IPV often develop psychological and behavioral problems that interfere with their ability to function normally in school, at home, and with peers. They may be injured during violent outbursts, sometimes while attempting to intervene on behalf of a parent. Many children are victims of abuse themselves. It is estimated that there is at least a 50% concurrence rate between IPV and child abuse. Children who grow up in violent households learn that violence is appropriate in intimate relationships. A history of having witnessed IPV as a child is a strong predictor for becoming a batterer in adulthood. In addition to sporadic outbursts of violence, children who live in households with IPV experience disruptive events that can overtly or subtly affect the child's development. Although partner violence often occurs between male perpetrators and female victims, it may also occur bi-directionally and may be better conceptualized as family or interpersonal-violence. Violence may escalate during the peri-natal period.

There is no particular behavioral consequence or disturbance that is specific to children who witness IPV. Some children are traumatized by fear for their caregiver's safety and feel helpless. Others may blame themselves for the violence. Children may have symptoms of **posttraumatic stress disorder,** depression, anxiety, aggression, or hypervigilance. Older children may have conduct disorders, poor school performance, low self-esteem, or other nonspecific behaviors. Infants and young toddlers are at risk for disrupted attachment and routines around eating and sleeping. Preschoolers may show signs of regression, irritable behavior, or temper tantrums. During school-age years, children may show both externalizing (aggressive or disruptive) and internalizing (withdrawn and passive) behaviors. Because of family isolation, some children have no opportunity to participate in extracurricular activities at school and do not form friendships. Adolescents in homes where IPV is present have higher rates of school failure, substance abuse, and risky sexual behaviors. These adolescents are more likely than their peers to enter into a violent dating relationship.

Because of the high concurrence of IPV and child abuse, asking about IPV is part of the screening for violence against children. Recognizing the importance of IPV screening in pediatric practice, the American Academy of Pediatrics has endorsed universal screening in this setting and suggests that intervening on behalf of battered women may be one of the most effective means of preventing child abuse. Without standardized screening, pediatricians may underestimate the IPV prevalence in their practices. Parents should not be screened together. Questions about family violence should be direct, nonjudgmental, and done in the context of child safety and anticipatory guidance (Table 25-1).

Intervention is needed for caregivers who disclose IPV. It is appropriate to show concern and to provide available community resources. It is important to assess for the safety of the victim and the children. In some states, physicians are mandated to report IPV. Information for families that provides details about community resources and state laws is helpful.

Table 25-1 Questions for Adults and Children Related to Family Violence

FOR THE CHILD
How are things at home and at school?
Who lives with you?
How do you get along with your family members?
What do you like to do with them?
What do you do if something is bothering you?
Do you feel safe at home?
Do people fight at home? What do they fight about? How do they fight?
ADDITIONAL QUESTIONS FOR THE ADOLESCENT
Do your friends get into fights often? How about you?
When was your last physical fight?
Have you ever been injured during a fight?
Has anyone you know been injured or killed?
Have you ever been forced to have sex against your will?
Have you ever been threatened with a gun or a knife?
How do you avoid getting in fights?
Do you carry a weapon for self-defense?
FOR THE PARENT
Do you have any concerns about your child?
Who helps with your children?
How do you feel about your neighborhood?
Do you feel safe at home?
Is there any fighting or violence at home?
Does anyone at home use drugs?
Have you been frightened by your partner?
Does your partner ever threaten you or hurt you?

YOUTH VIOLENCE

Youth violence is a leading cause of pediatric mortality in the United States. Homicide is the second leading cause of death for all children 1 to 19 years of age. Each year nearly 6000 children, primarily adolescents, are victims of homicide, and 4000 more commit suicide. Youth violence is a problem in urban, suburban, and rural communities and affects children across race and gender. Surveys of adolescents show that 30% to 40% of boys and 15% to 30% of girls report having committed a serious violent offense during childhood, including robbery, rape, aggravated assault, or homicide. Most of these crimes are not reported to the police, and the perpetrator is arrested in a few cases only. Although boys commit more crimes than girls, this gap has narrowed. Boys are much more likely to be arrested for their crimes. Self-reported violent events do not differ much between white and minority adolescents; the latter are more likely to be arrested for their crimes.

Most violent youth begin to exhibit their violent behaviors during early adolescence. **Bullying,** which peaks in middle school, is a form of aggression in which a child repeatedly and intentionally intimidates, harasses, or physically harms another child. Technology-assisted bullying behavior or cyber-bullying has become a major concern. Psychosocial consequences of being bullied include depression and suicidal ideation. Children who bully others are more likely to be involved with other problem behaviors, such as smoking and alcohol use. Bullying and being bullied are both associated with higher rates of weapon carriage and fighting. Although most bullies