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Increased Risk for Family Violence During the COVID-19 Pandemic

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Abbreviations: COVID-19 = coronavirus disease. Formerly, this disease was referred to as “2019 novel coronavirus” or “2019-nCoV”. CPS = child protective services. AAP = American Academy of Pediatrics. NCTSN = National Child Traumatic Stress Network.

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Contributors' Statement:

Dr. Kathryn Humphreys conceptualized the initial idea for the manuscript and wrote the first draft of the manuscript.

Drs. Myo Thwin Myint and Charles Zeanah made substantial contributions to the manuscript conception, and both reviewed and revised the manuscript.

All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

Although the public health benefits of social distancing, isolation, and quarantines are well-established and essential for reducing risk of transmitting COVID-19, the disease caused by the novel coronavirus (SARS-CoV-2), there are also likely consequences for these practices when considering the impact of violence in the home. Reports of increased domestic violence following quarantine orders in China have revealed the interpersonal violence risks of isolation. Indeed, a recent review of the psychological impact of quarantine published in *The Lancet* indicated increased anger, confusion, and posttraumatic stress symptoms, as well as evidence of increases in substance use in those subjected to quarantine.¹

These kinds of dysregulated emotions and substance use can increase violent behavior, especially within the family. Children's exposure to intimate partner violence, whether directly witnessed or overheard, is harmful and may lead to posttraumatic stress disorder and other serious emotional and behavioral problems.² Further, intimate partner violence and child abuse often co-occur,³ and it is likely that children will experience increased risk for maltreatment when isolated at home. In typical (i.e., non-pandemic) circumstances, rates of child maltreatment are alarming. In the U.S., one in eight children have confirmed maltreatment by child protective services (CPS) in their lifetime.⁴ Among these, recurrence of maltreatment is high.⁵

Increased risk for child exposure to family violence during periods of crisis

The authors are increasingly concerned about the risks for children and vulnerable families during this unprecedented period of isolation as childcare centers and schools necessarily close their doors. The risks are compounded by added pressures that many parents continue to work full time during these periods. If parents must leave their home to work, children face an increased risk for supervisory neglect (i.e., not having adequate supervision to keep children from harm). If working from home, parents with young children are forced to try to meet work demands while simultaneously caring for young children. Changes in routine are upsetting, confusing, and difficult for young children. Increased oppositional behavior and limit testing are expected and these behaviors are most likely to elicit harsh responses from parents. Coupled with parental anxiety and stress about financial, logistical, and existential concerns,

these interactions are likely a recipe for temper outbursts and verbal and physical abuse. Young children are the most vulnerable to abuse, with the highest abuse related fatalities among those younger than 12 months.⁶ Unfortunately, school closures mean that the largest source of reports to CPS will disappear, resulting in reduced detection of maltreatment. Further, given that well-visits and other routine medical care are being postponed due to the pandemic, clinicians are losing the opportunities to both detect and prevent maltreatment.

Recommendations for protecting children from harm

Several avenues for reducing risk to children are achieved indirectly through the advocacy efforts of clinicians. These include stimulus payments from the federal government to provide parents financial relief and legislation mandating guaranteed paid sick leave for all workers. Employers must have clearly communicated and reasonable expectations for employees responsible for caring for others. In particular, caring for young children will reduce productivity and hours of work will not align with typical “office hours.” Additional funding and support is needed for child welfare agencies and law enforcement, who employ essential workers unable to socially distance during their investigations, placements, and supervision of children needing protection.

For pediatricians and other health care professionals who interact directly with children and families, there is a need to maintain continuity of practice during times of disaster.⁷ While clinicians should discuss best practices to maintain hygiene, respond to school/childcare closures, and discuss COVID-19 with children, the authors urge the inclusion of monitoring risk for violence in the home during these visits. Doing so while following social distancing practices means that conducting many aspects of well visits using telehealth rather than postponing these important points of contact. Flexibility may be required to enable those without internet to participate in telehealth visits. Telehealth limits the ability to assess children or parents in a space in which they have privacy from an abuser, and thus clinicians should be attuned to non-verbal cues or other signs that violence is occurring. Clinicians should continue to report concerns about suspected abuse or neglect to local CPS.

It is likely too early to detect large increases in reports of maltreatment, but because the economic stresses of the pandemic and disruptions of families' usual sources of support will likely extend well beyond the period of "stay at home" orders, the risks of family violence will persist for some time. Recognizing that risk for family violence is high may help increase monitoring of the families being served and provide timely anticipatory guidance (see recommendations in Table 1).

In addition, given the increased risk for trauma exposure, as well as anxiety and grief, during and after this crisis, identifying and managing anger and stress that affect family interactions, screening for posttraumatic stress symptoms, and providing practical resources such as those published by the American Academy of Pediatrics (AAP) and National Child Traumatic Stress Network (NCTSN) are warranted. This role is consistent with the AAP statements regarding the pediatrician's role in supporting the well-being of children and families, particularly during challenging times, and in reducing risk for intimate partner violence and child maltreatment prevention. Overburdened families will experience the highest risks of violence and will require the most support. Systems ordinarily available to them are likely to be compromised but need to remain sensitive and responsive to these needs. This is important as our collective response to COVID-19 through social distancing and isolation may require these efforts for a prolonged period and will be unlike any challenge we have yet encountered.

Table 1. Recommendations for clinicians in their patient interactions and recommendations to make to parents.

Recommendations for clinicians:

1. Make violence potential part of every assessment.
2. Inquire about family stress levels and how parents manage stress.
3. Inquire about the co-parenting relationship.
3. Inquire about social supports available to and being used by the family.
4. Inquire about substance use and any recent increases.
5. Look for signs of stress, irritability, depression in the parent.
6. Look for harsh responses to child behaviors in parents.
7. Look for signs of fearfulness or dysregulation in children.
8. Look for indicators of controlling behaviors by one partner.
9. Identify families who are more at risk for violence based on previous encounters and conduct check-ins if there are no scheduled appointments for them in the near term to reduce the likelihood that otherwise high-risk families would be undetected.

Recommendations to make to parents:

1. Recognize that feelings of stress, anger, worry and irritability are expected given the demands of care of young children, especially if coupled with job demands, income loss, or job uncertainty.
2. Use consistent wake, bed, and mealtimes to provide structure for both children and parents.
3. Consider structuring the day in specific segments, for example, reading, inside/outside playtime, naptime, exercise, screen time, etc.
4. If two parents are home, consider a “tag team” approach to childcare.
5. Understand that increases in children’s challenging behaviors and limit testing are developmentally-typical responses that likely reflect distress and disruptions from typical routines.
6. Identify when feeling activated and use a coping strategy that helps (e.g., deep breaths; considering the things that they are grateful for), and if those don’t help, institute a household “quiet time” for rest.
7. Develop a plan to call a friend or family member in order to avoid engaging in violent behaviors.
8. Use reliable resources for parenting during the COVID-19 pandemic, such as www.healthychildren.org and <https://www.nctsn.org/resources/parent-caregiver-guide-to-helping-families-cope-with-the-coronavirus-disease-2019>.

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