

Domestic Violence and Children

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ABSTRACT

Domestic violence affects the lives of many Americans, including children. It is imperative that primary care providers working with children, including pediatric nurse practitioners, understand the dynamics of domestic violence, recognize domestic violence, and intervene appropriately. Domestic violence places children at risk physically, emotionally, and developmentally. The effect on children who witness domestic violence will be discussed. Primary care providers have a professional responsibility to screen for domestic violence. The primary care provider can play a pivotal role in breaking the cycle of family violence by timely identification of and appropriate intervention for domestic violence. *J Pediatr Health Care.* (2005). *19*, 206-212.

Domestic violence affects the lives of many Americans, including children. Physical violence is estimated to occur in 4 to 6 million intimate relationships each year (Rodriguez, Bauer, McLoughlin, & Grumbach, 1999). Domestic violence accounts for more than half of the homicides of women in the United States (Bureau of Justice Statistics, 2005). More than 3 million American children between the ages of 3 and 17 years witness domestic violence every year (U.S. Department of Justice, 1998). It is imperative that primary care providers, including pediatric nurse practitioners (PNPs), understand the dynamics of domestic violence, recognize domestic violence, and intervene appropriately.

DEFINITION OF DOMESTIC VIOLENCE

Domestic violence is known by a variety of names: intimate partner abuse, family violence, wife beating, battering, marital abuse, and partner abuse, to name a few. Domestic violence is not any single behavior but rather a pattern of many physical, sexual, and/or psychological behaviors perpetrated by a current or former intimate partner (Rodriguez et al., 1999). Domestic violence is gender-neutral; however, women are more likely to experience physical injuries or psychological consequences (Rodriguez et al.). These assaultive and coercive behaviors are designed to manipulate, control, and dominate the partner to achieve compliance and dependence (Vantage, 1998).

EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN

Children are affected by domestic violence in a variety of ways. Domestic violence in the household is often accompanied by other major developmental risk factors for children such as poverty, female-headed household, and low education level

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of primary care giver (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997). Children in violent households may be involved in the violence by feeling the need to call for help or by being identified as a cause of the dispute that led to the abuse.

Children who live in violent households also are at risk for physical injury both prenatally and postnatally (Christian, Scribano, Seidl, & Pinto-Martin, 1997; Peedicayil et al., 2004). Prevalence rates for domestic violence during pregnancy range from 0.9% to 20.1% depending on the definition for violence in the study (Peedicayil et al.). Harner (2004) states that domestic violence is the major cause of trauma-related visits to health care providers during pregnancy. Physical trauma is the leading cause of maternal death during pregnancy not associated with childbirth, with homicide being the cause of death in just over half of pregnant victims (Campbell, 1995). Physical violence during pregnancy increases the risk of adverse pregnancy outcomes such as antepartum hemorrhage, preterm labor, or fetal loss (Peedicayil et al.). Low infant birth weight also can result from battering during pregnancy (Campbell; Curry, Perrin, & Wall, 1998). Abdominal trauma resulting in placental damage, uterine contractions, or premature rupture of membranes can directly lead to low infant birth weight (Campbell & Lewandowski, 1997). Low infant birth weight can also result from maternal infection as the result of forced sex or exacerbation of chronic maternal health problems such as diabetes or hypertension from the trauma (Campbell & Lewandowski). The link between domestic violence and low birth weight also may be related to increased maternal stress and through the association of violence with other factors for low birth weight, such as maternal smoking and substance abuse (Campbell & Lewandowski).

Children often are inadvertent victims of violence between adult family members. Christian et al.

(1997) reviewed the records of 139 children who presented to the emergency department with injuries resulting from domestic violence and found the age of the child victim to range from 2 weeks to 17 years, with a mean age of 5 years. The most common mechanism of injury was a direct hit (Christian et al.). Children younger than 2 years were most frequently injured while being held by a parent. Thirty-nine percent of children were injured attempting to intervene in the violence (Christian et al.). The majority of injuries the children incurred were minor; however, 9% required hospitalization and 2% required intensive care or surgical intervention (Christian et al.).

Domestic violence within the family places a child at increased risk for sexual and physical abuse. Kaufman and Henrich (2000) estimate that approximately 40% of children who witness domestic violence are also physically abused. The severity of the domestic violence appears predictive of the severity of the child abuse (DiLauro, 2004). The abuser is typically the batterer of the mother, but the mother may also physically abuse the children (Wilden, Williamson, & Wilson, 1991). Mothers in domestic violence relationships are more likely to physically and/or emotionally abuse their children than are mothers in nonviolent relationships (Lutenbacher, Cohen, & Conner, 2004; Margolin & Gordis, 2003). Campbell and Lewandowski (1997) state that the risk of child abuse would be especially severe in families where wife abuse began or increased in severity during pregnancy or where the anger appeared to be directed against the unborn child. Lesniak (1993) suggests an association between violence or the ever-present threat of violence within the family and child sexual abuse. Fear of domestic violence is one reason a mother will stay in a relationship when she is aware of child sexual abuse (Hornor, 2002).

Children living with domestic violence are at risk not only physically but also psychologically and emo-

tionally. First of all, children of battered women tend to be much more aware of the battering than their parents imagine (Groves, 1999). Children who witness domestic violence respond in a variety of ways. Some children remain relatively unscathed from their experiences, whereas others reveal any of a range of psychopathology or adjustment problems (Groves). Groves discusses factors that appear to affect children's responses to witnessing domestic violence, such as what the child actually saw or heard; the child's temperament or personality; the age of the child at the time(s) of exposure; the severity and chronicity of the violence; and the availability of adults who can emotionally protect the child.

Maughan and Cicchetti (2002) propose that exposure to domestic violence indirectly affects child adjustment by disrupting parent-child relationships and parenting practices. The negative changes in parenting that result from domestic violence are what lead to the child's emotional and behavioral problems, not the domestic violence directly (Maughan & Cicchetti).

In general, children are more likely to develop negative psychological effects from witnessing domestic violence if they witness severe or chronic violence, if they are younger, if the violence is frequent, and if it is perpetrated in close proximity to them (Knapp, 1998). Infants in violent households tend to have disrupted sleeping and feeding patterns with resulting poor weight gain (Knapp). These infants can exhibit excessive screaming and be slow to reach developmental milestones. Domestic violence also may negatively affect mother-infant bonding (Mahoney & Campbell, 1998).

Withdrawn, subdued, or mute behaviors are commonly seen in preschoolers who witness domestic violence (Knapp, 1998). Preschoolers also may exhibit anxiety and clinging behavior, suffer nightmares, and reenact the domestic violence in

TABLE. States with sentence upgrades in the penal code for committing domestic violence in the presence of a child

State	Sentence upgrade
Alaska	Yes
Arizona	Yes
Arkansas	Yes
Florida	Yes
Georgia	Yes
Hawaii	Yes
Idaho	Yes
Illinois	Yes
Minnesota	Yes
Montana	Yes
Ohio	Yes
Oklahoma	Yes
Utah	Yes
Washington	Yes

Adapted from Zink et al., 2004.

their play (Knapp). Regression may occur with reoccurrence of toileting accidents and thumb sucking.

School-aged children who witness domestic violence may be noted to have a change in behavior or react inconsistently (Knapp, 1998). School performance may decline or the child may complain of vague somatic complaints, such as headaches or stomachaches. The child is torn between a desire to help or rescue the victim and the need to keep a family secret (Mahoney & Campbell, 1998). School-aged children may begin to feel responsible for the violence.

Adolescents in domestically violent homes express rage, shame, and betrayal (Knapp, 1998). These feelings may be manifested by rebellious behaviors such as truancy, dropping out of school, drug/alcohol use, and running away. Adolescents also may exhibit loss of impulse control.

Wright, Wright, and Issac (1997) state that witnessing the battering of their mothers may be as traumatic to children as being victims of abuse themselves. Finkelstein and Yates (2001) report that children from violent families are at a 30% to 40% higher risk for psychopathology than are those from nonviolent families. Johnson et al. (2002) found

witnessing domestic violence to be a significant predictor of aggression, depression, anger, and anxiety in children. Witnessing domestic violence as a child increases the risk for the child to be in a violent relationship as an adult (Knapp, 1998; Ornduff, Kelsey, & O'Leary, 2001). Boys who observe their fathers battering

found to increase the potential to perpetrate child physical abuse as an adult (Knapp). Dumas, Margolin, and John (1994), in a study of family violence spanning three generations, found witnessing family violence to be predictive of aggression toward women or children across all three generations but only for males.

Post-traumatic stress disorder (PTSD) is another important effect of witnessing domestic violence. The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing the disorder (Groves, 1999). The American Psychiatric Association's 1994 *Diagnostic and Statistical Manual* (DSM-IV) lists diagnostic criteria for PTSD. The criteria includes exposure to a traumatic event in which the person witnessed or experienced an event that involved actual or threatened death or serious injury to self or others and the individual's response involved intense fear, helplessness, horror, or, in children, disorganized

Timely identification of domestic violence coupled with appropriate intervention and referral by the primary care provider is crucial in minimizing the effects of domestic violence on children and other family members.

their mothers have a 1000% increased risk of abusing their future spouses (Knapp). Battered wives and battering husbands share one important risk factor: witnessing domestic violence as a child (Knapp; Ornduff et al.). Ornduff et al. found childhood physical abuse to be uniquely related to adult relationship violence and may be a risk factor for victimization in adult relationships. Also, witnessing domestic violence as a child has been

or agitated behavior. PTSD also involves the persistent re-experience of the traumatic event by recurrent and intrusive recollections of the event, repetitive play expressing a theme of the trauma, repetitive dreams of the event or frightening dreams without recognizable content, flashbacks of the traumatic event or acting or feeling as if the traumatic event were reoccurring, and/or intense psychological distress or physiologic reactions at exposure

BOX 1. Domestic violence questions for parent and children

Parent

1. Do you ever feel afraid in your home?
2. What happens when you and ___ (partner's name) argue?
3. Do arguments ever become physical? (ie, hitting, kicking, pushing, throwing or punching/breaking objects)
4. Have you ever been threatened with a weapon? (eg, gun, knife, other)
5. Have you ever felt trapped or like a prisoner in your own home? Does your partner ever lock you in/out of the house or take your car keys?
6. Have your children ever seen or heard violence in the home?
7. Have the police ever been involved due to violence in your home?
8. Is the violence ever directed at the children? Does ___ (partner's name) ever hit, kick, push, or yell at your child when he is angry?
9. How do you and ___ (partner's name) discipline the children?

Child

1. What happens when mommy and daddy (or appropriate partner names) argue/fight? Is there any hitting, pushing, etc.?
2. How do you feel when mommy and daddy (or appropriate partner names) fight?
3. What happens to you when you get in trouble?
4. If hitting or other physical forms of discipline occur, ask the following: What are you hit with? Where on your body? Does it ever leave a mark/bruise? Who hits/kicks you? How often does it happen?

to cues to the trauma. Victims of PTSD exhibit persistent avoidance of stimuli associated with the trauma and numbing of responsiveness. Persistent symptoms of increased arousal also are associated with PTSD, such as difficulty falling or staying asleep, anger outbursts or irritability, difficulty concentrating, hypervigilance, or an exaggerated startle response.

Groves (1999) states that children who witness domestic violence may exhibit aggressive behavior, decreased social competencies, depression, fears, anxiety, sleep disturbances, and learning problems. The children's emotional responses to the violence, such as intense terror, fear of death, and fear of loss of a parent, underlie many of the emotional/behavioral problems they exhibit. Children also may feel rage, guilt, and a sense of responsibility for the violence (Groves). Witnessing domestic violence may invoke in children feelings of helplessness and they may come to see the world as unpredictable, hostile, and threatening (Groves).

Mahoney and Campbell (1998) found that children who witness domestic violence at all developmental ages exhibit the behavior of aggres-

sion or withdrawal but manifest these behaviors differently. When defining children's experiences in witnessing domestic violence, it is critical to consider contextual factors that may affect children and their responses to the violence such as poverty, family structure and processes, community violence, and other forms of victimization such as child abuse (Prinz & Feerick, 2003).

IDENTIFICATION

Primary care providers, including PNP's, are in a unique position to identify domestic violence and intervene appropriately. Timely identification of domestic violence coupled with appropriate intervention and referral by the primary care provider is crucial in minimizing the effects of domestic violence on children and other family members. Medical providers providing care to women, including OB-GYN and family practice providers, have a responsibility to question patients regarding domestic violence. This is especially pertinent to medical providers treating women during pregnancy, given the increased risk of domestic violence with pregnancy and the potentially negative impact on fetal outcome. In the past decade, many

professional health care organizations have issued position statements regarding routine screening of patients and their families for domestic violence, including the [American Academy of Pediatrics \(AAP\), 1999](#); [American Association of Colleges of Nursing, 2002](#); [American College of Nurse Midwives, 1997](#); [American Nurses Association, 2000](#); and [National Association of Pediatric Nurse Practitioners, 2001](#) (cited in [Lutenbacher et al., 2004](#)). The AAP has classified the abuse of women as a pediatric problem. The National Association of Children's Hospitals and Related Institutions (NACHRI) (2004) states that a minority of women will seek medical care for themselves when abused but almost all will bring their children for medical care; therefore, the pediatric setting may be a woman's only point of access to enter domestic violence intervention programs. Despite recommendations from professional organizations, routine screening for domestic violence by medical providers remains low ([Borowsky & Ireland, 2003](#); [Erickson, Hill, & Seigel, 2001](#); & [Rodriguez et al., 1999](#)). Erickson et al. surveyed pediatric providers and found that only 12% to 15% of providers routinely

BOX 2. National resources for domestic violence victims

National Domestic Violence Hotline

1-800-799-SAFE (7233)

1-800-787-3224 (TDD)

The hotline is staffed 24 hours a day by trained counselors who can provide crisis assistance and information about shelters, legal advocacy, health care centers, and counseling.

Battered Women's Justice Project

1-800-903-0111, ext. 3

215-351-0010

A national resource and advocacy center providing assistance to women defendants, their defense attorneys, and other members of their defense teams in an effort to ensure justice for battered women charged with crimes.

Family Violence Prevention Fund

Phone 415-252-8900

National Coalition Against Domestic Violence

Phone 202-745-1211

National Resource Center on DV

Phone 800-537-2238

For state resources, see the following Web site:

<http://www.feminist.org/911/crisis.html>

Data from Feminist Majority Foundation, 2005.

screen for domestic violence at well-child visits.

Parkinson, Adams, and Emerling (2001) indicated that although current rates of screening for domestic violence in the pediatric office setting are low, most mothers favor domestic violence screening and that it may actually increase satisfaction with care. The AAP (1999) recommends violence-prevention counseling and screening as early as the prenatal visit and continuing into adulthood and responding to problems identified with appropriate treatments and referrals.

NACHRI (2004) identifies potential barriers to domestic violence screening in the pediatric setting: balancing the need to help the mother with the imperative to put the child's interests first; changing attitudes of staff regarding domestic violence; and confronting fear of intervention among abused women. When screening for domestic violence, it is important that questions be asked in a private setting, using a nonjudgmental, empathetic manner. One should never criticize or shame the victim or say things such as, "Why don't you just leave?" One should be supportive and let the victim know that physical, verbal, or

emotional abuse is never acceptable in a relationship. It is important to understand that the victim best knows when it is safe to leave the abusive relationship and seek help. Health care providers should encourage the victim to make a plan in case they decide to leave the abusive relationship and be aware that rash, intrusive intervention by professionals can escalate the cycle of violence.

IMPLICATIONS FOR PRACTICE

Once the primary care provider has identified the problem of domestic violence within the family, the primary care provider is then presented with the dilemma of appropriate intervention. The primary care provider should be aware of local experts who can assist when questions arise regarding how best to intervene. Local domestic violence shelters as well as child advocacy centers or children's hospitals can be an excellent resource to the primary care provider regarding best practice intervention with a family when domestic violence has been identified, especially if children are involved.

The clinician should provide the domestic violence victim, typically the mother, with local domestic vio-

lence crisis numbers and counseling resources. The health care practitioner should listen to what the victim has to say and do not judge if they are unable to leave the relationship or accept counseling. Domestic violence frequently coexists with all types of child abuse: physical abuse, sexual abuse, and neglect. Therefore, children should be assessed for child maltreatment and, if suspected, reported to child protective services according to state laws. Children also should be questioned regarding their knowledge of the domestic violence, keeping in mind that children are often much more aware of the violence than adults may think.

Not all children who witness domestic violence will need individual therapeutic intervention. However, the child should be referred to a therapist with clinical expertise in working with children who have witnessed domestic violence. An assessment, which involves a focused clinical interview that explores the child's experience with the violence, along with data collection from parents and teachers, needs to be completed to determine the need for ongoing therapy (Groves, 1999).

Groves (1999) discusses goals of

therapeutic intervention with children who witness domestic violence. The first goal of therapy is to promote open discussion of the children's experiences. Second, it is important to help children understand and cope with their emotional reactions to the violence, at the same time encouraging positive behavior patterns (Groves). The third goal of therapeutic intervention is to decrease the symptoms the children are exhibiting in response to the violence (Groves). Lastly, it is vitally important to help the family create a safe, stable, and nurturing environment. Children cannot recover from the effects of domestic violence if their exposure to the violence continues (Groves).

Primary care providers, including

the definition of child abuse/neglect (Zink et al.). Many states include such language as "substantial risk" or "imminent danger" or "physical harm" or "mental injury" in their child abuse definition or reporting statutes (Zink et al.). These terms could be interpreted by legal professionals to include witnessing domestic violence. It is important for the primary care provider to understand when this legislation affects their responsibility to report concerns to child protective services. Local child advocacy centers or child abuse specialists located at children's hospitals are an excellent source of information to primary care providers questioning their legal and moral obligation to report to child protective services when a child is witness-

violence. All well-child visits should include questions to the accompanying parent and to the child when age appropriate regarding all aspects of family violence, including domestic violence and child abuse (see Box 1). Crisis information from local domestic violence shelters and national organizations should be discreetly placed in waiting areas and/or examination rooms (see Box 2). The link between domestic violence and child abuse should not be forgotten by the primary care provider, and when domestic violence is identified as a problem within the family, the possibility of the coexistence of child abuse should be assessed.

The primary care provider can play a pivotal role in breaking the cycle of violence. Timely identification of and appropriate intervention for domestic violence occurring within the family of a child can greatly improve the quality of life not only for that child but for all family members. The psychological trauma of the child witnessing domestic violence can be reduced by decreasing the child's exposure to the violence and linking the child and family to mental health resources, thus helping the child and family heal.

Local domestic violence shelters as well as child advocacy centers or children's hospitals can be an excellent resource to the primary care provider regarding best practice intervention with a family when domestic violence has been identified, especially if children are involved.

PNPs, who identify domestic violence occurring in the presence of children also must decide if a report should be made to child protective services. Alaska is the only state that defines domestic violence in the presence of children as child abuse within its juvenile code (Zink et al., 2004). California, Colorado, and Kentucky require the provider to report domestic violence occurring in the presence of a child when a weapon is utilized (Zink et al.). Witnessing domestic violence is included in the definition of child abuse/neglect in Alaska and Utah (Zink et al.). Georgia and Minnesota indicate within their criminal law that exposure to domestic violence is child abuse/neglect, yet domestic violence exposure is not included in

ing domestic violence.

There is a growing trend toward the enactment of legislation related to domestic violence committed in the presence of a child (Zink et al., 2004). Many states have language that upgrades the abusers' sentences when domestic violence is committed in the presence of a child; a misdemeanor may become a felony (see Table). The upgraded legislation does not affect the primary care provider's responsibility to report to child protective services.

Primary care providers, including PNPs, are in a unique position to identify domestic violence occurring within the families of the children for whom they provide care. Primary care providers have a professional responsibility to screen for domestic

REFERENCES

- American Academy of Pediatrics Task Force on Violence. (1999). The role of the pediatrician in youth violence prevention in clinical practice and at the community level. *Pediatrics*, 103, 173-181.
- American Association of Colleges of Nursing. (2002). Violence as a public health problem. Retrieved February 1, 2005 from <http://www.aacn.nche.edu/Publications/positions/violence.htm>
- American College of Nurse-Midwives. (1997). Position statement: Violence against women. Retrieved February 1, 2005 from <http://www.midwife.org/prof/display.cfm>
- American Nurses Association. (2000). Position statement on violence against women. Retrieved February 1, 2005 from <http://ana.org/readroom/position/social/viowomen.pdf>
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, ed. 4. Washington, D.C.: Author.

- Borowsky, I., & Ireland, M. (2003). National survey of pediatricians' violence prevention counseling. *Archives of Pediatrics & Adolescent Medicine*, *153*, 1170-1176.
- Bureau of Justice Statistics. (2005, February 1). Domestic violence statistics. Retrieved from <http://www.ojp.usdoj.gov>
- Campbell, J. (1995). Nursing assessment for risk of homicide with battered women. *Advances in Nursing Science*, *8*, 36-51.
- Campbell, J., & Lewandowski, L. (1997). Mental and physical health effects of intimate partner violence on women and children. *The Psychiatric Clinics of North America*, *20*, 353-374.
- Christian, C. W., Scribano, P., Seidl, T., & Pinto-Martin, J. (1997). *Pediatric injury resulting from family violence*. *Pediatrics*, *99*. Retrieved from <http://www.pediatrics.org/cgi/content/full/99/2/e8>
- Curry, M., Perrin, N., & Wall, E. (1998). Effect of abuse on maternal complications and birth weight in adult and adolescent women. *Obstetrics and Gynecology*, *92*, 530-534.
- DiLauro, M. D. (2004). Psychosocial factors associated with types of child maltreatment. *Child Welfare*, *53*, 69-96.
- Doumas, D., Margolin, G. S., & John, R. S. (1994). The intergenerational transmission of aggression across three generations. *Journal of Family Violence*, *9*, 157-175.
- Erickson, M., Hill, T., & Seigel, R. (2001). Barriers to domestic violence screening in the pediatric setting. *Pediatrics*, *108*, 98-102.
- Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M., & Marcus, S. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 116-122.
- Feminist Majority Foundation. (2005, February 3). Domestic violence. Retrieved from <http://www.feminist.org/911/crisis.html>
- Finkelstein, J., & Yates, J. K. (2001). Traumatic symptomatology in children who witness marital violence. *International Journal of Emergency Mental Health*, *3*, 107-114.
- Groves, B. (1999). Mental health services for children who witness domestic violence. *Domestic Violence and Children*, *9*, 122-130.
- Harner, H. M. (2004). Domestic violence and trauma care in teenage pregnancy: Does paternal age make a difference? *JOGNN*, *33*, 312-319.
- Hornor, G. (2002). Child sexual abuse: psychosocial risk factor. *Journal of Pediatric Health Care*, *16*, 187-192.
- Johnson, R. M., Kotch, J. B., Catellier, D. J., Winsor, J. R., Dufort, V., Hunter, W., et al. (2002). Adverse behavioral and emotional outcomes from child abuse and witnessed violence. *Child Maltreatment*, *7*, 179-186.
- Kaufman, J., & Henrich, C. (2000). Exposure to violence and early childhood trauma. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed.) (pp. 195-207). New York: The Guilford Press.
- Knapp, J. F. (1998). The impact on children witnessing violence. *Pediatric Clinics of North America*, *45*, 355-363.
- Lesniak, L. P. (1993). Penetrating the conspiracy of silence: Identifying the family at risk for incest. *Family and Community Health*, *16*, 66-76.
- Lutenbacher, M., Cohen, A., & Conner, N. M. (2004). Breaking the cycle of family violence: Understanding the perceptions of battered women. *Journal of Pediatric Health Care*, *18*, 236-242.
- Mahoney, D. L., & Campbell, J. M. (1998). Children witnessing domestic violence: A developmental approach. *Clinical Excellence for Nurse Practitioners*, *2*, 362-369.
- Margolin, G., & Gordis, E. B. (2003). Co-occurrence between marital aggression and parents' child abuse potential: The impact of cumulative stress. *Violence and Victims*, *18*, 243-258.
- Maughan, A., & Cicchetti, D. (2002). Impact of child maltreatment and interadult violence on children's emotion regulation abilities and socioemotional adjustment. *Child Development*, *73*, 1525-1542.
- National Association of Children's Hospitals and Related Institutions. (2004). Understanding the link between child abuse and domestic violence: An essential part of family-centered care. *NACHRI Profile Series*, May, 4-15.
- National Association of Pediatric Nurse Practitioners. (2001). NAPNAP Position statement on child maltreatment. Retrieved February 2005 from <http://napnap.org/positions/pos-childmaltreatment.html>
- Ornduff, S. R., Kelsey, R. M., & O'Leary, D. (2001). Childhood physical abuse, personality, and adult relationship violence: A model of vulnerability to victimization. *American Journal of Orthopsychiatry*, *71*, 322-331.
- Parkinson, G. W., Adams, R. C., & Emerling, F. G. (2001). *Pediatrics*, *108*. Retrieved from <http://www.pediatrics.org/cgi/content/full/108/3/e43>
- Peedicayil, A., Sadowski, L. S., Jeyaseelan, L., Shankar, V., Jain, D., Suresh, S., et al. (2004). Spousal physical violence against women during pregnancy. *BJOG*, *111*, 682-687.
- Prinz, R. J., & Feerick, M. M. (2003). Next steps in research on children exposed to domestic violence. *Clinical Child and Family Psychology Review*, *6*, 215-219.
- Rodriguez, M. A., Bauer, H. M., McLoughlin, E., & Grumbach, K. (1999). Screening and intervention for intimate partner abuse. *JAMA*, *282*, 468-474.
- U.S. Department of Justice. (1998). Prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey. Washington, DC: U.S. Government Printing Office.
- Vantage. (1998). Domestic violence: Update for healthcare providers. Retrieved November 11, 2004, from <http://vantageproed.com/viol/viol.htm>
- Wilden, S. R., Williamson, W. D., & Wilson, G. S. (1991). Children of battered women: Developmental and learning profiles. *Clinical Pediatrics*, *30*, 299-304.
- Wright, R. J., Wright, R. O., & Issac, N. E. (1997). Response to battered mothers in the pediatric emergency department: A call for an interdisciplinary approach to family violence. *Pediatrics*, *99*, 186-192.
- Zink, T., Kamine, D., Musk, L., Sill, M., Field, V., & Putman, F. (2004). What are providers' reporting requirements for children who witness domestic violence? *Clinical Pediatrics*, *43*, 449-460.