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## Pediatricians' Practices and Desired Resources for Addressing Intimate Partner Violence

**Sarah Scott, MPH,**

Division of Adolescent and Young Adult Medicine, University of Pittsburgh, Pittsburgh, PA, USA

**Maya I. Ragavan, MD, MPH, MS,**

Division of General Academic Pediatrics, University of Pittsburgh, Pittsburgh, PA, USA

**Erin Mickiewicz, BA,**

Division of General Academic Pediatrics, University of Pittsburgh, Pittsburgh, PA, USA

**Alexandra Handrinos, BA,**

Division of General Academic Pediatrics, University of Pittsburgh, Pittsburgh, PA, USA

**Joseph Amodei, MFA,**

Immersive Media Program, School of Arts, Science & Business, Chatham University, Pittsburgh, PA, USA

**Judy C. Chang, MD, MPH,**

Department of Obstetrics, Gynecology & Reproductive Sciences, and Internal Medicine, University of Pittsburgh, Pittsburgh, PA, USA

**Zaneta Balaban, BA,**

American Academy of Pediatrics, Itasca, IL, USA

**Virginia Duplessis, MSW,**

Futures Without Violence, San Francisco, CA, USA

**Sarah DeGue, PhD,**

Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA, USA

**Andres Villaveces, MD, MPH, PhD,**

Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA, USA

Correspondence regarding this article should be directed to Sarah Scott, MPH, Division of Adolescent and Young Adult Medicine, University of Pittsburgh, Pittsburgh, PA, USA. ses273@pitt.edu.

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**Elizabeth Miller, MD, PhD,**

Division of Adolescent and Young Adult Medicine, University of Pittsburgh, Pittsburgh, PA, USA

**Kimberly A. Randell, MD, MSc**

Division of Emergency Medicine, Children's Mercy, Kansas, MO, USA

University of Missouri–Kansas City School of Medicine, Kansas, MO, USA

University of Kansas School of Medicine, Kansas, KS, USA

## Abstract

To explore pediatricians' perspectives on supporting intimate partner violence (IPV) survivors, including (a) clinical practices and resource use, (b) ideal resources, and (c) barriers to the use of existing resources, we conducted dyadic and individual virtual interviews with pediatricians recruited through Twitter and the American Academy of Pediatrics Council, section, and chapter listservs. The interviews were approximately 60 minutes in length, audio recorded, and transcribed verbatim. We used a thematic analysis approach and hybrid deductive–inductive coding. Twenty-three pediatricians participated in 14 interviews. We identified four themes. Participants' current practices primarily focused on IPV screening and response to disclosure. They described strategies for IPV resource provision and decision-making involving child protective services. They identified multilevel barriers to addressing IPV, including barriers, such as time, identified in previous studies as well as barriers related to the COVID-19 pandemic, telehealth, the electronic health record, and disclosure-focused approaches. The participants desired provider-facing and caregiver-facing resources to strengthen the capacity to address IPV; some were unaware of currently available resources. They noted the need for continued attention to optimizing systems to enhance their capacity to support IPV survivors. Pediatricians report varying practices to address IPV and identify several surmountable barriers to supporting IPV survivors. Our study suggests that disclosure-driven clinical practices, confidentiality concerns, and lack of resources limit pediatricians' capacity to address IPV. Additional resource development and dissemination efforts are needed to improve the awareness of IPV resources currently available to pediatricians and families.

## Keywords

intimate partner violence; child protective services; barriers; facilitators; pediatrics

## INTRODUCTION

Intimate partner violence (IPV) is a prevalent pediatric public health concern, as one in four U.S. children is exposed to parental or caregiver IPV (Hamby et al., 2011). Childhood IPV exposure is considered an adverse childhood experience and has numerous negative child health impacts, including developmental delays, low uptake of vaccinations, poor lung function, and poor nutrition (Gilbert et al., 2013; Holmes et al., 2022; Levendosky et al., 2013). Caregivers who are IPV survivors may experience a range of physical and mental health problems, such as anxiety, depression, chronic pain, and traumatic brain injuries, which may also impact their parenting and their child's health (Campbell, 2002).

IPV survivors may interact with healthcare for acute and preventive services, including those for their children. Primary care settings may be particularly well suited to support survivors and their children because of long-lasting relationships and trust with providers (Feder et al., 2009). Survivors often speak to a primary care provider first, before they talk to others about IPV (Feder et al., 2009). Several interventions have been established to support survivors within primary care settings. One example of an approach to supporting survivors in healthcare settings is Confidentiality, Universal Education, Empowerment, and Support (CUES; Miller et al., 2017). This approach includes brief information about healthy relationships and the health impacts of violence, sharing national and local resources, and referral to local advocacy programs if a disclosure occurs (Miller et al., 2017). When used in school and college health centers and family planning clinics, CUES improved the knowledge of the patient on community resources and the confidence of the provider in discussing IPV (Miller et al., 2017).

Pediatricians have an important role in supporting IPV survivors, which may be heightened during large-scale disruptions to usual mechanisms for resource access, such as the COVID-19 pandemic (Risser et al., 2022). Pediatric healthcare settings offer unique opportunities to support IPV survivors and their children, as adults often will not seek medical care themselves but will bring their children to the doctor (Martin et al., 2001; Thackeray et al., 2023). Additionally, the impacts of IPV on their children are a common motivation for help-seeking, and most caregivers find it acceptable for pediatricians to address IPV (Dowd et al., 2002; Newman et al., 2005; Randell et al., 2012). The American Academy of Pediatrics (AAP) has long recognized pediatricians' role in supporting IPV survivors; the recommended means include universal IPV education and resource provision, clinic- or hospital-based IPV advocates, and connecting survivors to local IPV agencies and other community-based organizations (American Academy of Pediatrics, n.d.; Thackeray et al., 2023). However, little is known about current practices used by pediatricians to address IPV. Prior research identified a lack of training, time, resources, and funding, as well as pediatrician discomfort, as limiting pediatricians' capacity to address IPV (Borowsky & Ireland, 2002; Erickson et al., 2001; McColgan et al., 2010; Randell et al., 2015). Intervention and advocacy efforts have attempted to address these barriers with resources and clinical programs developed to help healthcare providers better support IPV survivors and their children (AAP, 2022; Cruz et al., 2013; Litzau et al., 2020; Loza-Avalos et al., 2022; Mancheno et al., 2021; McColgan et al., 2010; Randell et al., 2018). For example, some children's hospitals have implemented hospital-based IPV advocacy initiatives that include universal screening and/or education, community agency partnership, and/or multidisciplinary staff education (Cruz et al., 2013; Litzau et al., 2020; Mancheno et al., 2021; McColgan et al., 2010). Concurrently, multiple changes within the healthcare landscape have potentially impacted pediatrician practices around IPV and the factors impacting the implementation of such practices (Colbert et al., 2020; Evans, 2016; Schapiro & Mihaly, 2021; The Joint Commission, 2022). These changes include the advent of the electronic health record (EHR), increased use of telehealth catalyzed by the COVID-19 pandemic, and the increased focus on identifying and supporting patients and families with health-related social needs (e.g., current Joint Commission and Centers for Medicare and Medicaid Services requirements to screen for health-related social needs; Colbert et

al., 2020; Evans, 2016; Schapiro & Mihaly, 2021; The Joint Commission, 2022). Recent evidence suggests that some of these changes may have exacerbated previously known barriers or resulted in additional barriers and facilitators to addressing IPV in pediatric healthcare settings (Ragavan et al., 2020; Rahman et al., 2022; Randell et al., 2022; Shum et al., 2022).

The aim of this study was to better understand pediatricians' current practices around IPV and desired IPV resources, as well as barriers and facilitators around the use of currently available practices and resources to support caregivers who are IPV survivors. This study addressed a key gap in understanding individual pediatrician practices around IPV, given the paucity of recent studies addressing this topic, and may facilitate the development and dissemination of resources that can enable pediatricians to better support IPV survivors.

## MATERIALS AND METHODS

### Study Design

This qualitative study utilized dyadic interviews with pediatricians and a thematic analysis approach. Dyadic interviews provide an opportunity for discussion around commonalities and differences between two participants with a shared identity (Morgan, 2016). This method was selected to generate discussion between participants, especially regarding shared and differing opinions of current practices, needed resources, and dissemination strategies. This study was part of a larger project to improve service provision for IPV survivors during the COVID-19 pandemic. The study was reviewed by the university's institutional review board and determined to be exempt from requirements for federal data collection.

### Participants and Recruitment

Eligibility criteria were being English-speaking, U.S. pediatricians. We recruited through AAP council and section email listservs and Twitter®, as well as listservs from three state AAP chapters involved in the larger project. Interested pediatricians completed an initial survey assessing specialty, state of practice, and availability. We matched participants for dyadic interviews based on their availability. Interviews took place from February to June 2022.

### Interview Procedure

The study team developed a semistructured interview guide and iteratively refined the guide as new themes and probes emerged. Interview domains aligned with our study aims: current practices, desired resources, and existing resources for supporting IPV survivors in pediatric healthcare settings. The approximately 1-hour interviews were audio recorded and conducted on Zoom® by trained research assistants. A second research assistant attended to facilitate technology use and take notes. The participants provided verbal consent and completed an online demographic survey before the interview. The participants received a \$50 gift card and a list of resources to support IPV survivors.

## Data Analysis

Interviews were transcribed verbatim, deidentified, and then uploaded to Dedoose®, an online platform for analyzing qualitative data. We used a thematic analysis approach and hybrid deductive–inductive coding (Braun & Clarke, 2006; Patton, 2015). Deductive codes were based on the interview domains. Two team members independently coded five transcripts and then consolidated these codes into the codebook. Each transcript was coded independently by two team members; the coding team met regularly to discuss discrepancies, reach consensus, and refine the codebook as needed. A third team member served as a consensus mediator if needed. Following coding, broad themes were identified and then refined with feedback from the study team.

## RESULTS

Twenty-three pediatricians participated in five single interviews and nine dyadic interviews; we reached thematic saturation. Table 1 describes pediatricians' demographics.

We identified four themes: (a) pediatricians' approach to IPV focused primarily on resource provision and consideration for child protective services (CPS) referral in the context of IPV disclosure; (b) multilevel barriers inhibit pediatrician's support for IPV survivors; (c) pediatricians want caregiver-facing and provider-facing resources to enhance their capacity to address IPV; and (d) sustained, responsive, systems-level facilitators can enhance pediatricians' capacity to support IPV survivors. Representative quotations are given below and in Table 2.

### Theme 1: Pediatricians' Approach to IPV Focused Primarily on Resource Provision and Consideration for CPS Referral in the Context of IPV Disclosure

Pediatricians described varied practices around IPV; some depended on the clinical setting and resource availability, although commonalities emerged across all interviews. Practices centered on the identification of IPV, response and referral after disclosure, and CPS reporting in the context of IPV.

**Subtheme 1a: Practices Focused on IPV Screening.**—Several participants noted that screening for IPV and other health-related social needs is a routine part of their own or their healthcare team's practice. One pediatrician described screening as necessary: "I wouldn't know, necessarily, about violence unless I screen for it."

**Subtheme 1b: Resource Provision Primarily Occurs in the Context of Disclosure: Response to Disclosure Prioritizes Connection to Resources.**—No participants described a universal education approach to IPV resource provision (i.e., every caregiver receives information about IPV resources, regardless of disclosure). Rather, resource provision was discussed in the context of response to IPV disclosure, focusing on connection to resources for IPV and needs such as food insecurity and diapers. Participants in urban, academic settings often referred survivors to a social worker within their practice: "When we think the parents are suffering, we do offer a social worker to come and talk to them and they provide community resources for them. As well, I know they refer them to

centers where they can get therapy and psychiatry.” Those working in rural and community settings expressed limitations around resource provision:

It’s essentially just, we kick the kid outta the room, make sure we’re talking to the parent we have there, that they have the proper legal and law enforcement resources available to them and then if they don’t, we just say ‘Hey, we’re here available to you to be able to advocate on your behalf.’ But again, if it’s not involving the child, and because we don’t have a social work team, that’s the extent of our resources.

Participants more commonly described referral to local rather than national resources. A pediatrician colocated with an IPV shelter directly connected survivors to an IPV advocate. Participants used physical resources (e.g., brochures and safety cards) on a case-by-case basis; two reported sharing the National Domestic Violence Hotline and national community resource number (i.e., 211). Several participants described passive educational approaches to sharing resource information, such as posters in clinic restrooms.

**Subtheme 1c: Response to Disclosure May Include CPS Reporting.**—Several participants discussed considerations around reporting IPV exposure to CPS, including state-mandated reporting, differing perspectives on how child IPV exposure is defined, and uncertainty around CPS response:

It’s our mandate in [state] to call in witnessed domestic violence [by a child], which I think is always an interesting conversation to have in terms of how people view witnessing... I think that we have to err on the side of caution.

Child abuse pediatricians noted that a CPS report is often completed prior to their involvement:

I guess if it was a case where a parent was not involved with CPS and they are looking for help in terms of just domestic violence and trying to see what is available and then having a mandated report go through that way, I feel a little bit different about the system and how it works in terms of that, but that is a mandated report that still has to be made. Normally, the kids that I’m seeing, they’re already involved with CPS... It is a mandated report for domestic violence.

## **Theme 2: Multilevel Barriers Inhibit Pediatrician’s Support for IPV Survivors**

Participants identified multiple barriers to addressing IPV, including individual provider barriers, disclosure-driven practice barriers, and health system barriers.

**Subtheme 2a: Individual Provider Barriers.**—Participants described their lack of knowledge about IPV and relevant resources as barriers to supporting survivors. Some participants were hesitant to use available resources as designed. For example, one participant expressed concern about universal IPV education provided using resources from Futures Without Violence: “Maybe [the Futures Without Violence pocket card] can be helpful more so if you had a suspicion that someone was experiencing IPV... For those patients that you know and you know them pretty well, I feel like it might catch them off-guard a little bit if you handed them this.” Some participants also identified challenges related to IPV being a parent rather than a child issue. One pediatrician described this

quandary: “I think this is the tricky spot you’re in often as pediatricians. It’s the same with postpartum depression where if your patient is not the one who struggles, it is very hard to access and to know who should be the right person to provide support to the parent.”

**Subtheme 2b: Barriers due to Disclosure-Driven Practices.**—Aligned with an emphasis on resource provision primarily within the context of IPV disclosure, participants described that survivors not recognizing or being hesitant to disclose IPV resulted in barriers to resource provision:

They might not even know that there’s a problem. They might just be used to having these relationships where there’s a lot of power and control dynamics... I think it’s a really challenging entity because the individual has to view it that way for them to even disclose it in that context to us and sometimes they’re not at that stage or they’re never at that stage.

**Subtheme 2c: System-Level Barriers.**—Multiple health system-level barriers hinder supporting survivors in pediatric healthcare settings. Lack of time and low bandwidth to implement a new practice or introduce a new resource were commonly noted. A child abuse pediatrician shared the following:

I’m really fortunate... It’s expected as part of my job that I engage in panels that are called multidisciplinary team reviews throughout my state... I have the capacity to be engaged in these settings that a lot of other clinicians wouldn’t.

Additional system barriers included the lack of insurance reimbursement for addressing IPV and confidentiality risks related to online patient portals, the EHR, and telehealth. Furthermore, COVID-19 worsened system issues such as staff training challenges due to increasing staff turnover.

### **Theme 3: Pediatricians Want Caregiver-Facing and Provider-Facing Resources to Enhance Their Capacity to Address IPV**

Participants described caregiver and provider-facing resources that could enable pediatricians to better support IPV survivors.

**Subtheme 3a: Caregiver-Facing Resources.**—Participants highlighted the need for comprehensive, integrated resources to empower survivors. Several participants desired a national hotline, like “Poison Control but for IPV.” Participants expressed concerns that sharing resources created risk if discovered by an abusive partner. Strategies to minimize this risk included print materials with “just a nondescript logo and a phone number” and accessing online information during the healthcare visit so the survivor could clear their internet browser history before leaving. Participants noted that resources should be inclusive for those with lower literacy and who are non-English speaking. They also emphasized the importance of resources and policy changes outside of healthcare, including quality early education and daycare, stable housing, employment opportunities, economic support, and criminal justice protections.



**Subtheme 3b: Provider-Facing Resources.**—Participants desired resources to address their IPV knowledge deficits and IPV-related clinical challenges. Resources should be clear, concise, evidence-based, and inclusive. Some suggested packaging information on multiple topics as a “toolkit.” The suggested topics included IPV screening tools, scripts to facilitate conversations with parents and children about violence and relationships, clarification around the pediatrician’s role in addressing IPV, addressing IPV in different clinical settings (e.g., inpatient vs. clinic), identifying/accessing local resources, follow-up after disclosure, and CPS reporting. Participants noted the benefits of case-based training and emphasized the need for resources to enable support for diverse families, considering culture, language, gender, and sexuality. They recommended comprehensive training for the entire care team (e.g., providers, social workers, case managers, and administrative staff). On disseminating resources, one pediatrician shared that they “would certainly read a little, like, a blast or a bullet point or something like that. If you’ve got a 5–10-point bullet[ed list] almost like the *UpToDate* [an online clinical resource for providers] summary of recommendations.”

#### **Theme 4: Sustained, Responsive, Systems-Level Facilitators Can Enhance Pediatricians’ Capacity to Support IPV Survivors**

Participants shared several system-level factors that may improve care for IPV survivors, including institutional support, an “IPV champion,” and ongoing educational opportunities.

**Subtheme 4a: Institutional Support.**—Participants noted that institutional support such as engaged leadership, a multidisciplinary team approach, formalized partnerships with community organizations, and integrating IPV-related practices into usual processes can facilitate provider practice change. Onboarding new staff is helped by “having a culture where [IPV is] something that people care about... and so even folks who are new and starting understand that this is a part of the work that’s being done in this place.” IPV-related quality improvement projects may enhance provider practices to better support IPV survivors.

**Subtheme 4b: IPV Champion.**—Participants noted that they were more likely to change their practice if a colleague was a “topic champion.” Participants shared that they often do not have the time to identify and enact practice changes but will support their colleagues’ initiatives. One pediatrician expressed that if a colleague was “really passionate about [a topic] and they’re willing to take the grunt work of implementing a new practice change, then I’m usually willing to hop on board with that.”

**Subtheme 4c: Ongoing Opportunities to Gain Knowledge and Resources.**—Participants described formal and informal mechanisms to gain knowledge and resources. The use of formal mechanisms depended on employer policies and expectations as well as personal interest; informal mechanisms centered on influence from colleagues. A participant noted, “I do get a lot of new tools just from observing how the more senior residents do things. I’ll just take my questions to Google and look for reliable resources that are related that I can use. Then, maybe share it out with my classmates once I find something good.” Multidisciplinary rounds may facilitate discussions with colleagues about IPV. When



prompted to explain how they looked for IPV resources, several noted that they had not looked for resources on their own.

Participants recommended that formal opportunities to learn about IPV and strengthen their skills to support survivors span the entire career course, beginning in medical school and residency. Formal opportunities included local conferences (e.g., Grand Rounds and lunch-and-learns), professional society meetings, newsletters, and email. Continuing education credits may motivate the use of formal training opportunities; mandatory training may also be of use. Participants recommended both in-person and online asynchronous opportunities.

## DISCUSSION

This study revealed that pediatrician practices to support IPV survivors center on the identification of IPV and resource provision primarily in response to disclosure. In alignment with previous work, participants identified multilevel barriers to effective support for IPV survivors (Borowsky & Ireland, 2002; Evans et al., 2021; McColgan et al., 2010; Randell et al., 2015; Tarzia et al., 2021). The participants described resources that could enable pediatricians to better support survivors; some were unaware that such resources (e.g., national domestic violence hotline and scripts to discuss IPV with caregivers) were currently available (The National Domestic Violence Hotline, n.d.). Findings suggest that coordinated, sustained efforts across multiple dissemination channels may increase pediatricians' knowledge of best practices and available resources to support caregivers who are IPV survivors.

Participants' current strategies to support IPV survivors focused largely on IPV identification through caregiver disclosure. Participants noted the need for screening tools to detect caregivers experiencing IPV and described resource provision primarily within the context of IPV disclosure, that is, disclosure-based resource provision. However, screening- and disclosure-based resource provision reaches a limited number of survivors. Previous research has elucidated numerous barriers to IPV disclosure, including survivor concern for increased violence, loss of resources such as housing or income, or loss of child custody (Amel Barez et al., 2022; Heron & Eisma, 2021; Wright et al., 2022). Furthermore, when relying on disclosure-based resource provision, survivors who may not feel comfortable or safe disclosing IPV to their clinicians consequently do not receive information or support (Heron & Eisma, 2021). In one study, almost four of five survivors did not seek help from a medical professional (Black et al., 2011). Within a universal IPV screening program in a pediatric emergency department, only 0.3% of screens were positive (Litzau et al., 2020). Focusing on disclosure as the mechanism to facilitate resource provision may unintentionally place a greater emphasis on disclosure rather than survivor-centered resource provision. This paradigm may contribute to barriers that inhibit robust support for IPV survivors in pediatric and other healthcare settings.

Some participants' perspectives and knowledge were not aligned with survivor-centered processes. A few participants shared that survivors who did not disclose were themselves creating barriers to intervention and resource provision. In contrast, a survivor-centered approach recognizes that survivors should disclose only if they choose. Additionally, some

participants shared that they file CPS reports for all families experiencing IPV, which is not mandated by most state laws and may increase the risk for harm (Child Welfare Information Gateway, 2019; Lippy et al., 2020). A Delphi study around best practices for CPS reporting in the context of IPV found that experts were in consensus that a CPS report is not indicated universally for child exposure IPV and noted that nuanced consideration is required to determine the need for reporting (Ragavan et al., 2022).

Study findings align with prior research on barriers to healthcare-based IPV intervention and resource provision. More than 20 years ago, pediatricians perceived a lack of knowledge, standard practices, time, and support staff as barriers to addressing IPV (Erickson et al., 2001). More recently, a 2021 meta-synthesis of provider-level barriers described similar barriers, as well as the uncertainty of the provider on their role (Tarzia et al., 2021). Our study demonstrates the continued knowledge deficits of the provider. Some participants suggested the development of resources that are already available (e.g., national domestic violence hotline and IPV-related clinical scripts), highlighting a critical gap between resource availability and resource knowledge and utilization. Dissemination of evidence-based information is a well-documented challenge requiring multilevel solutions, including diverse learning opportunities, IPV champions to highlight best practices, collaboration with IPV agencies, and a multipronged strategy for information sharing (Dowd et al., 2002; Schubert et al., 2023). Our study, which was conducted in the latter half of the COVID-19 pandemic, also elucidated newer barriers such as increasing training challenges due to staff turnover. Additionally, participants noted concerns about confidentiality after IPV disclosure. Although confidentiality has previously been described as a barrier to addressing IPV in healthcare settings, the context of such concerns has shifted (Vranda et al., 2018). EHR implementation, including online patient portals, the 21st Century Cures Act, and telehealth, creates new challenges to ensuring confidentiality when addressing IPV in pediatric health settings (Manning, 2021; Shum et al., 2022; Simon, 2021). Pediatricians can mitigate risk by using coded documentation or a “secure” note, denying health record release (allowed under the 21st Century Cures Act “preventing harm exception”), or discussing documentation with survivors to facilitate survivor-informed documentation (Manning, 2021; Randell et al., 2022). Universal education on resources for IPV and other psychosocial determinants of health offers an opportunity to provide IPV resource information during telehealth visits (Ragavan et al., 2020).

Our study has several implications for clinical practice, research, and public policy. In clinical practice, the use of healing-centered engagement, which prioritizes relationships as central to healing, survivor strengths, and connection to resources, may facilitate improved support for survivors regardless of disclosure during the health visit (Ginwright, 2018). The CUES intervention, a healing-centered, universal education approach, has been shown to increase provider knowledge and improve outcomes for survivors (Miller et al., 2015, 2016, 2017). Developing standard practices to maintain confidentiality during telehealth visits and EHR documentation may reduce the risk related to confidentiality (Randell et al., 2022). Our findings suggest the need for improved dissemination of existing resources. Future research should identify effective dissemination and implementation strategies for IPV practices. Professional and healthcare institutions can work to raise awareness of existing resources, such as the National Domestic Violence Hotline and the AAP’s IPV web page. Aligned

with previous work, our findings also suggest the benefit of clinical practice guidelines and institutional policies that promote standard practices to support IPV survivors (Risser et al., 2022). While outside the scope of this study, participants also recommended policy changes beyond the healthcare system to better support IPV survivors, such as early childhood education, housing and financial support, and legal protections.

## STUDY LIMITATIONS

This study had several limitations. Most participants worked in urban, academic settings and were predominantly female, White, and in early career. Participants may have had greater interest and expertise in IPV than pediatricians as a whole. Due to missing appointments, we used a mix of dyadic and individual interviews; individual interviews do not generate the same type of conversation as dyadic pairings, although we did reach data saturation.

## CONCLUSION

Our study suggests that pediatricians center strategies to support IPV survivors on IPV identification and may be unaware of available IPV resources. Findings underscore the continued challenge of longstanding barriers related to time, knowledge, and funding that inhibit the capacity of pediatricians and the health system to support IPV survivors, as well as identify newer challenges related to the EHR and telehealth. This study also highlights the need for effective dissemination and implementation efforts around currently available IPV resources, as well as institutional, technological, and policy changes that may increase the capacity to support families experiencing IPV.

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**TABLE 1.**Demographics (*N* = 23)

Characteristic	% ( <i>N</i> )
Gender	
Woman/female	74% (17)
Man/male	26% (6)
Race/ethnicity <sup>a</sup>	
Non-Hispanic Black, African, or African American	9% (2)
Non-Hispanic White or Caucasian	52% (12)
Hispanic, Latino, Latina, or Latinx	17% (4)
Asian or Pacific Islander	9% (2)
Other	9% (2)
Prefer not to say	4% (1)
Age	
25–34	52% (12)
35–44	22% (5)
45–54	17% (4)
55–64	9% (2)
Specialty	
General pediatrics	48% (11)
Child abuse pediatrics	22% (5)
Other (developmental and behavioral, hospital pediatrics, and pediatric emergency medicine)	30% (7)
Practice setting	
Urban	53% (12)
Suburban	39% (9)
Rural	9% (2)
Practice location	
Northeast	30% (7)
South	26% (6)
Midwest	22% (5)
West	15% (4)
Prefer not to say	4% (1)
Institution	
Academic	60% (14)
Community	40% (9)
Years as pediatrician	
<1	9% (2)
1–2	9% (2)
3–5	35% (8)
6–10	9% (2)
11–15	9% (2)
16–20	9% (2)



Characteristic	% (N)
20+	22% (5)
Direct clinical time	
20%–39%	4% (1)
40%–59%	17% (4)
60%–79%	17% (4)
80%–100%	61% (14)

<sup>a</sup> Could select more than one option; race and ethnicity asked as a single question.

TABLE 2.

## Supplemental Participant Quotes

Theme/subtheme	Quote
Theme 1: Pediatricians' approach to IPV <sup>a</sup> focused primarily on resource provision and consideration for CPS <sup>b</sup> referral in the context of IPV disclosure.	
Subtheme 1a: Practices focus on IPV screening	"In our outpatient setting, we've found that we started screening for adverse childhood events in all families at their well child visits. With this, we found that we were identifying a lot more families with domestic violence and other issues of IPV, essentially."
Subtheme 1b: Resource provision primarily in the context of disclosure	"Just trying to get more information and understand what is the scope of the problem, and the nature, and yeah, the danger that the family is in, and then at that point trying—I would not try to handle it on my own. I would try to get [laughter] reinforcements like social work, my preceptor to help me navigate that. Again, yeah, I don't think that I've really been trained to do that full assessment or counseling in the most effective or sensitive way."
Subtheme 1c: Response to disclosure may include CPS reporting	"It's our mandate in <Location> to call in [a CPS report for] witnessed domestic violence, which I think is always an interesting conversation to have in terms of how people view witnessing. I think that, yeah, I always err on the side of caution 'cause DV <sup>c</sup> is dangerous."
Theme 2: Multilevel barriers inhibit pediatrician's support for IPV survivors.	
Subtheme 2a: Individual provider barriers	"Speaking as just a general pediatrician, what we cover is broad, so it's sometimes hard for us to be experts in everything. It's helpful when we have a framework for addressing a problem." "I think these milder forms or subtle forms we're just scared to, I think we're scared to engage. If it's obvious, then everyone's like, 'Oh, we had a call.' Everyone knows the three or four people that you call if it's an obvious thing, but if it's a lot more subtle, I think we're tending to say, 'Oh, this is just stress with being in the hospital and we'll sort of watch it over time.'"
Subtheme 2b: Barriers due to disclosure-driven practices	"We don't have crystal balls and people will only tell us so much... People become very good at hiding [IPV]."
Subtheme 2c: System-level barriers	"I don't know if I do that, but also am very cognizant of the fact that a lot of my time gets pulled into things where I'm not expected to be compensated." "We know that a person who uses harm may also be the parent... that may be present for a medical visit... They may use that access as yet another means of control. Now with the 21st Century Cures Act, they can access the medical record... and that person may actually be perpetrating harm against the child or the other parent. How do you still document in a way that doesn't risk harming the patient or nonoffending parent?" "I think one of the things I think about is, certainly, we're having increased turnover in our staff, and that can certainly be a barrier when there's new folks to bring them up to speed. I think that can also be facilitated by having a culture where that's something that people care about..."
Theme 3: Pediatricians want caregiver-facing and provider-facing resources to enhance their capacity to address IPV.	
Subtheme 3a: Caregiver-facing resources	"It would be nice to have a phone number that's sort of a consultation that's 24/7 and is a national number so that you can call, for example, when your social worker is not available or for places that don't have a social worker that you can call and talk through the scenario."
Subtheme 3b: Provider-facing resources	"Sometimes, someone is not directly disclosing but sort of disclosing, and then, when you try to hone in and get them to open up more, they shut down... Maybe I could use better training on how to do more—what's the word—not focused but just better interview skills or better skills to forensic."
Theme 4: Sustained, responsive, systems-level facilitators can enhance pediatricians' capacity to support IPV survivors.	
Subtheme 4a: Institutional support	"[Social workers] should be an integral part of the health system... because the honest-to-God truth, there are some very tangible limits to what you can do as a physician without that multidisciplinary element of a team."
Subtheme 4b: IPV champion	"I think if there was a person in our clinic that was an advocate—If there was a provider that had strong feelings about this and disseminating some sort of more formal screening and promoting this, whether it's our clinical social worker or whether that is a medical provider, I think that would definitely help it. Because I was just thinking about it would be nice to have the [IPV resource] cards, but where would the cards go and how do we get the cards?"
Subtheme 4c: Ongoing opportunities to gain knowledge and resources	"I probably learned about it the most after residency just from the AAP <sup>d</sup> and their emails. I think it would be more helpful to have a real training. I prefer in-person things... Then, it could be case based with different scenarios so that you learn how to help families in different challenging situations and different obstacles that they might face with a person who's an expert in navigating those scenarios and what kind of resources would be helpful." "I hear about resources through grand rounds [lectures] and other CME <sup>e</sup> opportunities. Then, I think what helps me take to the step is that if I have other colleagues and we all agree and we listen to the same information, there's momentum behind a behavior change." "We have, not every week, but maybe a few lunches per month. It's called Lunch and Learn, where we have our virtual presentation that's given on a specific topic. It's basically like grand rounds for the outpatient practice."

<sup>a</sup>Intimate partner violence.

<sup>b</sup>Child protective services.

<sup>c</sup>Domestic violence (i.e., IPV).

<sup>d</sup>American Academy of Pediatrics.

<sup>e</sup>Continuing medical education.

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