Child Abuse

A. Knowledge

Incidence: reports vary; approximately 3% of children are abused per annum

Mortality: strongly associated with poverty and unemployment

Evaluating histories presented for abuse

- One caretaker accuses the other caretaker
- Child accuses adult
- Sibling inflicted injury, e.g. spiral femoral fracture in preambulatory child
- Custody battles - effect on history?
- Developmental implications of various injuries e.g., Slapping an infant vs. a teenager

Physical diagnosis of abusive patterns of injury

- Bruises not located over extensor surfaces or bony prominences
- Dating of bruises
- Discrepancy between injury and history proffered in explanation
- Identification of other typical forms of inflicted injury

Laboratory evaluation of injury

- Skeletal survey
- Bone scan: when to use, e.g., in injury less than 72 hours old, bone scan is better at picking up fractures than standard x-ray
- Use of CT vs MRI for diagnosis of cerebral bleeds and other soft tissues trauma

Relation of child abuse to spousal and familial violence

Relation of alcohol and substance abuse

Relation of poverty, stress and social isolation to abuse

Need for developmental stimulation/early intervention

Responsibility of providers to report suspected child abuse and neglect to state social services agencies

B. Skills

Interviewing hostile parents

Ability to remain calm in the face of hostility

Ability to discuss alternative discipline styles in non paternalistic manner

Anticipatory guidance skills, e.g., educate parents to have

appropriate developmental expectations and appropriate disciplinary techniques based on child's developmental level
Understanding intergenerational patterns of abuse/physical discipline
Proper documentation of history and physical exam findings in the chart
Recognizing "pseudo-abuse": practices that may mimic abuse
How to testify in court

C. Attitudes
Ability to deal with physician's own anxiety when child abuse is addressed
Willingness to collaborate with other professionals
Seeing the parents as allies and, perhaps, as victims themselves
Recognizing the effects of racism/classism, sexism and poverty on patients and families
Recognizing society's history of bias in reporting child abuse based on race/class
Understanding parental fears and concerns re: adoption or removal of children from the home

D. Barriers
Societal acceptances of physical chastisement
Legal presumptions of family sanctity
Disagreement about what constitutes child abuse
Cultural variation in acceptance of "abuse" diagnosis
Poverty: results in stress which is strongly associated with abuse
Lack of sufficient funding for programs for abused children
Social service worker burnout

E. Advocacy
Political
Work to increase state support of programs for abused children
by presenting these issues to politicians in power
Legal
Willingly appear in court on behalf of abused children
Consider having input into the formulation of state child abuse
laws
Inservice training of medical professionals
Participation in community activities to educate the public about child abuse

References

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