Documentation, when done, should be succinct, using objective language—for example: "caregiver states her partner …" instead of "caregiver claims the alleged perpetrator …".[88] Any documentation about IPV should be shared with the survivor, so the survivor is aware of what is being recorded in the medical record. In cases in which the medical record may be accessed by the perpetrator, documentation should be kept as securely as possible and in accordance with state law, including creation of a protected encounter, by making the entire medical record confidential or documenting outside of the medical record. Providers should also consider the safety aspects of the medical record beyond provider documentation, such as problem lists, demographic information (particularly addresses and phone numbers), and letters. IPV-focused documentation should not be visible through patient online health portals, especially in cases in which the abusive partner has access to the medical record.

The EHR can also be used for IPV-related quality improvement, provider training, and research networks. Finally, health care systems should implement focused, longitudinal, and culturally sensitive IPV training programs and policy development for all members of the health care team, including health care professionals, front-desk staff, medical assistants, nurses, interpreters, security personnel, and health informatic specialists.

CONCLUSIONS

Despite a clear need for evaluation of outcomes of various approaches of identifying and addressing IPV, the evidence is overwhelming that children who are exposed to IPV are at risk for child maltreatment, child welfare involvement, and both short- and long-term medical, developmental, and behavioral health problems. Pediatricians have an opportunity and a responsibility to recognize and respond to IPV in the pediatric setting. Recognition of IPV in the child's environment allows for connection to resources and support and ultimately allows the pediatrician to provide more effective health care to children and their families.

Guidance for the Pediatrician and Pediatric Health Care Professional

1. Given the impact of IPV on children and the potential for improved outcomes with ongoing supportive services, pediatricians should consider providing universal education and resource provision to caregivers of childbearing age. Screening with a validated tool is also an option to effectively identify IPV. Pediatric health care professionals should be aware of the multiple structural drivers impacting the needs and lived experiences of IPV survivors and their children.
2. Pediatricians should ensure adherence to developmental screening guidelines and referral to developmental and/or behavioral specialists if indicated for children at risk or exposed to IPV.
3. The AAP is committed to creating and disseminating high-quality educational materials and tools for pediatricians to best support and create healing spaces for survivors of IPV and their children. Residency training programs and continuing medical education program leaders are encouraged to incorporate education on IPV and its implications for child mental and physical health and prevention and response strategies into the curricula of pediatricians and pediatric subspecialists. Organizers should consider partnering with regional domestic violence agencies to inform these offerings.
4. Pediatricians are encouraged to intervene in a sensitive and skillful manner that attempts to validate the lived experiences of IPV survivors and maximize the safety of parents and caregivers and child victims. Referrals to community resources, when available, to support IPV survivors with safety planning and counseling services is recommended.
5. Pediatricians should be cognizant of applicable IPV laws in their state, particularly as they relate to reporting abuse or concerns of children exposed to IPV.
6. Pediatricians are encouraged to advocate and support local and national multidisciplinary efforts to recognize, treat, and prevent IPV.

TABLE OF RESOURCES

Universal Approach Models

- CUES (Confidentiality, Universal education, Empowerment, Support)
  - o https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/implementing-universal-strategies.pdf
- PEARR (Provide privacy, Educate, Ask, Respect, and Respond)
  - o https://healtrafficking.org/wp-content/uploads/2018/08/PEARR-Tool-2020.pdf

Screening Instruments for IPV

1. Humiliation, Afraid, Rape, Kick (HARK) 4 Items
- Purpose is to assess emotional and physical IPV in the past year
2. Hurt, Insult, Threaten, Scream (HITS) 4 Items
- Purpose is to assess the frequency of IPV
3. Extended–Hurt, Insult, Threaten, Scream (E-HITS) 5 Items
- Purpose is to assess the frequency of IPV, including sexual violence
4. Partner Violence Screen (PVS) 3 Items
- Purpose is to assess physical abuse and safety
5. Woman Abuse Screening Tool (WAST) 8 Items
- Purpose is to assess physical and emotional IPV

*Additional information available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening

Example Statements of Providing Support Through Validation and Empathy

- Thank you for sharing this information with me.
- Thank you for trusting me with your story.
- I believe you.
- I am here to listen and support you.
- A lot of people experience things like this and it is not your fault.
- I know it takes a lot of courage to talk about it.
- There is a safe way out of this. I can connect you to some resources that can help.
- You are not alone.
- Nothing you did caused this.
- You are worthy and deserving of a safe and happy life.

National Resources

- Futures Without Violence provides groundbreaking programs, policies, and campaigns that empower individuals and organizations working to end violence against women and children around the world.
  - o www.futureswithoutviolence.org
- The National Domestic Violence Hotline provides 24/7 access to trained expert advocates to talk confidentially with anyone in the United States who is experiencing domestic violence, seeking resources or information, or questioning unhealthy aspects of their relationship.
  - o https://www.thehotline.org/help/
  - o 1-800-799-SAFE (7233)
  - o National Deaf Hotline video services available at 1-855-812-1001
- The American Academy of Pediatrics' Connected Kids program offers child health care providers a comprehensive, logical approach to integrating violence prevention efforts in practice and the community.
  - o https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Connected-Kids.aspx
- The World Health Organization's Clinical Handbook titled "Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence" is a resource for health care providers to guide appropriate responses to identification of IPV.
  - o http://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf;jsessionid=2BA58E813B52A1105271DB988D1AAC88?sequence=1
- The Centers for Disease Control and Prevention has technical packages and trainings for pediatric providers:
  - o Centers for Disease Control and Prevention. Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2019. https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf
  - o Niolon PH, Kearns M, Dills J, et al. Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2017. https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

LEAD AUTHORS

Jonathan Thackeray, MD, FAAP
Nina Livingston, MD, FAAP
Maya I. Ragavan, MD, MPH, FAAP
Judy Schaechter, MD, MBA, FAAP
Eric Sigel, MD, FAAP

COUNCIL ON CHILD ABUSE AND NEGLECT, 2019–2022

Suzanne Breen Haney, MD, FAAP, Chairperson
Andrew P. Sirotnak, MD, FAAP, Immediate Past Chairperson
Andrea Gottsegen Asnes, MD, FAAP
Amy R. Gavril, MD, MSCI, FAAP
Rebecca Greenlee Girardet, MD, FAAP
Amanda Bird Hoffert Gilmartin, MD, FAAP
Nancy Dayzie Heavilin, MD, FAAP
Sheila M. Idzerda, MD, FAAP
Antoinette Laskey, MD, MPH, MBA, FAAP
Lori A. Legano, MD, FAAP
Stephen A. Messner, MD, FAAP
Bethany Anne Mohr, MD, FAAP

Shalon Marie Nienow, MD, FAAP
Norell Rosado, MD, FAAP

LIAISONS

Heather C. Forkey, MD, FAAP – Council on Foster Care, Adoption and Kinship Care
Brooks Keeshin, MD, FAAP – American Academy of Child and Adolescent Psychiatry
Jennifer Matjasko, PhD – Centers for Disease Control and Prevention
Heather Edward, MD – Section on Pediatric Trainees
Elaine Stedt, MSW, ACSW – Administration for Children, Youth and Families, Office on Child Abuse and Neglect

STAFF

Tammy Piazza Hurley

COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION, 2019–2022

Benjamin Hoffman, MD, FAAP, Chairperson 2017–2022
Lois K. Lee, MD, MPH, FAAP, Chairperson 2022–2026
Phyllis F. Agran, MD, MA, MPH, FAAP
Alison Culyba, MD, PhD, MPH, FAAP
James Dodington, MD, FAAP
Michael Hirsh, MD, FAAP
Katherine Flynn-O'Brien, MD, MPH, FAAP
Aimee Grace, MD, FAAP
Maya Haasz, MD, FAAP
Brian Johnston, MD, MPH, FAAP
Sadiqa Kendi, MD, CPST, FAAP
Andrew Kiragu, MD, FAAP
Terri McFadden, MD, FAAP
Kathy Wingo Monroe, MD, FAAP
Kevin Osterhoudt, MD, MS, FAAP
Judy Schaechter, MD, MBA, FAAP
Milton Tenenbein, MD, FAAP
Mark Zonfrillo, MD, MSCE, FAAP
Kyran Quinlan, MD, MPH, FAAP, Immediate Past Chairperson

LIAISONS

Suzanne Beno, MD – Canadian Pediatric Society
Cinnamon Dixon, DO, MPH – Eunice Kennedy Shriver National Institute of Child Health and Human Development
Laura Dunn – National Highway Traffic Safety Administration
Jonathan D. Midgett, PhD – US Consumer Product Safety Commission
Bethany Miller, LCSW-C, Med – Health Resources and Services Administration
Judith Qualters, PhD, MPH – Centers for Disease Control and Prevention

STAFF

Bonnie Kozial

ABBREVIATIONS

AAP: American Academy of Pediatrics
ARA: adolescent relationship abuse
IPV: intimate partner violence

Address correspondence to Jonathan Thackeray, MD, FAAP. E-mail: thackerayj@childrensdayton.org

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

REFERENCES

1. Breiding MJ, Basile KC, Smith SG, Black MC, Mahendra RR. *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2015
2. Goodman LA, Smyth KF, Borges AM, Singer R. When crises collide: how intimate partner violence and poverty intersect to shape women's mental health and coping? *Trauma Violence Abuse.* 2009;10(4):306–329
3. Eraz E, Adelman M, Gregory C. Intersections of immigration and domestic violence: voices of battered immigrant women. *Fem Criminol.* 2009;4(1):32–56
4. Smith SG, Zhang X, Basile KC, et al. *The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief – Updated Release.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2018
5. Fridel EE, Fox JA. Gender differences in patterns and trends in U.S. homicide, 1976–2017. *Violence Gend.* 2019;6(1):27–36
6. Taylor BG, Mumford EA. A national descriptive portrait of adolescent relationship abuse: results from the National Survey on Teen Relationships and Intimate Violence. *J Interpers Violence.* 2016;31(6):963–988
7. Pinzon JL, Jones VF; Committee on Adolescence; Committee on Early Childhood. Care of adolescent parents and their children. *Pediatrics.* 2012;130(6):e1743–e1756
8. Centers for Disease Control and Prevention. Fast facts: preventing teen dating violence. Available at: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/teendatingviolence/fastfact.html. Accessed June 2, 2021
9. Futures Without Violence. Futures without violence. Available at: https://www.futureswithoutviolence.org/. Accessed June 2, 2021
10. 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

11. Etherington C, Baker L. From "buzzword" to best practice: applying intersectionality to children exposed to intimate partner violence. *Trauma Violence Abuse.* 2018;19(1):58–75
12. Monterrosa AE. How race and gender stereotypes influence help-seeking for intimate partner violence. *J Interpers Violence.* 2021;36(17-18):NP9153–NP9174
13. Ragavan MI, Thomas KA, Fulambarker A, Zaricor J, Goodman LA, Bair-Merritt MH. 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):946–963
14. 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):772–783
15. O'Neal EN, Beckman LO. Intersections of race, ethnicity, and gender: reframing knowledge surrounding barriers to social services among Latina intimate partner violence victims. *Violence Against Women.* 2017;23(5):643–665
16. 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
17. 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
18. Grant J, Mottet L, Tanis J, et al. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011
19. Cox J, Daquin JC, Neal TMS. Discretionary prosecutorial decision-making: gender, sexual orientation, and bias in intimate partner violence. *Crim Justice Behav.* 2022;49(11):1699–1719
20. Edleson JL. Children's witnessing of adult domestic violence. *J Interpers Violence.* 1999;14(8):839–870
21. Forkey H, Szilagyi M, Kelly ET, Duffee J; Council on Foster Care, Adoption, and Kinship Care; Council on Community Pediatrics; Council on Child Abuse and Neglect; Committee on Psychosocial Aspects of Child and Family Health. Trauma-informed care. *Pediatrics.* 2021;148(2):e2021052580
22. Hamby S, Finkelhor D, Turner H, Ormrod R. *Children's Exposure to Intimate Partner Violence and Other Family Violence. Juvenile Justice Bulletin NCJ 232272.* Washington, DC: US Government Printing Office; 2011
23. Evans S, Davies C, DiLillo D. Exposure to domestic violence: a meta-analysis of child and adolescent outcomes. *Aggress Violent Behav.* 2008;13(2):131–140
24. 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
25. McFarlane JM, Groff JY, O'Brien JA, Watson K. Behaviors of children who are exposed and not exposed to intimate partner violence: an analysis of 330 Black, white, and Hispanic children. *Pediatrics.* 2003;112(3 Pt 1):e202–e207
26. Hazen AL, Connelly CD, Kelleher KJ, Barth RP, Landsverk JA. Female caregivers' experiences with intimate partner violence and behavior problems in children investigated as victims of maltreatment. *Pediatrics.* 2006;117(1):99–109
27. Meltzer H, Doos L, Vostanis P, Ford T, Goodman R. The mental health of children who witness domestic violence. *Child Fam Soc Work.* 2009;14(4):491–501
28. McCabe KM, Lucchini SE, Hough RL, Yeh M, Hazen A. The relation between violence exposure and conduct problems among adolescents: a prospective study. *Am J Orthopsychiatry.* 2005;75(4):575–584
29. Gilbert AL, Bauer NS, Carroll AE, Downs SM. Child exposure to parental violence and psychological distress associated with delayed milestones. *Pediatrics.* 2013;132(6):e1577–e1583
30. Bair-Merritt MH, Blackstone M, Feudtner C. Physical health outcomes of childhood exposure to intimate partner violence: a systematic review. *Pediatrics.* 2006;117(2):e278–e290
31. Graham-Bermann SA, Seng J. Violence exposure and traumatic stress symptoms as additional predictors of health problems in high-risk children. *J Pediatr.* 2005;146(3):349–354
32. Baldry AC. Bullying in schools and exposure to domestic violence. *Child Abuse Negl.* 2003;27(7):713–732
33. Jaffe P, Wolfe D, Wilson SK, Zak L. Family violence and child adjustment: a comparative analysis of girls' and boys' behavioral symptoms. *Am J Psychiatry.* 1986;143(1):74–77
34. Bauer NS, Herrenkohl TI, Lozano P, Rivara FP, Hill KG, Hawkins JD. Childhood bullying involvement and exposure to intimate partner violence. *Pediatrics.* 2006;118(2):e235–e242
35. Miller E, Breslau J, Chung WJ, Green JG, McLaughlin KA, Kessler RC. Adverse childhood experiences and risk of physical violence in adolescent dating relationships. *J Epidemiol Community Health.* 2011;65(11):1006–1013
36. Stirling J, Amaya-Jackson L; American Academy of Pediatrics, Committee on Child Abuse and Neglect. Understanding the behavioral and emotional consequences of child abuse. *Pediatrics.* 2008;122(3):667–673
37. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics.* 2012;129(1):e232–e246
38. Danese A, McEwen BS. Adverse childhood experiences, allostasis, allostatic load, and age-related disease. *Physiol Behav.* 2012;106(1):29–39
39. Hasselle AJ, Howell KH, Thurston IB, Kamody RC, Crossnine CB. Childhood exposure to partner violence as a moderator of current partner violence and negative parenting. *Violence Against Women.* 2020;26(8):851–869
40. Kaufman J, Zigler E. Do abused children become abusive parents? *Am J Orthopsychiatry.* 1987;57(2):186–192
41. Cawson P. *Child Maltreatment in the Family: The Experience of a National Sample of Young People (NSPCC Child Maltreatment Study: 2nd Report).* London, UK: National Society for the Prevention of Cruelty to Children; 2002

42. Gelles RJ, Cavanaugh MM. Violence, abuse, and neglect in families and intimate relationships. In: McHenry PC, Price SJ, eds. *Families & Change: Coping With Stressful Events and Transitions*, 3rd ed. Thousand Oaks, CA: Sage Publications; 2005:129–154

43. Herrenkohl TI, Sousa C, Tajima EA, Herrenkohl RC, Moylan CA. Intersection of child abuse and children's exposure to domestic violence. *Trauma Violence Abuse.* 2008;9(2):84–99

44. McGuigan WM, Pratt CC. The predictive impact of domestic violence on three types of child maltreatment. *Child Abuse Negl.* 2001;25(7):869–883

45. Hamby S, Finkelhor D, Turner H, Ormrod R. 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):734–741

46. Kellogg ND, Menard SW. Violence among family members of children and adolescents evaluated for sexual abuse. *Child Abuse Negl.* 2003;27(12):1367

47. Osofsky JD. The impact of violence on children. *Future Child.* 1999;9(3):33–49

48. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 1998;14(4):245–258

49. Dube SR, Anda RF, Felitti VJ, Edwards VJ, Williamson DF. Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: implications for health and social services. *Violence Vict.* 2002;17(1):3–17

50. Stephens RP, Richardson AC, Lewin JS. Bilateral subdural hematomas in a newborn infant. *Pediatrics.* 1997;99(4):619–621

51. El Kady D, Gilbert WM, Xing G, Smith LH. Maternal and neonatal outcomes of assaults during pregnancy. *Obstet Gynecol.* 2005;105(2):357–363

52. Christian CW, Scribano P, Seidl T, Pinto-Martin JA. Pediatric injury resulting from family violence. *Pediatrics.* 1997;99(2):E8

53. Tiyyagura G, Christian C, Berger R, Lindberg D; ExSTRA Investigators. Occult abusive injuries in children brought for care after intimate partner violence: an exploratory study. *Child Abuse Negl.* 2018;79:136–143

54. Miller E. Healing-centered engagement: fostering connections rather than forcing disclosures. In: Ginsburgy KR, Brett Z, McClain R, eds. *Reaching Teens: Strength-Based, Trauma-Sensitive, Resilience-Building Communication Strategies Rooted in Positive Youth Development.* Itasca, IL: American Academy of Pediatrics; 2020

55. Ginwright S. The future of healing: shifting from trauma informed care to healing centered engagement. Available at: https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c. Accessed May 21, 2021

56. Ragavan MI, Culyba AJ, Muhammad FL, Miller E. Supporting adolescents and young adults exposed to or experiencing violence during the COVID-19 pandemic. *J Adolesc Health.* 2020;67(1):18–20

57. Ragavan MI, Miller E. Healing-centered care for intimate partner violence survivors and their children. *Pediatrics.* 2022;149(6):e2022056980

58. Martin SL, Mackie L, Kupper LL, Buescher PA, Moracco KE. Physical abuse of women before, during, and after pregnancy. *JAMA.* 2001;285(12):1581–1584

59. Ragavan MI, Query LA, Bair-Merritt M, Dowd D, Miller E, Randell KA. Intimate partner violence power and control behaviors in pediatric healthcare settings: perspectives of pediatric experts. *Acad Pediatr.* 2021;21(3):548–556

60. Zink T, Elder N, Jacobson J. How children affect the mother/victim's process in intimate partner violence. *Arch Pediatr Adolesc Med.* 2003;157(6):587–592

61. Early Childhood National Centers. Implementing universal education strategies on domestic violence in Head Start and early Head Start programs. Available at: https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/implementing-universal-strategies.pdf. Accessed June 2, 2021

62. CommonSpirit Health, HEAL Trafficking, Pacific Survivor Center. PEARR tool: trauma-informed approach to victim assistance in health care settings. Available at: https://medicine.uiowa.edu/emergencymedicine/sites/medicine.uiowa.edu.emergencymedicine/files/wysiwyg_uploads/PEARR-Tool-2020.pdf. Accessed June 2, 2021

63. 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

64. 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

65. 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

66. Randell KA, Sherman A, Walsh I, O'Malley D, Dowd MD. 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–e41

67. Correa NP, Cain CM, Bertenthal M, Lopez KK. Women's experiences of being screened for intimate partner violence in the health care setting. *Nurs Womens Health.* 2020;24(3):185–196

68. McCauley J, Yurk RA, Jenckes MW, Ford DE. Inside "Pandora's box": abused women's experiences with clinicians and health services. *J Gen Intern Med.* 1998;13(8):549–555

69. Dowd MD, Kennedy C, Knapp JF, Stallbaumer-Rouyer J. Mothers' and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. *Arch Pediatr Adolesc Med.* 2002;156(8):794–799

70. MacMillan HL, Wathen CN, Jamieson E, et al; McMaster Violence Against Women Research Group. Approaches to screening for intimate partner violence in health care settings: a randomized trial. *JAMA.* 2006;296(5):530–536

71. Curry SJ, Krist AH, Owens DK, et al; US Preventive Services Task Force. Screening for intimate partner violence, elder abuse, and

abuse of vulnerable adults: US Preventive Services Task Force final recommendation statement. *JAMA*. 2018;320(16):1678–1687

72. MacMillan HL, Wathen CN, Jamieson E, et al; McMaster Violence Against Women Research Group. Screening for intimate partner violence in health care settings: a randomized trial. *JAMA*. 2009;302(5):493–501
73. Klevens J, Kee R, Trick W, et al. Effect of screening for partner violence on women's quality of life: a randomized controlled trial. *JAMA*. 2012;308(7):681–689
74. Chuang C, Liebschutz J. Screening for intimate partner violence in the primary care setting: a critical review. *J Clin Outcomes Manag*. 2002;9(10):565–573
75. McFarlane J, Christoffel K, Bateman L, Miller V, Bullock L. Assessing for abuse: self-report versus nurse interview. *Public Health Nurs*. 1991;8(4):245–250
76. O'Doherty L, Hegarty K, Ramsay J, Davidson LL, Feder G, Taft A. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev*. 2015;2015(7):CD007007
77. Rezey ML. Separated women's risk for intimate partner violence: a multiyear analysis using the National Crime Victimization Survey. *J Interpers Violence*. 2020;35(5-6):1055–1080
78. Center for the Study of Social Policy. Strengthening families: increasing positive outcomes for children and families. Available at: https://cssp.org/our-work/project/strengthening-families/. Accessed June 2, 2021
79. US Department of Health and Human Services, Child Welfare Information Gateway. State statute search. Available at: https://www.childwelfare.gov/topics/systemwide/laws-policies/state/. Accessed April 1, 2020
80. Bloomberg American Health Initiative. Extreme risk protection order: a tool to save lives. Available at: https://americanhealth.jhu.edu/implementERPO. Accessed April 1, 2020
81. US Department of Homeland Security, US Citizen and Immigration Services. Bona fide determination process for victims of qualifying crimes, and employment authorization and deferred action for certain petitioners [policy alert]. Available at: https://www.uscis.gov/sites/default/files/document/policy-manual-updates/20210614-VictimsOfCrimes.pdf. Accessed September 21, 2021
82. Howarth E, Moore THM, Welton NJ, et al. *IMPRoving Outcomes for Children Exposed to Domestic ViolencE (IMPROVE): An Evidence Synthesis*. Southampton, UK: NIHR Journals Library, Public Health Research; 2016
83. Cruz M, Cruz PB, Weirich C, McGorty R, McColgan MD. Referral patterns and service utilization in a pediatric hospital-wide intimate partner violence program. *Child Abuse Negl*. 2013;37(8):511–519
84. Rahman R, Huysman C, Ross AM, Boskey ER. A look at intimate partner violence and the COVID-19 pandemic: trends at a pediatric hospital. *Pediatrics*. 2022;149(6):e2021055792
85. Miller E, McCaw B, Humphreys BL, Mitchell C. Integrating intimate partner violence assessment and intervention into healthcare in the United States: a systems approach. *J Womens Health (Larchmt)*. 2015;24(1):92–99
86. US Congress. 21st Century Cures Act. H.R. 34. 114th Congress (2015-2016). Available at: https://www.congress.gov/bill/114th-congress/house-bill/34/. Accessed June 2, 2021
87. Office of the National Coordinator for Health Information Technology. Cures Act final rule: information blocking exceptions. Available at: https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf. Accessed October 19, 2022
88. 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):824–832