Family Violence

Intimate Partner Violence,
Child Abuse, and
Their Overlap

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Topics to be discussed

- Intimate Partner Violence (IPV):
  - Definitions, incidence, risk factors
  - Harm to children from IPV
  - IPV → child abuse
  - Screening for IPV
- Child Abuse
  - Definitions, incidence, risk factors
  - Child Physical Abuse
  - Child Sexual Abuse
- Effects of Family Violence
- Protecting children

Intimate Partner Violence

- Definitions:
  - **World Health Organization:** "Any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship"
  - **Centers for Disease Control and Prevention:** "A pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation and intimidation"

Pre-test question

- IPV is most correctly characterized as:
  - a. a sexual predilection or paraphilia
  - b. exerting power and control over another
  - c. sadistic behavior
  - d. punishing another for wrong behavior

What is Intimate Partner Violence?

- One person exhibiting power and control over another
- Takes many forms
  - Physical abuse
  - Sexual abuse
  - Intimidation, coercion, threats
  - Emotional abuse
  - Economic abuse
  - Social isolation

Pre-test question

- IPV victims can include:
  - a. male victims of female perpetrators
  - b. males or females in homosexual relationships
  - c. adolescents
  - d. all the above

Scope of the Issue

- Between 10% and 69% of women worldwide report being physically assaulted by an intimate partner at some point in their lives

World Health Organization 2008

- An estimated 1.5 million women and 830,000 men are physically or sexually abused by an intimate partner annually in the United States

National Violence Against Women Survey 2000

- In 2004, IPV resulted in over 1500 deaths in the United States, 75% of whom were women

Scope of the Issue

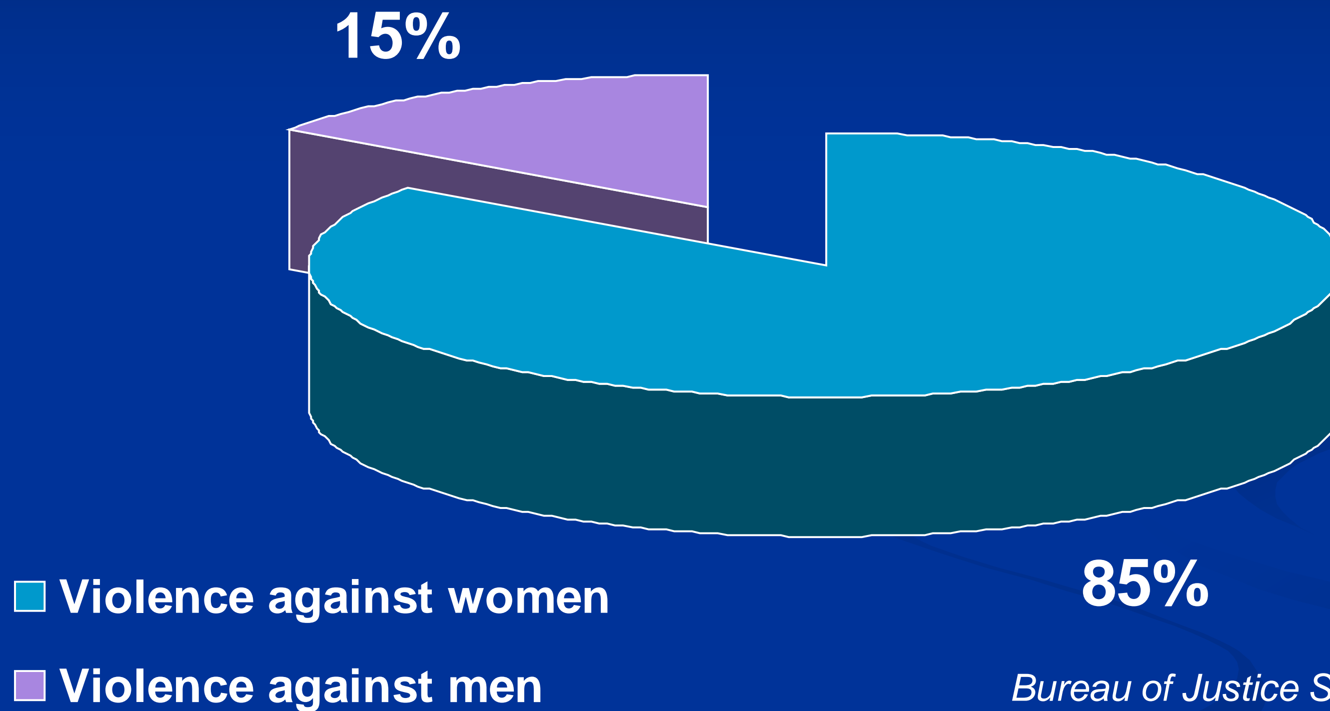
- When one considers emotional and psychological abuse, it is estimated that one in three women worldwide will be abused in her lifetime

Population Reports 1999

- 22% lifetime prevalence of intimate partner violence for females; 8% for males

National Violence Against Women Survey 2000

IPV Epidemiology



Bureau of Justice Statistics 2001

IPV Epidemiology

- Same-Gender Partners:
  - Prevalence of approximately 25-35%

Gunther 1999

  - Similar types of violence reported

McClennen 2005

- Adolescent Population:
  - Approximately one in three adolescent girls in the United States is a victim of physical, emotional or verbal abuse from a dating partner

Davis 2008

  - Two in five "tweens" (ages 11 and 12) report that their friends are victims of verbal abuse in relationships

Tween and Teen Dating Violence and Abuse Study 2008

- *Individual*
  - History of family violence during childhood
  - Mental health issues
  - Substance abuse
- *Relational*
  - Conflict, instability, discord
  - Stressors (Financial, job, child-rearing)

IPV Risk Factors cont'd

- *Community*
  - Poorly equipped to respond to the issue
  - "Refusing to take a stand"
- *Societal*
  - Devalue the independence of women
  - Promotion of violence as a means of conflict resolution

Pre-test question

- Children living in homes with IPV are at risk of harm due to all the following except:
  - a. police involvement
  - b. direct physical trauma during IPV
  - c. long-term trauma from witnessing IPV
  - d. child physical abuse

IPV and the Child

- "The abuse of women is a pediatric issue"

  American Academy of Pediatrics 1998
- Millions of children are exposed to IPV every year
- Children who grow up in homes with IPV are at increased risk of harm:
  - As a *victim* of the abuse
  - As a *witness* to the abuse

The Child as a Victim of IPV

- Pregnancy issues:
  - Increases a woman's risk of being abused
  - Abuse often begins or accelerates during pregnancy
  - Up to 20% of pregnant women are abused by an intimate partner

Sharps 2007

The Child as a Victim of IPV

- Indirect fetal risks:
  - Pyelonephritis
  - Chorioamnionitis
  - Higher HIV risk
  - Less prenatal care
  - Maternal polysubstance use

Chambliss 2008
Cokkinides 1999

The Child as a Victim of IPV

- Direct fetal risks:
  - Preterm labor
  - Preterm delivery
  - Low birth weight
  - Uterine rupture/Placental abruption
  - Intracranial injury
  - Neonatal death, including elective abortion

El Kady 2005
Neggers 2004
Stephens 1997

The Child as a Victim of IPV

- Injury to a child in the act of IPV may not be a purposeful act against the child:
  - Infant being held in mother's arms while she is abused
  - Young children are often unable to get out of harm's way
  - Older children/adolescents may be harmed trying to protect the abused caregiver

Case example 1

- 5-year-old girl's parents in a fight
- Police called, mother and children taken to police station to file report
- Child goes to restroom and urinates blood
- Ambulance takes child to hospital
- Child admitted to Pediatric ICU

Case example 1

- Father tried to punch…mother? Child?
- Struck child's flank
- Kidney fracture
- Needed surgical procedure, several day stay in PICU
- Mother initially protective
- 8-year-old brother blamed child for father's removal from home

Case example 2

- 13-month-old boy presents to ED after a shelf broke and a small glass bottle fell on his head while he walked under it
- Projectile vomiting in ED, then became unconscious
- Emergency CT done

Case example 2

- Injuries: abrasions to scalp, large acute subdural hemorrhage, brain bruise
- Scene investigation
  - Shelf in trash
  - No holes in walls
  - No glass on floor
  - Unusual family arrangement
- Interview with other kids: IPV between 2 adults in the home led to injury

Risk of exposure for infants

- Impact on brain development
- Increased irritability, increased crying, poor health

Davidson 1978
Alessi 1984

- Lack of responsiveness to adults, poor eating, poor sleeping habits

Layzer 1986

- Increased emotional arousal

Cummings 1981

Risk of exposure for school-age children

- Internalizing behaviors:
  - Anxiety
  - Depression
  - Withdrawal
  - Somatic complaints
- Externalizing behaviors:
  - Attention problems
  - Aggressive behavior
  - Rule-breaking actions

McFarlane 2003
Hazen 2006

Risk of exposure for school-age children

- Social functioning difficulties
- Aggressive with peers
- Bullying
- Poor academic performance
- Long-standing stress/anxiety

Jaffe 1986

- Propensity to continue the cycle of violence

Kaufman 1987

The Child as a Witness to IPV

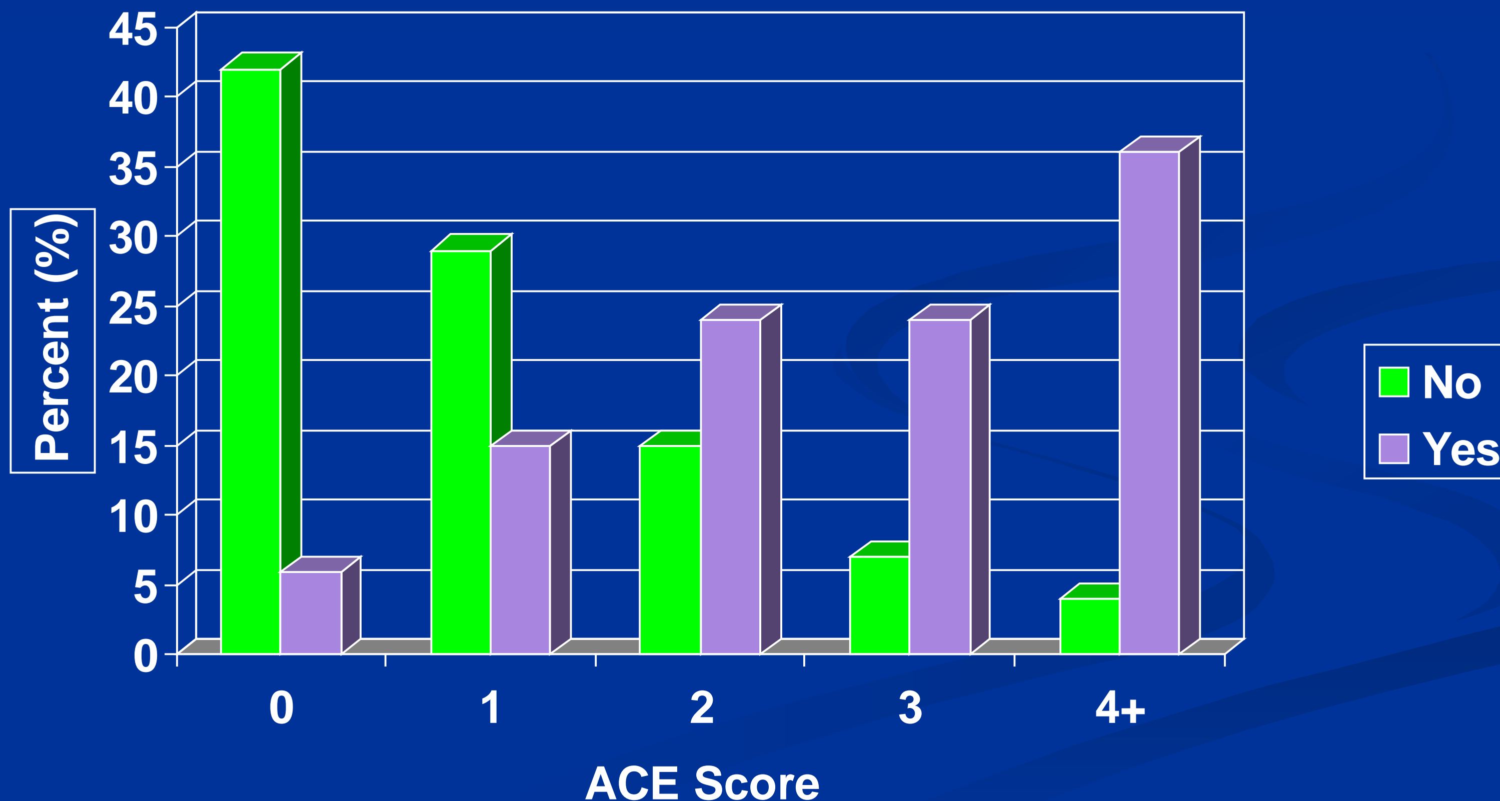
- Adverse Childhood Experiences (ACE) Study:
  - Self-report of adults in Kaiser Permanente health plan
  - Response rate 68%: 9000 women, 8000 men
  - Mean age 55 +/- 15 yrs

Felitti 1998

The Child as a Witness to IPV

- ACE definitions:
  - Verbal abuse
  - Physical abuse
  - Sexual abuse
  - Emotional neglect
  - Physical neglect
  - Household substance abuse
  - Mental illness in household
  - Parental separation or divorce
  - Incarcerated household members
  - *Witness domestic violence*

The Child as a Witness to IPV



The Child as a Witness to IPV

Adults exposed to IPV as a child

	OR	95% CI
Emotional abuse	6.0	4.9-7.2
Substance abuse	5.6	4.9-6.3
Physical neglect	4.9	3.9-6.1
Physical abuse	4.8	4.2-5.5
Sexual abuse	2.6	2.3-2.9
Incarcerated household member	3.3	2.6-4.2
Parental divorce	3.9	3.4-4.4

Dube 2002

The Child as a Witness to IPV

- Persons who had experienced four or more ACE exposures had:
  - 4-12 fold increased health risk for
    - Alcoholism
    - Drug abuse
    - Depression
    - Suicide attempts
  - 2-4 fold increased health risk for
    - Smoking
    - > 50 sexual partners and STI
  - 1.4-1.6 fold increased risk for
    - Physical inactivity and severe obesity

The Child as a Witness to IPV

- The number of ACE exposures showed a graded relationship to the presence of:
  - Ischemic heart disease
  - Cancer
  - Chronic lung disease
  - Skeletal fractures
  - Liver disease

IPV Exposure and Health Outcomes

- As the frequency of witnessing IPV as a child increased, so too did:
  - Self-reported alcoholism
  - Illicit drug use
  - IV drug use
  - Depressed affect

The Child as a Victim of IPV

- Co-occurrence of child abuse and IPV:
  - In 30 to 60% of families where one is occurring, the other will be found.

Edelson 1999

  - If IPV present in the home:
    - Physical child abuse 3.4 times more likely
    - Child psychological abuse 2.0 times more likely
    - Child neglect 2.0 times more likely

McGuigan 2001

The Child as a Victim of IPV

- In homes of abused children:
  - 45% prevalence of physical violence against the caregiver within her lifetime
  - 29% of caregivers had one or more incidents of abuse within the last year

Hazen 2004

- IPV often *precedes* child maltreatment!

Pre-test question: screening

- Screening for IPV
  - a. is universally accepted as a necessary thing
  - b. will identify the vast majority of victims of IPV
  - c. can be considered a means of primary prevention of child abuse
  - d. cannot be used with adolescents or homosexuals

So maybe, screening for IPV may help prevent some child abuse

Not so fast, though…

Definitions

- Screening
  - The application of an instrument or tool to a set group of patients regardless of their reasons for seeking medical care
- Case-finding
  - The application of an instrument or tool to a group of patients with specific signs, symptoms or risk indicators

Screening

1. Does screening identify the target condition?
2. Does the treatment lead to favorable outcome?
3. Does screening do more good than harm?

Identifying the target population

How does IPV present?

- Overt physical injuries are rare
  - Injuries may be covered by clothing
  - Injuries may be purposely masked by the patient
- Recognize that women who are victims of IPV may not seek medical care for themselves, but rather will present with their children
- Subtle signs are much more common!

Subtle signs of IPV

- Depression
- Anxiety
- Failure to keep appointments
- Reluctance to answer questions about home
- Frequent complaints not borne out by evaluation
- Presence of controlling partner

IPV Screening Efficacy

Publication	*Population Screened*	*Number Participating*	*Survey Instrument*	*Overall IPV rates*
Bradley 2002 *British Medical Journal*	Women attending a general practice	1692	Survey developed by Dobash et al	39% 95% CI 36-41%
Duffy 1998 *Pediatrics*	Mothers seeking care for their children in an emergency department	157	Modified Abuse Assessment Screen	52% CI not reported
Parkinson 2001 *Pediatrics*	Mothers of children seen for well-child visit	553	Questions recommended by the AMA	16.5% 95% CI 14-20%
Richardson 2002 *British Medical Journal*	Women attending a general practice	1035	Unspecified	41% 95% CI 38-44%
Siegel 1999 *Pediatrics*	Mothers of children seen for well-child visit	154	Questions recommended by the AMA	31% CI not reported

Barriers to IPV Assessment

- Insufficient training/education
- Insufficient time
- Lack of appropriate resources
- Fear of offending/angering the caregiver
- Belief that IPV is not an issue in their patient population

Individual Barriers to Seeking Help

- Low self-esteem, guilt, self-blame
- Fear of reprisal
- Children
  - Need to keep family together
  - Importance of a paternal figure
  - Disruption of the children's lives
  - Fear of CPS involvement and possible loss of custody

More Individual Barriers to Seeking Help

- Gender considerations:
  - Males ashamed to disclose abuse by a female
- Same-sex relationships:
  - "Double-closeted…conspiracy of silence"

McClennen 2005

- Failure to recognize violence as a problem
- Conflicting emotional states
  - Love for the perpetrator
  - Hope for change
- Practical concerns
  - Unemployment
  - Financial dependence
  - Current lifestyle
  - Social isolation

Societal/Cultural Barriers to Seeking Help

- Language barriers
  - Primary language
  - Cognitive or communication disorders
- Cultural barriers
- Consequences related to immigration status
- Lack of community openness
- Lack of perceived or actual community support
- Stigma associated with shelter living
- Invalidation by peers and family

- Belief that legal system is not helpful
- Lack of health care provider understanding
- Lack of health care provider knowledge
- Cost of medical care
- Fear of CPS reporting

Efficacy of Intervention?

What services are available?

- Primary care counseling
- Referral to shelters
- Referral to personal/vocational counseling
- Batterer intervention
- Structured advocacy services
  - Sullivan 1992:
    - Women followed longitudinally
    - Increased quality of life
    - Decreased rates of abuse (lost at 3-year study)

- *None of these are particularly targeted for children*

Efficacy of Intervention?

"There is a lack of good evidence to guide clinical decision-making, and no studies have linked screening to treatment intervention in a way that allows us to determine whether routine screening for violence against women does more good than harm."

MacMillan JAMC 2003

**Also review: Wathen JAMA 2003*

Potential Harms of Screening?

Is there a risk of "reprisal violence?"

- Post-shelter use
- Children services reporting
- Escalation of emotion

U.S. Preventative Services Task Force

- 2004 recommendation on IPV screening:

  "Insufficient evidence to recommend for or against routine screening of…women for intimate partner violence…"

- Similar to findings of Canadian Task Force on Preventive Health Care

IPV Screening Tools

- Partner Violence Screen (3 items)

Feldhaus, JAMA 1997

- American Medical Association (4 items)

AMA 1992

- Abuse Assessment Screen (5 items)

McFarlane, JAMA 1992

- Woman Abuse Screening Tool (8 items)

Lent, J Fam Pract 2000

- Composite Abuse Scale (30 items)

Hegarty, J Fam Violence 1999

IPV Screening Rates

Publication	*Population Screened*	*Overall Assessment Rates*
Bair-Merritt 2004 *Ambulatory Pediatrics*	Pediatric chief residents	21%
Borowsky 2002 *Pediatrics*	Practicing family and pediatric physicians	8% and 5% respectively
Elliott 2002 *J Gen Intern Med*	National sample of 2400 physicians	10%
Sugg 1999 *Arch Fam Med*	Primary care clinic provider teams	<20% asking consistently
Thackeray 2007 Submitted to *Child Abuse and Neglect*	Child advocacy centers	29%

How Best to Assess for IPV?

- Verbally administered assessments

- Self-administered assessments
  - Computerized survey
  - Written survey

➢ Poorer detection rates

McFarlane 1991
Norton 1995
Freund 1996
Collins 1999

➢ Less patient comfort

Anderst 2004
Bair-Merritt 2006
Thackeray 2007

How Best to Assess for IPV?

- MacMillan *JAMA* 2006:
  - Randomized controlled study of three IPV screening techniques:
    - Computerized
    - Face-to-Face
    - Written
  - Nearly 2500 participants asked to rate screening techniques on:
    - Ease
    - Preference
    - Privacy
  - Face-to-face screening scored lowest in all three domains

To Screen or Not to Screen?

- Clinicians should:
  - Maintain a degree of awareness about the issue of IPV
  - Be mindful of clinical presentations that suggest risk
  - Be aware of the effects of IPV on the child, and consider incorporating questions regarding family violence into anticipatory guidance

Reporting Child Victims

- What constitutes a child witness?
  - A child is a witness to domestic violence when an act that is defined as domestic violence is committed in the presence of or witnessed by the child (5 states)
  - A child who is physically present or can see/hear the violent act (14 states)
  - A child who is in the "vicinity" – within 30 feet or the same residential unit, regardless of whether the child is actually present (1 state)

Child Information Welfare Gateway

Reporting IPV

- Adult victims
- Child witnesses

Reporting Child Victims

- As of July 2007, approximately 20 states addressed, in statute, the issue of children who witness IPV in the home.

Child Information Welfare Gateway

Reporting Child Victims

- Does it matter who the child is?
  - Child must be related to the victim or the perpetrator (10 states)
  - Laws apply to any child present (10 states)
  - Law applies only to the noncustodial child of a noncustodial parent (1 state)

Child Information Welfare Gateway

Reporting Child Victims

- When is witnessing IPV harmful to the child?
  - Does a child sitting on the lap of his mother during a violent episode have the same experience as a child upstairs playing in the bedroom?
  - Is there a threshold of exposure that causes harm?

Zink 2004

Reporting Child Victims

- What is the capacity of CPS to serve children who witness IPV?
  - Budgetary and staffing constraints
  - Minnesota experience
  - What options are available to offer parents?
    - Respite care
    - Education and support groups
    - Home visitation programs

Zink 2004

Reporting Adult Victims

- Does mandatory reporting of failure to protect further victimize the mother/victim?
  - Many researchers do not support removing children in these situations
  - Is removal:
    - Helping the child?
    - Punishing the batterer?
    - Being used inappropriately against victims?

Zink 2004

Reporting Adult Victims

- Guidelines for juvenile and family court judges advise that:

  "It is particularly short-sighted to remove children from the care of their battered mothers without first trying to remove or change the source of the domestic violence risk, the batterers."

Schechter 1999

Reporting Adult Victims

- How does mandatory reporting of the child who witnesses IPV affect the mother/victim's disclosure of IPV?
  - Many women recognize the impact of IPV on their children
  - Does mandatory reporting prevent mothers from disclosing?

Zink 2004

A Therapeutic Approach

- Knowledge of community resources
  - AMA/state medical associations
  - 1-800-799-SAFE
  - www.endabuse.org
  - AAP's Connected Kids program
- Knowledge of existing state laws
- Safety planning
- Development of protocol/action plan

Conclusions

- Intimate partner violence is not just a violent act against a caregiver – it should be considered a direct risk to a child's health
- Intimate partner violence often precedes child maltreatment and identification of the former may prevent the latter

Conclusions

- Although evidence is limited regarding IPV screening, it seems reasonable to do so given the risks to a child's health and development
- Whenever possible, self-administered assessments should be used as a screening tool

The Child as a Victim of IPV

- Co-occurrence of child abuse and IPV:
  - In 30 to 60% of families where one is occurring, the other will be found.

Edelson 1999

  - If IPV present in the home:
    - Physical child abuse 3.4 times more likely
    - Child psychological abuse 2.0 times more likely
    - Child neglect 2.0 times more likely

McGuigan 2001

Pre-test question

- What is the most common type of child maltreatment?
  - a. Neglect
  - b. Emotional abuse
  - c. Sexual abuse
  - d. Physical abuse

Child Maltreatment

- Centers for Disease Control and Prevention (CDC) define child maltreatment as:

any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child

Risk Factors

- Child
- Parent
- Family
- Community

Risk factors: the child

- Disability
  - Physical ailments/illness – require more care
  - Mental retardation, autism, etc.
- Difficult “temperament” or behavior

Risk factors: the parent

- Substance abuse
- Depression
- Other mental illness
- Poor coping ability
- Limited intelligence
- Impulsivity
- Poor anger control
- History of having been maltreated

Risk factors: the family

- Intimate partner violence
- Poverty
- Single parent
- Multiple children
- Stress
- Lack of health insurance
- Inadequate food
- Lack of support

Risk factors: the community

- Poverty
- Crime
- Violence
- Substance abuse
- Social isolation
- Lack of supports
- Parental “control” issues

Protective Factors

- Child
- Family
- Community

Protective factors: the child

- Good health
- Normal development
- Above-average intelligence
- Hobbies and interests
- Good peer relationships
- Personality factors
  - Positive disposition and self-esteem, good social skills, internal locus of control, etc.

Protective factors: the family

- Secure attachment
- Supportive family environment
- Parental rules/structure
- Extended family support & involvement
- Parents with good coping skills
- Family expectations of pro-social behavior
- High parental education
- Mid- to high-SES
- Religious faith participation

Protective factors: the community

- Access to health care & social services
- Consistent employment available
- Adequate housing
- Good schools
- Supportive adults outside of the family

Child Neglect: Definition

- Helfer, Dubowitz:
  - "a condition in which a child's basic needs are not met, regardless of cause"
- Acts of omissions
- By those responsible for child's health and well-being
- Actual and potential harm
  - Laws: clear and identifiable harm or injury

Failure to meet needs…

- Food
- Clothing
- Shelter
- Health care
- Education
- Supervision, safe-keeping, and protection
- Nurturance

Incidence of Neglect

- >50% of CPS substantiated cases
- Physical neglect is most common
- Nearly half of child fatalities due to maltreatment are from some form of neglect
- Case-definition and labeling are a problem

Child Physical Abuse

- An act committed by a caregiver that results in a child being injured or harmed
- Clinical definition broader than legal definition
- States have varying definitions
- Fine line between corporal punishment and child physical abuse

Evaluating the injured child

MOST IMPORTANT POINT:

ANY child can be abused

ANY injury can be abusive

Irrelevant facts

- Race / Ethnicity
- Marital status
- Religion / church attendance
- Housing
- Socio-economic class
- Interpersonal interactions
  - Listen to bad vibes
  - IGNORE the absence of bad vibes

Injury characteristics: Physical abuse RED FLAGS

- No history provided
- Changing history
- History inconsistent with exam findings
  - Implausible (laws of physics)
  - Injury too severe
  - >1 organ system involved
  - Injuries in various stages of healing

RED FLAGS cont'd

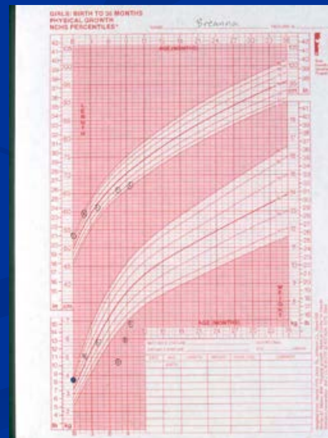
- History developmentally impossible
- Delay in seeking medical care
- History not corroborated
- Previous abusive / concerning injuries
- Remember, ANY injury may be abusive, even without red flags

A good History includes…

- Exact details of the injury incident
- Precipitating event
- Child’s response to injury
- Caregiver’s response to injury
- Others in the home/with access to child
- History from child, if possible

Important Past Medical History

- Primary Care Physician
- Growth, immunization status
- Previous injuries
- Detailed developmental history and current abilities
- Parental perception of child

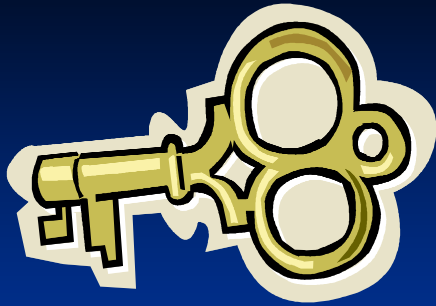


A good Physical includes…

- Growth parameters, plotted correctly on the growth chart
- Exact description of injuries, with measurements/diagrams/photos
- Close look at scalp, ears, frenula, palate, all skin
- Eye exam
- Neurologic exam
- Palpate bones
- Anogenital exam

X-rays

- Skeletal survey
  - For children <2 years if concerned about abuse
  - Must be done according to standards
    - NO BABYGRAMS
    - Obtain additional views if concerned
  - Skeletal surveys in older kids rarely needed - depends on the specifics
- Site-specific x-rays as indicated



The Key:

DOCUMENT,
DOCUMENT,
DOCUMENT!

Bruises

Pre-test question: bruises

- A 3-month-old baby has a small bruise to the face. The parents, who have no history with child welfare or law enforcement, state that the child rolled over onto a toy in his crib. An intern calls in a referral to child welfare (or law enforcement) alleging possible abuse. The correct course of action is to:
  - a. perform a complete investigation including interviews with each parent and home assessment, as well as make sure child receives a skeletal survey.
  - b. reassure the intern that this is not abuse based on the lack of history with the family and the minor nature of the injury.
  - c. reassure the intern that this is not abuse because the history matches the injury.
  - d. perform a screening assessment and close out the case when nothing unusual turns up.

Pre-test question: bruises

- A 15-month-old toddler has multiple bruises on his forehead, shins, abdomen, and buttocks. They are of different sizes and colors, with some being purple, some green, some brown, and some yellow. A medical provider provides you with ages for each of the bruises, stating that some are 2 days old, some are 4, and some are 7 days old. Your correct course of action is to:
  - a. determine who the child's caretakers were on each of the days in question, then interview each about the specific injuries.
  - b. place the child in protective custody due to concerns about repeated abuse.
  - c. arrest the child's parents due to the repeated abuse suffered by the child and failure to protect from repeated abuse.
  - d. ask for another medical opinion from a different clinician.

Bruises

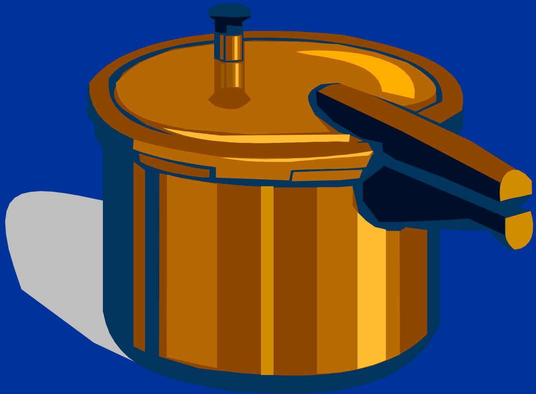
- "Kids who don't cruise don't bruise"
- Abdominal bruises on any child are suspicious
- Dating of bruises is imprecise!
- Progression:

  Red → blue → green → yellow → brown
- Don't try to estimate age, just describe!

Be concerned if…

- Child not yet cruising
- Bruises in abnormal location
- Pattern marks visible
- Multiple different ages

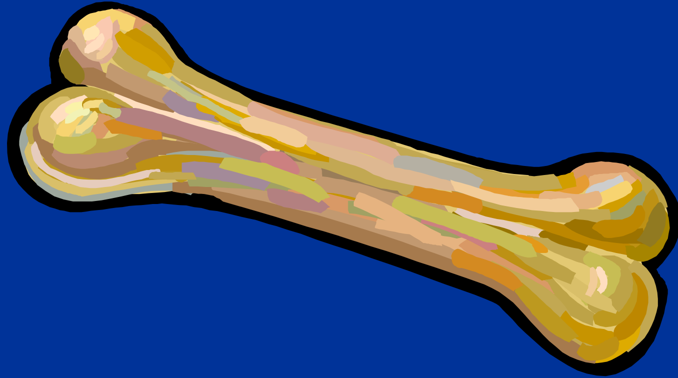
Burns



Burns

- Beware of "the sibling did it"
- Delay in seeking care is common
- Burns change in appearance *quickly*
- Look for pattern marks, symmetry, unusual location
- Is developmental ability consistent?
- What happened before and after the burn?
- Consider NEGLECT as contributing factor

Fractures



Pre-test question: fractures

- Which fracture is always due to abuse?
  - a. transverse fracture of the humerus
  - b. oblique fracture of the humerus
  - c. spiral fracture of the humerus
  - d. none of the above

Fractures

- Any fracture can be caused by abuse!
- Need to correlate with mechanism of injury
- Spiral fracture: means torsion
  - Spiral fracture ≠ abuse necessarily!
  - Non-spiral fracture ≠ accident necessarily!
- The absence of bruising does NOT rule out abuse

Fractures

- Myth: all spiral fractures are abuse
- Fact: some spiral fractures are abuse, some are not – just means torsion
- Myth: all abusive long-bone fractures are spiral
- Fact: abusive fractures can be any type
- Myth: CPR causes rib fxs in babies
- Fact: CPR almost never causes rib fxs

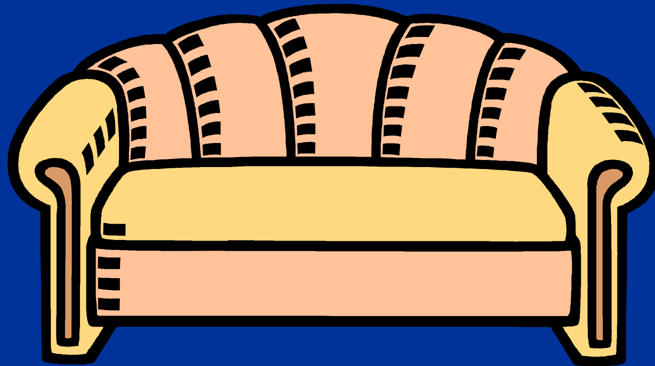
Abdominal Injuries

- Can present late – child already dying or dead
- Abdominal bruising may be indicator of underlying injury
- Any abdominal organ can be injured, esp:
  - Liver
  - Small intestine
  - Pancreas

Symptoms and Signs

- May be subtle, initially
- Abdominal pain, vomiting, shock, lethargy, death
- Time depends on which organ is injured
  - Liver - > bleeding
  - Intestine - > infection

Head Injuries



Components of AHT

- **Head injury -** neurologic injury
- subdural hematoma or other intracranial bleeds or injury
- Retinal hemorrhages
- Associated fractures
- Few, if any, external physical findings

AHT: Clinical Presentation

- Often non-specific
  - Vomiting
  - Irritable
  - Poor feeding
  - Low grade fever
- Altered mental status
- Seizures
- Apnea

AHT: Mechanism of Injury

- Impact injury – soft or hard surfaces
- Infants are uniquely susceptible to shaking injury
  - Relatively large heads
  - Relatively weak neck muscles

Neurological Outcomes

- 12-25% mortality
- 22-30% normal
- 50% with variable levels of cognitive or neurologic impairment
- Can't always tell right away!

Important points about AHT

- Short falls only cause major injuries in *very* unusual circumstances
- The subdural hematoma of a shaken baby is NOT the primary injury - the injury to the neurons is
- There are many causes of retinal hem; some RH are non-specific
- Clinicians won't diagnose it unless they think of it! (non-specific symptoms are common)

AHT

- In one study:
  - 31% of children with AHT were not diagnosed at first presentation
  - 27% of those were re-injured
  - 40% had medical complications
- In another study:
  - 45% of AHT kids had evidence of prior injury; no accidental TBI kids did

Sexual Abuse

Pre-test question: Sexual abuse

- A 6-year-old girl has disclosed sexual abuse by her mother's boyfriend. She told her father that he had been rubbing her genitalia on top of her clothes. She told a forensic interviewer that for the last 6 months he has been putting his finger in her vagina and it hurts. A medical examination reveals that the child has a normal hymen. Your correct course of action is to:
  - a. ask the family if the child has a history of lying or of discord with the mother's boyfriend.
  - b. tell the family that the child must have made up the allegations because her hymen is normal.
  - c. tell the family that the child must have made up the allegation because her disclosure changed.
  - d. schedule an interview with the boyfriend and tell the family to keep the child away from him while you continue to investigate.

How common?

- ? 1% of children experience some form of sexual abuse each year.
- By 18 years of age:
  - 12-25% of girls
  - 8-10% of boys

AAP Clinical Report, *The Evaluation of Sexual Abuse in Children, Pediatrics*, August 2005

How common really?

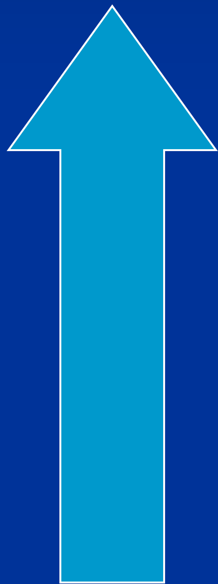
- Who knows?
- Highly under reported
- Secretive, hidden offense
- Disclosure without appropriate intervention
- Children's fear of disclosure
  - Fear of perpetrator's threats
  - Embarrassment / shame
  - Concern for disrupting the family or for perpetrator

Perpetrators

- Usually a relative or friend
- Rarely an attack by a stranger
- Build trust over time (grooming)
- Hold position of trust or authority
- Mostly male (90%)
- <u>20% adolescent perpetrators!</u>

Evidence in SAb Cases

Most common



Least common

1. Behavioral changes
2. Disclosure
3. Physical exam findings
4. Pregnancy, witnesses, semen, etc.

Least specific

Most specific*

Behavioral changes

- Regression – bed wetting, thumb sucking
- Clingy Behavior – return of separation anxiety
- Sleep Disturbances – nightmares, inability to sleep alone
- Change in Appetite
- School Problems – declining performance, attention problems

Behavioral changes, cont'd

- Social Problems
  - aggression / anger with peers or family members
  - Sexualized play inappropriate for age
- Substance Abuse
- Psychiatric
  - Depression
  - Suicidal Ideation or Gestures
  - Self-injurious Behavior

Behavioral changes, cont'd

- Important to distinguish developmentally appropriate from precocious behavior
- Classic example – masturbation
  - Often normal behavior
  - Can appear at 12-18 months
  - Concern when it occurs in excess (?)
  - Usually manual stimulation, concern with use of foreign objects
  - Some, but <u>certainly not all</u>, children who masturbate are victims of sexual abuse.

Sexualized behavior

- Developmentally precocious and <u>concerning</u> behaviors include the following:
  - Attempts at intercourse or simulated intercourse
  - Putting mouth on other's genitals
  - Asking others to participate or perform sex acts
  - Elements of force
- May be alternative explanation, though
  - Porn on internet or TV
  - Inappropriate exposure to sexual activity

Disclosure

- Disclosure is a *process*, not an *event*
  - Rarely does complete disclosure come out all at once
  - “Change” in statements may not indicate lack of credibility
  - Don’t discard disclosures with fantasy elements
- Minimize interviews
- Allow free narrative format
- Keep child’s age and development in mind

Physical exam findings

- Myth: If a girl has been abused, her hymen will be torn/gone
- Fact: >90% of abused girls have NORMAL exams
  - Corollary: a normal exam tells you *nothing* about abuse

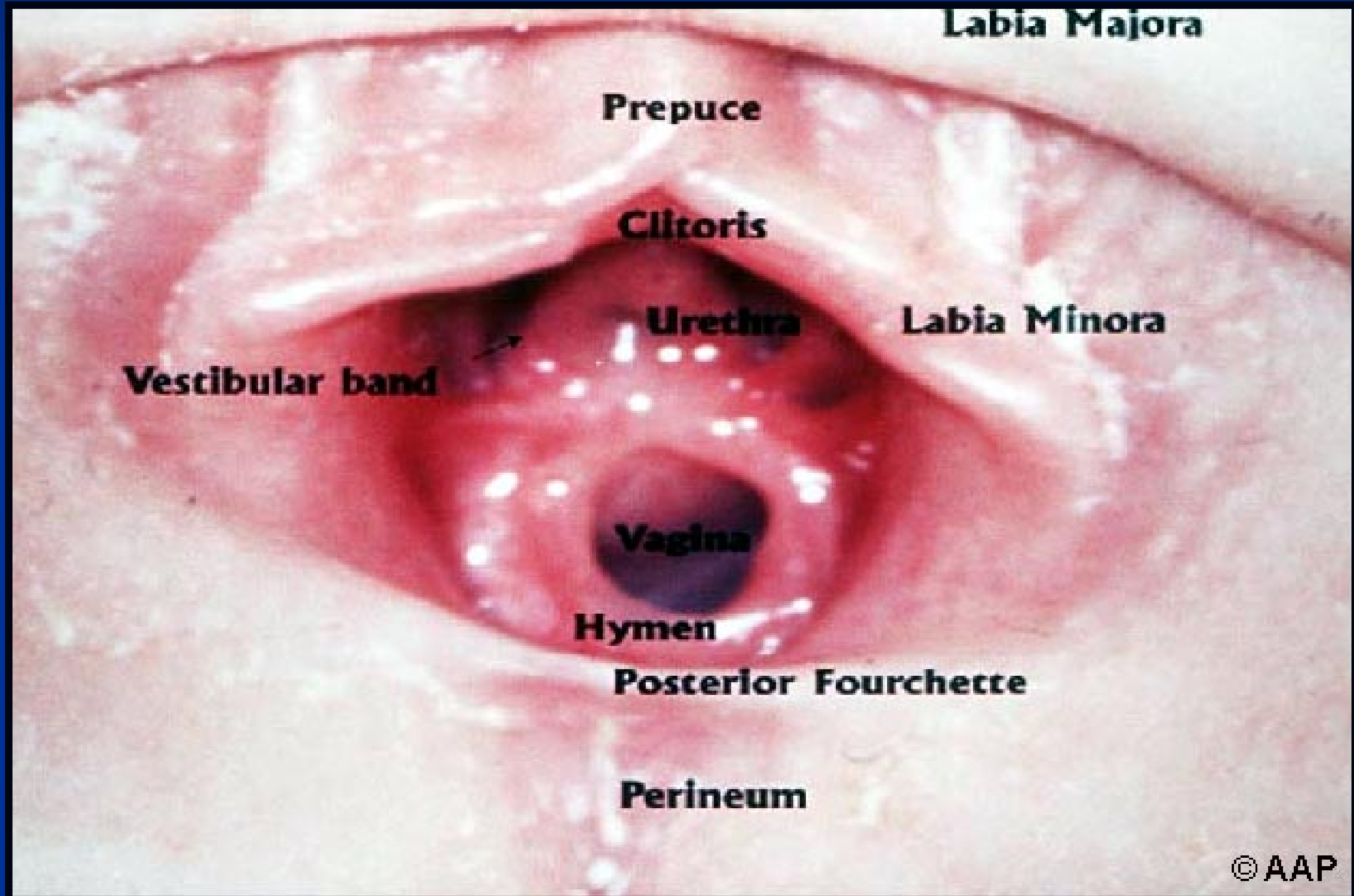
Physical findings

- Myth: All SAb kids need a SANE exam (rape kit)
- Fact: SANE exams are only for acute (<72 hours) cases
  - Corollary: most cases are not emergencies and the exam can wait

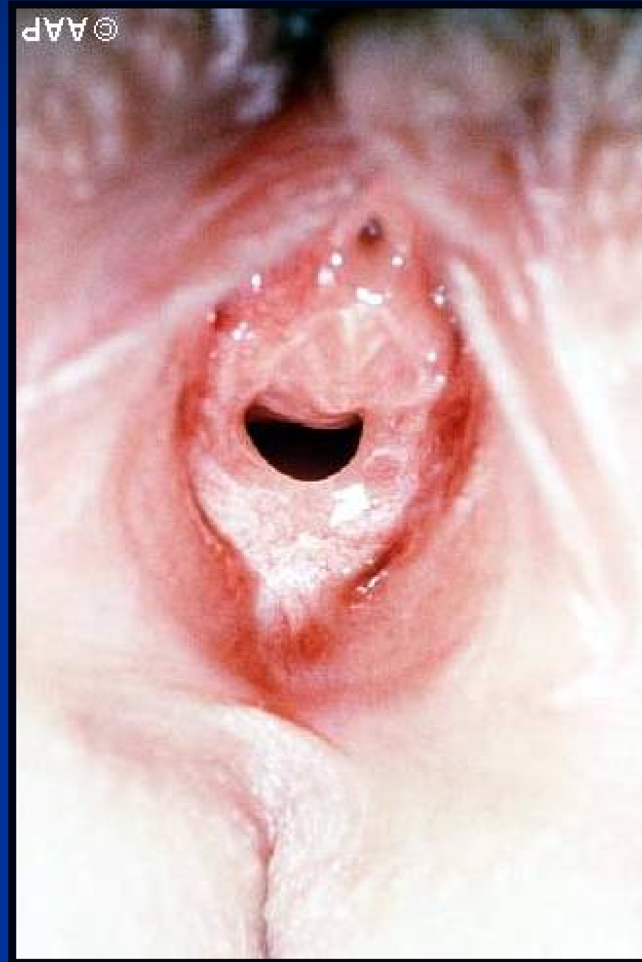
Physical findings

- Exams are best done *not* in the ED
- Purpose of exam:
  - Injuries
  - Evidence
  - STDs
  - Normality
- Clinicians need to know normal anatomy
- Don't underestimate the elasticity of the anogenital area

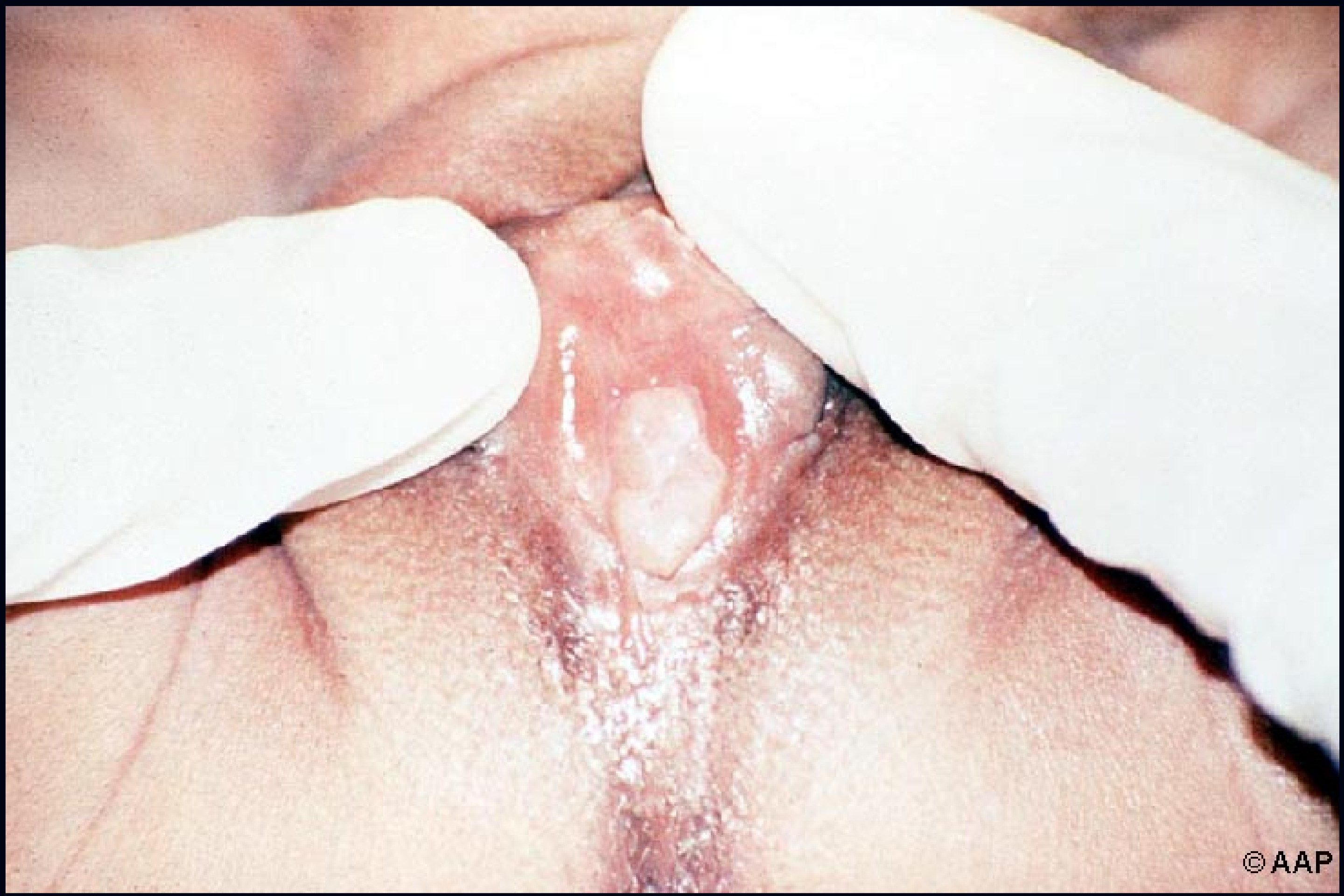
Anatomy



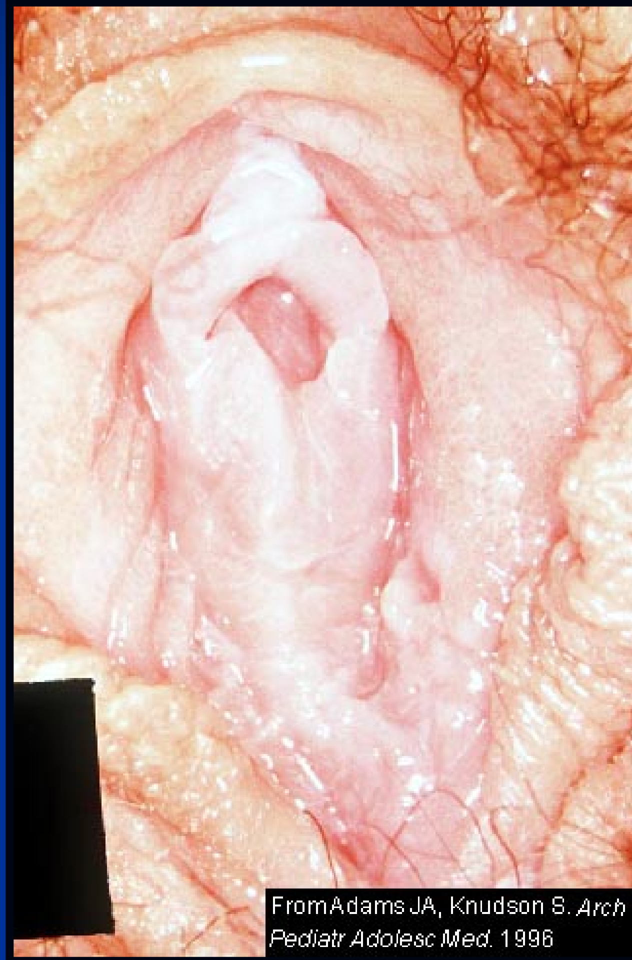
Normal prepubertal girl



Normal infant girl



Normal adolescent girl



Exams

- A speculum exam should NEVER be done on a prepubertal girl unless she's under anesthesia – very rarely needed
- A competent clinician should be able to do the exam with traumatizing the child
- It's okay to wait for the child to be emotionally stable before doing the exam

Mimics

- Medical conditions or accidental trauma can confuse a clinician!
  - Lichen sclerosis
  - Urethral prolapse
  - UTI
  - Hemangioma
  - Labial agglutination
  - Straddle injury

Most specific findings

- Witness to the abuse
- Presence of semen
- Pregnancy – with DNA testing
- Sexually transmitted infections
  - Gonorrhea
  - Syphilis
  - Chlamydia
  - (NOT warts or HPV, though)
  - STI's must be tested for in the right manner!

Prevention

Much harder than recognition!

Prevention

- Secondary/tertiary prevention
  - Recognition of abuse going on
  - Prevention of further abuse, or of sibs
- Home visitation
- SBS education programs

Applicability to Child Abuse

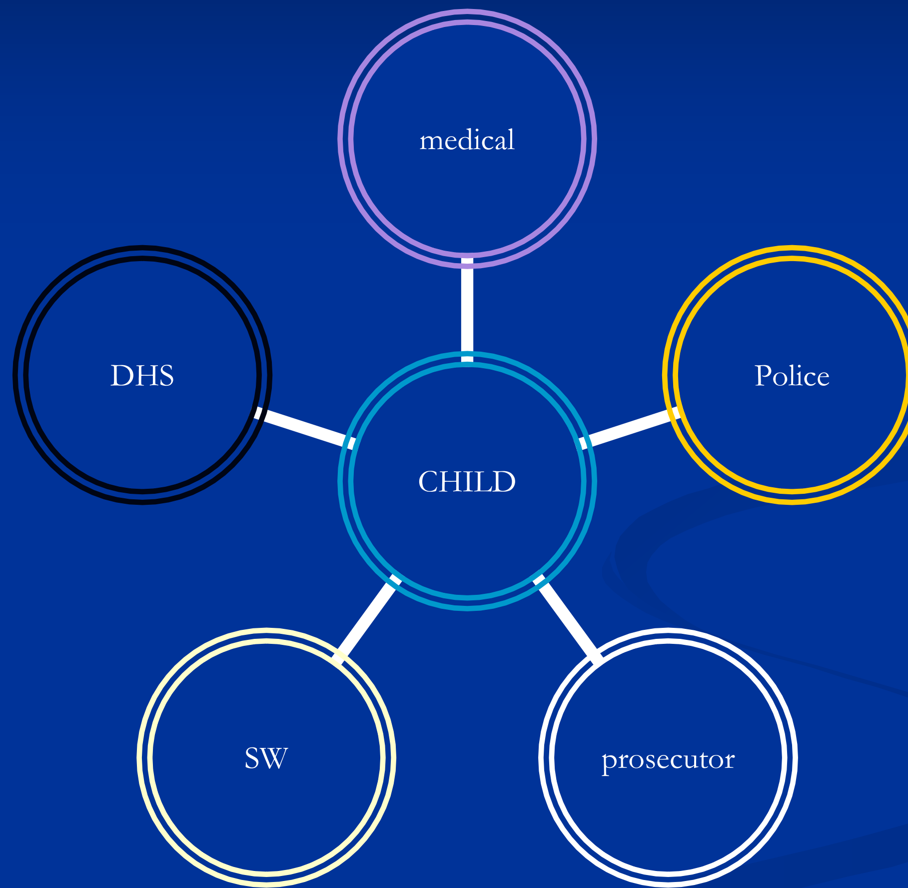
- All those with “primary” information:
  - parents, grandparents, teachers, doctors, nurses, social workers, daycare providers, babysitters, etc.
- All those who need information:
  - Doctor, CW case workers, law enforcement, prosecutors, foster parents, defense attorneys, etc.

Applicability to Child Abuse, cont'd

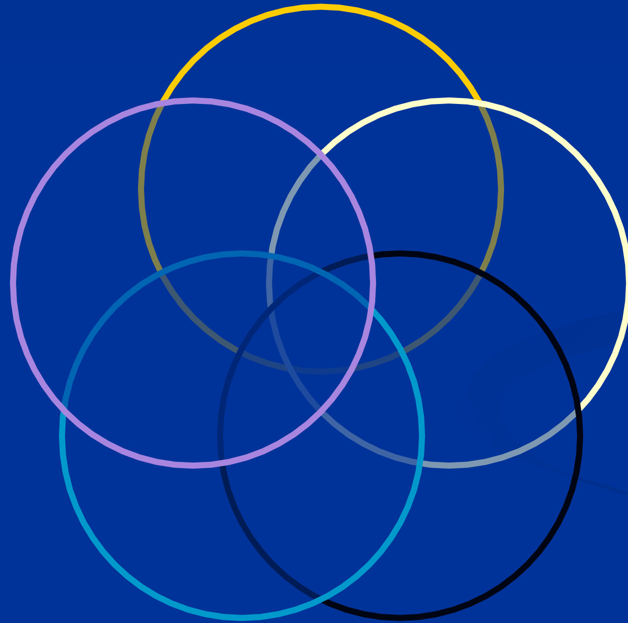
Each organization has different goals:

- Medical: patient care
- CW: safety of the child (family preservation?)
- Law enforcement: identifying the perpetrator
- Prosecution: prosecuting the defendant
- Social work: depends on the specific environment

Need to move from this…

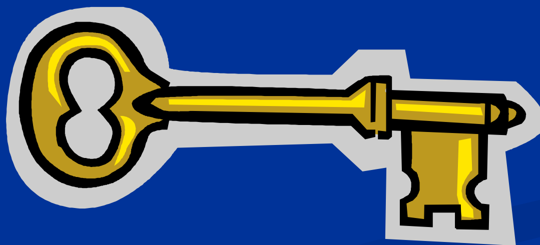


...to this!



Turf battles and the Silo effect may cause harm to a child!

Communication is the key!



But…

- …you need the right people on the team!
- Medical Providers:
  - Poorly trained – if trained at all
  - Don't want to be involved
  - Don't evaluate the child appropriately
  - Don't document thoroughly
  - Won't/can't testify