The Father's Hand Print
Facilitator's Guide

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Topic: Physical Abuse

Abstract:
A significant number of children suffer physical abuse by parents and other caregivers. Many children so injured will be seen in offices and emergency rooms for initial treatment. Health care providers should know how to recognize families at risk for child maltreatment, and become familiar with state laws on reporting suspected abuse. Properly trained clinicians can help protect the child and assist families in receiving the treatment and support they need. The case presents the story of Lisa, a 9-month old girl who has been injured, and turns out to be a victim of physical abuse.

Goal:
To provide residents with a basic understanding of the clinician's role in managing possible child physical abuse.

Objectives:
By the end of this session, learners will:
1. Know the signs and symptoms of child physical abuse.
2. Know the legal requirement for reporting *suspected* abuse or neglect.
3. Describe the role of the clinician in management of child abuse.

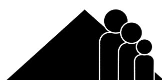
Prerequisite Case: N/A

Related Cases:
"Margaret's Secret" (Sexual Abuse)
"The Silent Cry" (Neglect)
"Jose's New Family" (Atypical Behaviors)

Themes: Child Development and Behavior

Key Words:
Child abuse, mandatory reporting, hematoma, case report, skeletal injuries

Bright Futures Core Concepts:
While all of the Core Concepts are included in each case, this particular case can be used to highlight communication, advocacy, and prevention/health promotion.



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Materials Provided:

- Facilitator's Guide
- 3-part Case Narrative: Part I, Part II, and Epilogue
- Handout #1: Differential Diagnosis of Child Abuse
- Handout #2: Specificity of Skeletal Injuries
- Handout #3: Principles of Effective Brief Interventions
- Bibliography

Facilitator Preparation:

Before the teaching session, facilitators should become familiar with the child protection laws within their own state. Many states have a specific form that providers must complete in cases of suspected abuse or neglect (e.g., "51A" in Massachusetts). It may be helpful to hand out copies of this form during the session and discuss the procedures for notifying state child protective services.

At the end of the guide we have included a section entitled, "**Independent Learning/Prevention Exercises**," that will further stimulate group and individual education on this topic.

Suggested Format for a One Hour Session:

We anticipate that case facilitators will modify implementation of the case session to best fit their educational setting and learners. For detailed recommendations on case facilitation, please see the chapter entitled, "A Brief Guide to Facilitating Case-Discussion," found in *The Case Teaching Method; and Growth in Children and Adolescents* (book 1 of this series).

Introduction: Physical abuse constitutes about 25% of cases reported to child protective service agencies. In the U.S., approximately 11-20% of children suffer "severe" parent-child violence, characterized by parental kicking, biting, punching, hitting with an object, beating, threatening, or using a gun or a knife. *Bright Futures Guidelines* for the nine-month-old visit suggest screening questions that may help identify families at risk for abuse or neglect:

"How are things going in your family?"
"Have there been any major changes or stresses in your family since your last visit?"
"Now that [Lisa] can move on her own more, what changes have you made in your home to insure her safety?"
"How does it feel to have Lisa becoming more independent?"
"What are your thoughts about discipline?"

In addition, pediatricians must be vigilant when examining children, particularly injured children. Physical findings that are not consistent with history should always arouse suspicion. In this case, the findings do match the historical account. Mr. White, however, has unrealistic expectations regarding his daughter's behavior, and does not understand the importance of child-proofing the home.

When a physician who has a prior professional relationship with a family suspects that a child is being abused by the parent(s), conflict may arise between the physician's duty to report the abuse and the parents' desire to keep that concern between the physician and family. Physicians resolve this problem by calling parents' attention to the reporting mandate and by being neutral in their attitudes and supportive of needed interview. Referral of the family to a new primary care physician may be necessary. The problem cannot legally be resolved by failing to report the suspected abuse because this can endanger the child.

Open the Discussion: Introduce the case title and the session goal. Explain that this will be an interactive case discussion and not a lecture. Distribute Part I of the case and ask one or more of the participants to read it aloud.

Part I

Mr. and Mrs. White come to your clinic for the first visit of nine-month old Lisa. They have just moved into your city. Lisa was the product of a normal spontaneous vaginal delivery (NSVD) at 40 weeks gestation, with no prenatal complications. She has had no hospitalizations or surgeries, and is on no medication. She has not yet had her 6-month immunizations. Developmental milestones are appropriate for her age. Her parents state that they have been moving around quite a lot as Mr. White has been looking for steady work. He has just found a job as a salesman for an automotive supply company. He is 20 years old and is attending college at night. Mrs. White is 18 years old and left high school to get married three years ago. They are presently living in an apartment with Mrs. White's sister and her three children.

On physical examination, Lisa is at the 25th percentile for height and weight, and 50th percentile for head circumference. She is an alert, difficult to examine female who clings to her father during most of the exam. The only physical finding of note are echymotic areas on both buttocks that appear to be handprints. When you ask her parent how this happened, Mr. White states quite openly "*We had to give her a little spanking. She's been opening up the cabinet under the kitchen sink even though we told her "NO". We have to teach her what's right. What else could we do?"* When questioned further, the Whites deny any prior physical punishments of Lisa.

Following this reading, ask all participants "*So what do you think about this case? What would you like to focus on during our discussion today*?" List agenda items on a blackboard or flipchart. Then use the questions below to guide the discussion. Remember that the key to successfully leading a small group is facilitation of the discussion rather than lecture. Draw as many participants as possible into the discussion. Allow silences while group members think about questions. Present material from the discussion guide only when needed to complement or redirect the group discussion.

Guiding Questions for Discussion:

<u>Is this child abuse? How do you weigh parent level of education and different regional/cultural child rearing practices in making your decision?</u> These are common and difficult questions, and the answers are seldom clear cut. Physical abuse is defined as inflicted injury to a child and can range from minor bruises or lacerations to severe neurologic trauma and death. Child abuse is relatively easy to diagnose in situations of inflicted injury, but may become more of a judgment call in situations where

the parent was apparently disciplining a child. According to the Diagnostic and Statistical Manual for Primary Care, Child and Adolescent Version (DSM-PC), harsh discipline or improper parenting may be considered a "Quality of Nurture Problem." This phenomenon requires provider intervention in the form of parental guidance, but does not necessarily require a mandated report of physical abuse. In matters of discipline, one may consider the cultural context, but in the end, clinicians should adopt a concept of "reasonableness," (i.e., were these actions those of a reasonable parent?). A spanking might be within the bounds of accepted discipline for some families, but is not reasonable in an infant. Clinicians should also consider whether or not there is a pattern of abusive behavior. In Lisa's case, initial history suggested that the spanking given by Mr. White was an isolated occurrence.

What types of injuries should make one suspect abuse?

- bruises, especially if inconsistent with the proffered explanation (excessive), or in unusual locations
- bruises and welts forming regular patterns, perhaps resembling the shape of the article used to inflict the injury (e.g., hand, belt buckle, electrical cord)
- cigar or cigarette burns, especially on the soles, palms, back, and buttocks
- immersion burns (stocking or glove-like distribution without splash burns on extremities, doughnut-shaped on buttocks or genitals)
- patterned burns resembling an electrical appliance (e.g., iron, burner, grill) or rope burns, particularly on wrist, ankles, neck, torso
- skull, rib, long bone, metaphyseal (corner) fractures (*see Handout #1*)
- abdominal injuries such as intramural hematoma of the duodenum or proximal jejunum, intestinal perforation, splenic rupture, pancreatic injury, abdominal wall bruising
- subdural hematoma (often caused by blunt trauma or violent shaking), subarachnoid hemorrhage, cerebral infarction (secondary to cerebral edema)
- retinal hemorrhages
- a pattern of recurrent injuries, even if each individual event seems to have an adequate explanation

Distribute Handout #1: Differential Diagnosis of Child Abuse, and review the contents.

Are there other studies, consultations, or evaluations indicated? (*See Handout #1*) In making the diagnosis, the clinician must conduct a thorough health assessment, including a history, physical examination (with particular attention to the skin), and developmental assessment. One should also consider laboratory studies (e.g., skeletal survey, bone scan, coagulation studies) which are useful in delineating the nature and extent of current trauma, in defining the presence of previous trauma, and in excluding other medical causes. A skeletal survey is mandatory in children under 2 years who are thought to have been abused and in children less than 1 year who have been severely neglected. Finally, an assessment by a social worker may be indicated to obtain

information about family stressors. There are many factors thought to increase the risk of child abuse:

- Child with disabilities, prematurity, behavioral problems (crying)
- Domestic violence
- Substance abuse
- Parental immaturity
- Parental expectations inconsistent with child development
- Social isolation
- Family stress from illness, poor finances, divorce
- Adult caretakers who themselves were abused as children

What is your plan for follow-up? In this case, the family should return to your clinic within 2-3 weeks, when a social worker can be available to meet with them. In settings where no social worker is available, the clinician should set aside sufficient time for further assessment of family needs. In the interim, a visiting nurse could be assigned to assess their home environment and work on further educating the parents.

Should you file a mandated report to the Department of Social Services? Just about every state jurisdiction requires that a report be filed with the Department of Social Services whenever there is suspected child abuse or neglect. (The clinician must have "reasonable cause to believe" that the child is being abused; "proof" is not required.) Reporters acting in good faith are given immunity from parental lawsuits. When child abuse is suspected, the clinician has several objectives:

- To understand the historical antecedents of the child's injury and to assess the plausibility of the explanation provided. A lack of explanation is particularly worrisome.
- To determine the magnitude of the ongoing risk to the child, guiding the choice between protective or family supportive interventions.
- To form a relationship with the family that fosters and supports their participation in subsequent diagnostic and therapeutic work with other professionals.
- To explain to the family the case report and protective service process - what the clinician and others will be doing to protect the child and to help his or her parents

Whether or nor a report should be filed based on the information in Part I of the case is unclear. Participants should list the pros and cons.

Distribute Part II of the case and have participant(s) read it aloud.

Part II

After discussion with your colleague, you decide not to file a mandated report to the state authorities at this time. Instead, the plan will include:

- Parent education regarding developmental expectations, child-proofing the home, and appropriate disciplinary methods
- Weekly home visits by a nurse to assess child safety
- A follow-up appointment in two weeks with both you and a social worker (none was available today).

Her parents seem genuinely surprised when you tell them that Lisa is too young to understand the danger posed by her "explorations", and agree to install safety latches on all the cabinets. They also agree to try alternatives to spanking, and to cooperate with the remainder of your plan.

The Whites do not keep their scheduled follow-up appointment in two weeks. Since they have no phone, you call the visiting nurse. She tells you that "things looked fine" during the first visit, but the family has not been home for subsequent visits even though she had set appointment times with them in advance. She shares your concern, and agrees to visit them unannounced the next day and insist they bring Lisa back to your clinic right away.

Three days later, Lisa and her mother show up in your clinic. Mrs. White apologizes for missing the appointment and tells you she is worried about Lisa's right leg. "*She woke up this morning crying a lot and won't move it. I don't know what's wrong with her*." Lisa is lying quietly on the examination table. Her right thigh appears larger than the left, and is painful on passive range of motion. An x-ray reveals a midshaft spiral fracture of the right femur. Skeletal survey is positive for periostial new bone formation on the left femur and also on the left proximal tibia. There is no evidence of metabolic bone disease.

Distribute Handout #2: Specificity of Skeletal Injuries.

<u>What is your interpretation of these findings?</u> The nature of Lisa's femur fracture is highly suspicious for abuse, especially as there is no corresponding history of injury and she is not yet walking or capable of climbing up on top of high objects at age 9-months. The presence of other healing fractures is confirmatory (see Handout #2).

<u>What should you do now?</u> An important part of the outpatient assessment is the gathering of information to assess the ongoing risk to the child if she returns home. Is the child or the caretaker who brought the child in at risk for further violence, particularly now that there is an allegation of physical abuse? Will the child, if she is old enough to report abuse herself, be threatened or harassed by family members? In this case, Lisa should be admitted to the hospital directly. She has a serious medical condition (the femur fracture) requiring treatment. In addition, admission to the hospital will give the clinician and other professionals time to assess whether or not it is safe for Lisa to go home.

Distribute Handout #3: A Guide to Brief Interventions.

<u>What will you say to Mrs. White?</u> Parents should always be told when a report of suspected abuse or neglect is made. Clinicians must not avoid this difficult but necessary aspect of management. The "FRAMER" and "ATTUNE" mnemonics summarize the important principles that should guide this process. Have another person present as there is "strength in numbers." In case there is confusion or disagreement later about what was said, you will have someone to back you up. Begin by listing the facts that have led to your concern (the hand prints, fracture, etc.) This should begin as a short monologue, with dialogue to follow later. If interrupted, ask the parent to try to let you finish explaining your observations, and then you will then be happy to listen to their perspective. Tell the parents you would like to work with them; all of you have the child's best interest at heart. When you suspect child abuse, avoid accusation. State your concern about the nature of injury, and that "someone may have abused your child."

Explain that you are obligated to file a report with the Department of Social Services *on behalf of the child*, not *against* the parents. If other professionals are involved, they must all communicate with each other and one person should be designated to act as spokesperson. Do not avoid the family once the child is hospitalized. Keep them informed about what is going on. Acknowledge how difficult this process is for them.

Distribute the Bibliography page and Epilogue. Ask someone to read the Epilogue aloud.

Epilogue

Lisa was admitted to the hospital for her femur fracture. The investigator from the state Department of Social Services (DSS) met with the medical team and family. Both of Lisa's parents denied injuring her, and were unable to explain how the fracture might have happened. As Lisa has had multiple caretakers, including several teenage cousins, no one could establish with certainty how the injuries occurred.

DSS attempted to place Lisa with a family member but could find no suitable relative in your state. Lisa was therefore placed temporarily in a foster home. As part of the DSS service plan, Lisa's mother and father started attending parenting classes and counseling. After two months, Lisa's parents separated and Mr. White moved out of state. Mrs. White disclosed to her family worker that he had struck her on more than one occasion and that she planned to file for divorce. She denied ever seeing him abuse Lisa.

After several more months, Lisa was returned to her mother.

Lisa comes to your clinic for catch-up immunizations and well care. There have been no further injuries.

<u>Optional Learning Exercise:</u> Facilitators may wish to have participants role-play the conversation regarding the suspicion of abuse, with one participant playing the role of the clinician and two others playing the part of Mr. and Mrs. White.**

Refer back to group's learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Independent Learning/Prevention Exercises: Facilitators may wish to assign "Independent Learning/Prevention Exercises" to the group, particularly if time constraints hinder the completion of the case. The following list includes suggestions to explore the available community resources that focus on Child Physical Abuse, as well as other areas of pertinent interest that can be integrated during or after the session. If the exercise is done in the absence of the facilitator, learners should take notes on their experience, then discuss with a faculty member for feedback.

1. Brainstorm/role play with the group: "How and when primary care providers should talk to parents about discipline. How to assess varying cultural views of discipline."
2. Find a parental stress hotline (can be found by facilitator before session) and inquire further about its services.
3. Invite a Department of Social Services (or state child protective services) worker to speak to the group about state services.

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After discussion with your colleague, you decide not to file a mandated report to the state authorities at this time. Instead, the plan will include:

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- weekly home visits by a nurse to assess child safety;
- a follow-up appointment in two weeks with both you and a social worker (none was available today).

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Handout #1: Differential Diagnosis of Child Abuse

Clinical Findings	Differential Diagnosis	Differential Tests
Cutaneous Lesions		
Bruising	Trauma	Rule out other disease
	Hemophilia	Prothrombin time, partial thromboplastin time
	Von Willebrand's disease	Von Willebrand's panel
	Henoch Schonlein purpura	Typical distribution of lesions
	Purpura fulminans	Rule out sepsis
	Ehlers-Danlos syndrome	Hyperextensibility
Local erythema or bullae	Burn	Clinical history and characteristics
	Staphylococcal impetigo	Culture, Gram stain
	Bacterial cellulitis	Culture, Gram stain
	Pyoderma gangrenosum	Culture, Gram stain
	Photosensitivity and phototoxicity reactions	History of sensitizing agent, oral or topical
	Frostbite	Clinical history and characteristics
	Herpes, zoster or simplex	Scraping, Culture
	Epidermolysis bullosa	Skin biopsy
	Contact dermatitis, allergic or irritant	Clinical characteristics
Ocular findings		
Retinal hemorrhage	Shaking or other trauma	
	Bleeding disorder	Coagulation studies
	Neoplasm	
	Resuscitation	History
Conjunctival hemorrhage	Trauma	
	Bacterial or viral conjunctivitis	Culture, Gram stain
	Severe coughing	History
Orbital swelling	Trauma	
	Orbital or periorbital cellulitis	Complete blood count, culture, sinus radiographs
	Metastatic disease	Radiograph, CT scan; CNS examination
	Epidural hematoma	Radiograph, CT scan; CNS examination
Hematuria	Trauma	Rule out other disease
	Urinary tract infection	Culture
	Acute or chronic forms of glomerular injury (e.g., glomerulonephritis)	Renal function tests, biopsy
	Hereditary or familial renal disorders (e.g., familial benign recurrent hematuria)	History
	Other (e.g., vasculitis, thrombosis, neoplasm, anomalies, stones, bacteremia, exercise)	History, cultures, radiologic studies

Clinical Findings	Differential Diagnosis	Differential Tests
Acute abdomen	Trauma	Rule out other disease
	Intrinsic gastrointestinal disease (e.g., peritonitis, obstruction, inflammatory bowel disease, Meckel's diverticulum)	Radiographs, stool tests, and others
	Intrinsic urinary tract disease (infection, stone)	Culture, ultrasound, intravenous pyelogram
	Genital problems (e.g., torsion of spermatic cord, ovarian cyst)	History, physical examination, radiograph, ultrasound, laparoscopy
	Vascular accident, as in sickle cell crisis	Angiography, sickle cell studies
	Other (e.g., mesenteric adenitis, strangulated hernia, anaphylactoid purpura, pulmonary disease, pancreatitis, lead poisoning, diabetes)	As appropriate
Osseous lesions		
Fractures (multiple or in various stages of healing)	Trauma	
	Osteogenesis imperfecta	Radiograph and blue sclerae
	Rickets	Nutritional history
	Birth trauma	Birth history
	Hypophosphatasia	Decreased alkaline phosphatase
	Leukemia	Complete blood count, bone marrow
	Neuroblastoma	Bone marrow, biopsy
	Status after osteomyelitis or septic arthritis	History
	Neurogenic sensory deficit	Physical examination
Metaphyseal lesions, epiphyseal lesions, or both	Trauma	
	Scurvy	Nutritional history
	Menkes syndrome	Decreased copper, decreased ceruloplasmin
	Syphilis	Serology
	"Little League" elbow	History
	Birth trauma	History
Subperiosteal ossification	Trauma	
	Osteogenic malignancy	Radiograph and biopsy
	Syphilis	Serology tests
	Infantile cortical hyperostosis	No metaphyseal irregularity
	Osteoid osteoma	Response to aspirin
	Scurvy	Nutritional history
Sudden infant death syndrome	Unexplained	Autopsy
	Trauma	Autopsy
	Asphyxia (aspiration, nasal obstruction, laryngospasm, sleep apnea)	"Near-miss" history
	Infection (e.g., botulism)	Cultures, bacterial and viral
	Immunodeficiency	Immunoglobulins
	Cardiac arrhythmia	Autopsy
	Hypoadrenalism	Electrolytes, ACTH stimulation test
	Metabolic abnormality	Ca^{++}, Mg^{++}, other
	Hypersensitivity to cow's milk protein	

Adapted from Newberger EH. Child Physical Abuse. Primary Care 1993;20(2):317-27.

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Handout #2: Specificity of Skeletal Injuries as Evidence of Child Abuse

Specific Fractures

Metaphyseal-epiphyseal (<2 years of age)

Thoracic cage	Rib
	Sternum
Shoulder	Scapula
Clavicle	Medial (sternoclavicular)
	Lateral (acromioclavicular)
Spine	Vertebral body (anterior compression)
	Spinous process

Highly suggestive fractures/patterns

Multiple: bilateral, symmetric
Repetitive/different age of fractures
Hands, feet
Skull, complex fracture line
Associated nonskeletal injury; intracranial, visceral

Nonspecific fractures

Diaphyseal (shaft of long bone)
Clavicular, midshaft
Skull, linear

Adapted from Reece RM, editor. Child Abuse: Medical Diagnosis and Management. Malvern, PA: Lea and Febiger, 1994.

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Handout #3: Principles of Effective Brief Interventions

When you suspect abuse:

F Give parents a listing of the **FACTS** that have led to your concern.

R Explain that you are legally **REQUIRED TO REPORT** your concern to child protection authorities on behalf of the child.

A State that a formal **ASSESSMENT** is needed to determine the exact nature of the problem and need for treatment.

M Present a **MENU** of alternatives for evaluation and treatment services.

E **EMPATHY**. Acknowledge how difficult this process is for everyone involved.

R Insist that you receive a **REPORT BACK** from the assessment and insist on open communication with the child protection worker. This will let you know it has been done and help you better care for the child.

While the child is hospitalized:

A **AVOID ACCUSATION**. State your concern about the nature of the injury and that someone may have abused their child

T **TELL THE TRUTH**. Explain that you are obligated to file a report with the child protection authorities on behalf of the child, not *against* the parents.

T **TEAM APPROACH**. Tell the parents you would like to work with them; all of you have the child's best interest at heart.

U **UNITED FRONT**. There must be open communication among all professionals, with one designated to act as spokesperson. Avoid splitting.

N **NEWS**. Do not avoid the family. Keep them informed about what is going on.

E **ENSURE SAFETY.** Determine whether or not it is safe to let the child return home.

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Suggested Readings (Annotated):

Jones J, editor. ***A Guide to References and Resources in Child Abuse and Neglect*****. Elk Grove Village, IL: American Academy of Pediatrics; 1994** . This soft cover book produced by the AAP is a comprehensive reference on child physical abuse, sexual abuse, neglect, and factitious illnesses. There are specific sections on topics such as abdominal injuries, head injuries, fractures, etc. Each section includes an annotated bibliography of recently published scientific articles.

Newberger EH. Child physical abuse. ***Primary Care*** **1993;20(2):317-27.** This is a comprehensive review article which covers history, ethical considerations, interviewing guidelines, and diagnosis of child physical abuse. There is a very useful table on differential diagnosis including a guide to laboratory and radiological studies.

Sirotnak AP, Krugman RD. Physical abuse of children. ***Pediatrics in Review*** **1994;15(10):394-9.** October 1994. This article is a concise review of child physical abuse that includes brief tables on diagnosis, social/environmental factors, and suspicious fractures. There are several useful photographs illustrating injuries and a discussion of reporting and management strategies.

Educational Resources on the World Wide Web:

*American Academy of Child and Adolescent Psychiatry—Facts for Families***.** This site provides access to the AACAP's award winning "Facts for Families" pamphlet series on various developmental topics. The Physical Abuse information sheet is #5, "Hidden Bruises."
http://www.aacap.org/publications/pubcat/facts.htm