


MEDICINE AND SOCIETY

Witnessing Domestic Violence: The Effect on Children

MELISSA M. STILES, M.D., University of Wisconsin-Madison Medical School, Madison, Wisconsin

 *Am Fam Physician.* 2002;66(11):2052-2067

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

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

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

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

Age Span Differences

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

Preschool-aged children who witness intimate violence may develop a range of problems, including psychosomatic complaints such as headaches and abdominal pain. They also can display regressive behaviors such as enuresis, thumb sucking, and sleep disturbances. During the preschool years, children turn to their parents for protection and stability, but these needs are often disrupted in families with partner abuse. Increased anxiety around strangers and behaviors such as whining, crying, and clinging may occur. Nighttime problems such as insomnia and parasomnias are more frequent in this age group. Children in this age group who have witnessed domestic violence also may show signs of terror, manifested by yelling, irritability, hiding, and stuttering.^{5,8,11}

TABLE 1

Potential Effects in Children Who Witness Violence*

<i>Age</i>	<i>Potential effects</i>
Infants	Needs for attachment disrupted
	Poor sleeping habits
	Eating problems
	Higher risk of physical injury
Preschool children	Lack feelings of safety
	Separation/stranger anxiety

<i>Age</i>	<i>Potential effects</i>
	Regressive behaviors
	Insomnia/parasomnias
School-aged children	Self-blame
	Somatic complaints
	Aggressive behaviors
	Regressive behaviors
Adolescents	School truancy
	Delinquency
	Substance abuse
	Early sexual activity

*—Effects categorized according to age.

Information adapted from references [3](#) and [5](#).

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

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

Resilience

It is important to note that many children who witness domestic violence do not have adverse cognitive, behavioral, and emotional effects. Several variables may lessen the effects of witnessing violence. These variables include female gender, intellectual ability, higher levels of socioeconomic status, and social support for the children. The studies on resilience also have

been limited by small sample sizes but show promise in identifying potential protective factors that mediate the negative effects of witnessing domestic violence.¹⁴

Prevention and Screening

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

Physicians can begin violence prevention measures in the clinic. Because violence is, in large part, a learned behavior, physicians should assess the parents' methods of resolving conflict and their responses to anger.¹⁵ Optimally, this discussion should begin when a couple is contemplating having a child or during prenatal examinations. Couples should be educated about the negative effects that arguments and fights have on children. They should be encouraged to be consistent with discipline and to keep children out of their disagreements. Physicians can also discuss nonviolent forms of discipline, such as time-outs and removal of privileges.^{16,17}

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

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

TABLE 2

Steps to Discourage Domestic Violence

Counsel parents about developmentally appropriate means of disciplining their children.

Counsel parents about nonviolent ways to resolve conflict.

Educate parents about the negative consequences of arguments on children and each other.

Ask about the presence of guns or other weapons in the home.

Advise parents to limit their children's television viewing.

Screen for domestic violence.

Display resource materials in the office.

Information from references [15](#), [16](#), and [20](#) through [22](#).

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

TABLE 3

Questions for Screening Intimate Partner Violence

The rightsholder did not grant rights to reproduce this item in electronic media. For the missing item, see the original print version of this publication.

If a child presents with emotional or behavioral problems, an inquiry about family violence should be made. Because such symptoms are not specific for witnessing domestic violence, the physician also should inquire about other etiologies, such as child abuse, marital discord, peer relationships, sexual violence, and community violence. Depression and alcohol and drug abuse also should be considered. Age-specific screening questions can be incorporated into well-child examinations and sports physicals ([Table 4](#)).^{1,15-20,24,25}

TABLE 4

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

Fighting: When was your last pushing-shoving fight? How many fights have you been in during the past month? The past year?

Injuries: Have you ever been injured in a fight? Do you know anyone who has been injured or killed?

Sexual violence: What happens when you and your boyfriend (or girlfriend) have an argument? Have you ever been forced to have sex against your will?

Threats: Have you ever been threatened with a knife? A gun?

Self-defense: How do you avoid getting in fights? Do you carry a weapon for self-defense?

Information from references [15](#) through [20](#).

Identification of Domestic Violence

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

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

State laws require physicians to report a diagnosis or impression of probable child abuse or neglect to the authorities. Witnessing domestic violence is not defined as a mandatory reportable form of child abuse. Reporting requirements for domestic violence vary by state, so physicians should be aware of their own state laws. Five states have mandatory reporting (California, Kentucky, New Hampshire, New Mexico, and Rhode Island). Community and

national resources for victims of domestic violence should be offered to the patient ([Table 5](#)). Many shelters also provide services for children who have witnessed violence. Safety assessment and planning for patients and children are paramount ([Table 6](#)).^{1,23} A follow-up appointment or telephone call should be scheduled to ensure that the patient will have access to a primary care provider.^{1,23-26}

TABLE 5

National Resources for the Prevention of Domestic Violence

National Domestic Violence Hotline: 800-799-SAFE (7233)

National Resource Center on Domestic Violence: 800-537-2238

Family Violence Prevention Fund: www.fvpf.org (<http://www.fvpf.org>)

American Medical Association: www.ama-assn.org (<http://www.ama-assn.org>)

American Academy of Pediatrics: www.aap.org (<http://www.aap.org>)

American Academy of Family Physicians: [www.familydoctor.org](https://familydoctor.org) (<https://familydoctor.org>)

Minnesota Center Against Violence and Abuse: www.mincava.umn.edu (<http://www.mincava.umn.edu>)

TABLE 6

Helping Patients Plan for Safety

Do you feel safe going home? If not, where could you go?

Are you aware of your local resources?

Can you keep money, important papers, and telephone numbers in a safe place?

Are there weapons in the home? Can they be removed or placed in a safe, locked area?

Do you have a friend or family member with whom you can stay?

Where would you go in an emergency? How would you get there?

Information from references [1](#) and [23](#).

Community Advocacy

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

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

Author Information

MELISSA M. STILES, M.D. is an associate professor in the Department of Family Medicine at the University of Wisconsin-Madison Medical School. Dr. Stiles earned her medical degree from the University of Iowa College of Medicine, Iowa City, and completed a residency in family medicine at the University of Wisconsin-Madison Medical School.

The author thanks Richard Roberts, M.D., J.D., Susan Stiles, Ph.D., and Kathleen Walsh, D.O., M.S., for their review of the manuscript.

The author indicates that she does not have any conflicts of interest. Sources of funding: none reported.

Address correspondence to Melissa M. Stiles, M.D., Department of Family Medicine, University of Wisconsin-Madison Medical School, 777 S. Mills St., Madison, WI 53715. Reprints are not available from the author.

Reference(s)

1. Flitcraft AH, Hadley SM, Hendricks-Matthews MK, McLeer SV, Warshaw C. Diagnostic and treatment guidelines on domestic violence. Chicago, Ill.: American Medical Association, 1992.
2. Carlson BE. Children's observations of inter-parental violence. In: Roberts AR. Battered women and their families: intervention strategies and treatment programs. New York: Simon & Schuster, 1984.

3. Jaffe PG, Hurley DJ, Wolfe D. Children's observations of violence: I. Critical issues in child development and intervention planning. *Can J Psychiatry*. 1990;35:466-70.
4. Jaffe PG, Wolfe D, Wilson S, Zak L. Similarities in behavioral and social maladjustment among child victims and witnesses to family violence. *Am J Orthopsychiatry*. 1986;56(1):142-5.
5. Rhea MH, Chafey KH, Dohner VA, Terragno R. The silent victims of domestic violence—who will speak?. *J Child Adolesc Psychiatr Nurs*. 1996;9(3):7-15.
6. Kashini JH, Allan WD. The impact of family violence on children and adolescents. Thousand Oaks, Calif.: Sage Publications, 1998.
7. Edleson JL. Children's witnessing of adult domestic violence. *J Interpers Violence*. 1999;14:839-70.
8. Wolak J, Finkelhor D. Effects of partner violence on children. In: Domestic violence literature review, synthesis, and implications for practice. U.S. Air Force and the National Network for Family Resiliency, 1997.
9. Attala JM, Bauza K, Pratt H, Vieira D. Integrative review of effects on children of witnessing domestic violence. *Issues Compr Pediatr Nurs*. 1995;18:163-72.
10. Spaccarelli S, Coatsworth JD, Bowden BS. Exposure to serious family violence among incarcerated boys: its association with violent offending and potential mediating variables. *Violence Vict*. 1995;10:163-82.
11. Osofsky JD. The effects of exposure to violence on young children. *Am Psychol*. 1995;50:782-8.
12. Rossman BB. Descartes' error and posttraumatic stress disorder: cognition and emotion in children who are exposed to parental violence. In: Holden GW, Geffner RA, Jouriles EN, eds. Children exposed to marital violence. Washington, D.C.: American Psychological Association, 1998.
13. Maker AH, Kemmelmeier M, Peterson C. Long-term psychological consequences in women of witnessing parental physical conflict and experiencing abuse in childhood. *J Interpers Violence*. 1998;13:574-89.
14. Kolbo JR. Risk and resilience among children exposed to family violence. *Violence Vict*. 1996;11:113-28.

15. Dukarm CP, Holl JL, McAnarney ER. Violence among children and adolescents and the role of the pediatrician. *Bull N Y Acad Med*. 1995;72:5-15.
16. Kashani JH, Daniel AE, Dandoy AC, Holcomb WR. Family violence: impact on children. *J Am Acad Child Adolesc Psychiatry*. 1992;31:181-9.
17. Stein MT, Perrin EL. Guidance for effective discipline. American Academy of Pediatrics. Committee on Psychosocial Aspects of Child and Family Health. *Pediatrics*. 1998;101:723-8.
18. Kellermann AL, Rivara FP, Somes G, Reay DT, Francisco J, Banton JG, et al. Suicide in the home in relation to gun ownership. *N Engl J Med*. 1992;327:467-72.
19. Kellermann AL, Rivara FP, Rushforth NB, Banton JG, Reay DT, Francisco JT, et al. Gun ownership as a risk factor for homicide in the home. *N Engl J Med*. 1993;329:1084-91.
20. Alpert EJ, Sege RD, Bradshaw YS. Interpersonal violence and the education of physicians. *Acad Med*. 1997;72(1 Suppl):S41-50.
21. Knapp JF, Dowd MD. Family violence: implications for the pediatrician. *Pediatr Rev*. 1998;19:316-21.
22. Stingham P. Violence anticipatory guidance. *Pediatr Clin North Am*. 1998;45:439-48.
23. Zink T. Should children be in the room when the mother is screened for partner violence?. *J Fam Pract*. 2000;49(2):130-6.
24. Eisenstat SA, Bancroft L. Domestic violence. *N Engl J Med*. 1999;341:886-92.
25. Warshaw C, Alpert E. Integrating routine inquiry about domestic violence into daily practice. *Ann Intern Med*. 1999;131:619-20.
26. American Academy of Pediatrics. The role of the pediatrician in recognizing and intervening on behalf of abused women. *Pediatrics*. 1998;101:1091-3.
27. Wilson-Brewer R, Spivak H. Violence prevention in schools and other community settings: the pediatrician as initiator, educator, collaborator, and advocate. *Pediatrics*. 1994;94:623-30.

This content is owned by the AAFP. A person viewing it online may make one printout of the material and may use that printout only for his or her personal, non-commercial reference. This material may not otherwise be downloaded, copied, printed, stored, transmitted or reproduced in any medium, whether now known or later invented, except as authorized in writing by the AAFP. See [permissions \(https://www.aafp.org/about/this-site/permissions.html\)](https://www.aafp.org/about/this-site/permissions.html) for copyright questions and/or permission requests.