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PROTOCOL FOR THE STUDY OF INTERPERSONAL PHYSICAL ABUSE OF CHILDREN

CHILD HEALTH AND DEVELOPMENT
DIVISION OF FAMILY HEALTH
INJURY PREVENTION PROGRAMME
DIVISION OF EMERGENCY AND HUMANITARIAN ACTION
AND
DIVISION OF MENTAL HEALTH

WORLD HEALTH ORGANIZATION

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PROTOCOL FOR THE STUDY OF INTERPERSONAL PHYSICAL ABUSE OF CHILDREN

Child Health and Development, Division of Family Health,
Injury Prevention Programme, Division of Emergency and Humanitarian Action,
and
Division of Mental Health

World Health Organization
Geneva, Switzerland

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PART A

INTRODUCTION

The First World Summit for Children was held at the United Nations on 30 September 1990. More than 70 world leaders pledged to fight the hunger, poverty, disease, exploitation, neglect, and illiteracy that afflict children in both developing and industrialized countries.

Only one year earlier, the Convention on the Rights of the Child was adopted by the UN General Assembly.(1) Setting minimum standards of protection for children's survival, health and education, as well as providing explicit protection against exploitation at work, against physical or sexual abuse, and against the degradations of war, the Convention is the first agreement among the nations of the world on the legally-defined rights of the child. As of 20 July 1994, 163 countries have ratified it and 11 other countries have signed but not yet ratified.

Article 19 of the Convention states that countries "shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."

Translating the goals of the World Summit and the Convention into action requires detailed knowledge of the health status of children in each country. In the area of child maltreatment, reliable information is scarce in all but a few industrialized nations. Conflicting definitions of child abuse and neglect (CAN), difficulties in identifying cases of CAN, and variations in reporting requirements make cross-national comparisons virtually impossible.

To increase awareness of CAN as a community health issue and provide more reliable information for policy planning and social action, the World Health Organization divisions of Family Health; Emergency and Humanitarian Action; and Mental Health are proposing a research initiative on child maltreatment. This proposal builds on the deliberations of the CIOMS Round Table Conference on "Battered Children and Child Abuse" (2); the recommendations of respected researchers in the field of abuse and neglect (3); publications from the national incidence survey in the United States (4-6); and the experience of a previous multi-national study of unintentional injuries among children.(7)

PART B

RATIONALE FOR RESEARCH INTO CHILD MALTREATMENT

Child abuse is a hidden problem in many countries, both because data is lacking and because the issue is laden with shame and denial. Yet child maltreatment is a problem in both developed and developing countries:

- Conferences on child abuse and neglect have been held in Nairobi, Accra, Jakarta, Harare, Bogota, Santo Domingo, Rio de Janeiro, among other cities;

- Of the 36 million children in Brazil who come from poor families (those with a monthly per capita income below one-quarter of the minimum wage), 7 million (20%) have been abandoned or separated from their families;

- In Australia, in 1988, there were an estimated 38000 cases of notified child abuse out of a population of 4.4 million aged under 17 years;

- Between 1983 and 1987, estimates of the number of children suffering abuse or serious neglect in England and Wales rose from 11300 to 23500;

- The most recent national incidence study in the U.S.A. was undertaken in 1987. Almost 2.2 million episodes of child abuse or neglect were estimated to have occurred that year, an increase of 225% since 1976;

There is every reason to believe that child abuse/neglect will become even more prevalent as countries make the transition from regulated economies to more open market economies with fewer structures for social welfare; as urban expansion exceeds available medical and social services; as rural to urban migration disrupts social and family networks; as women join the work force in increasing numbers; and as civil unrest, economic disruption, and war displace families from their homes and cultural moorings.

The primary goal of the proposed research is to obtain information that can be directly used to improve the lives of children and families. The WHO protocol is designed to:

- obtain a clearer picture of the <u>nature</u> and <u>severity</u> of physical child abuse in a defined population;

- explore possible risk factors for physical abuse in different countries;

- provide crude estimates of the incidence of physical abuse;

- generate hypotheses concerning avenues of prevention at the national and local levels.

This information will be useful to policy-makers considering laws and regulations in the area of children's rights and protection; medical and child welfare providers designing programmes to meet the needs of at-risk children and families; leaders of professional societies (in medicine, jurisprudence, law enforcement, education, and social work) interested in improving educational and training programmes; and community leaders for their targeted child health problems.

As the first step toward approaching this complicated and controversial problem, the protocol targets a very specific aspect of child maltreatment: those child victims with obvious physical signs of abuse who are treated by physicians in hospitals and non-private health centres. It can be adapted to meet the situational needs of individual countries and

medical settings. For example, a "core" version of the protocol (consisting of the items with an asterisk) can be used in settings with a minimum of resources and personnel. Conversely, the protocol can be expanded in the future to include:

- other forms of maltreatment (e.g., sexual abuse, abandonment, physical neglect);
- other data-collection personnel (e.g., police, social workers, teachers);
- other settings (e.g., schools, private physician offices, welfare agencies).

The overall goals of this research are action-oriented: to raise awareness within the health sector and among the community-at-large of the importance of maltreatment as a child health issue; and to attract additional resources for the identification, treatment, and prevention of all forms of child abuse and neglect.

PART C

METHODOLOGICAL CONCERNS

Several important questions arise when considering any such research initiative. These include:

What type or types of studies should be undertaken at this time?

- epidemiologic studies or multi-disciplinary research (sociology, anthropology, psychology, law, family and women's studies, etc.)
- standardized, multi-country research or country-specific research
- studies of incidence or studies of risk factors

What aspects of maltreatment should be studied?

- social, institutional, and interpersonal
- physical, sexual, emotional and educational
- abuse and neglect
- intra-familial and interpersonal (includes extra-familial)

How shall the maltreatment be defined?

- observable harm and endangerment
- severity

- perpetrators
- intent

What is proposed is a multi-country, prospective study of interpersonal physical abuse of children identified by physicians working in hospitals and non-private health centres. The methodologic considerations in choosing this approach are presented in the paragraphs that follow.

TYPES OF STUDIES

The major epidemiologic approaches to clarifying the nature and incidence of child abuse and neglect are outlined in Table 3. Published examples of each approach appear in Appendix A.

Determining the "true" incidence of maltreatment within a population is complicated by the lack of consensus about what constitutes abuse and neglect; difficulties in identifying cases (e.g., distinguishing intentional from non-intentional injuries or uncovering cases of abuse when the child shows no obvious physical signs); and reluctance to report identified cases. In countries where centralized reporting systems exist, there is the additional problem of duplicated reports: a seriously-injured child may generate a report at her school, the police station, the local social welfare agency, and the children's protection registry, for example.

The protocol outlined in the pages that follow is for a prospective, physician-based study of children suffering observable, physical abuse. This approach aims at Level 3 of the "Levels of Recognition of Child Abuse and Neglect" (Figure 1, reference 4): cases that become known to a segment of community professionals (in this study, physicians working in hospitals or non-private health centres).

The advantages of this approach are that:

1. standardized definitions and criteria for inclusion can be specified;
2. core data can be gathered on all cases;
3. resources for diagnosis (e.g., x-ray machines) and treatment (e.g., social service follow-up) are more likely to be available;
4. duplication of reports by multiple agencies is not a problem.

Major disadvantages also need to be recognized. Only children brought to medical attention will be included. This means that children from families in rural areas, with private physicians, or who choose not to bring their children in for care--and children who die outside of hospitals--will not be represented or will be under-represented in the data. When the study findings are reported, these limitations must be pointed out. This initial study is not a true incidence study, although crude estimates of incidence can be made if attention is paid to representative sample selection and collection of denominator data (e.g., total number of emergency cases treated during the study period).

RATIONALE FOR TARGETING PHYSICAL ABUSE AT THE INTERPERSONAL LEVEL

Dimensions of "normal" or "healthy" childhood--physical, emotional, psychological, mental, developmental, spiritual--can be compromised by maltreatment at many levels (Table 1). Even at the interpersonal level, there is a spectrum of harm that includes acts of commission (abuse) and omission (neglect), acts where the intent to harm the child may be overt or absent (Table 2). There is no universal standard for categorizing acts as "abusive." Social and cultural norms vary over time, among countries, and even within different communities.(8-10)

Countries also differ in terms of the depth of awareness of child abuse and neglect as a societal issue; the amount of resources available for research and intervention; and the extent to which a formalized protective system for children, including centralized reporting mechanisms, has been developed. This presents a substantial challenge to international research efforts. Individualized national initiatives can focus on the types of maltreatment that are most urgent and relevant to a particular country. They can target the problems most amenable to change, given the available resources and existing socio-political climate.

> At the same time, individualized initiatives are not enough. Child abuse is a problem that is hidden and ignored for important social and cultural reasons in many places. When brought to attention, its existence is widely denied. Action against child abuse often threatens entrenched political, religious and economic interests...This reality suggests that, in addition to encouraging individualized initiatives, international organizations need to adopt a few worldwide priorities in the child abuse area and campaign to get attention to these priorities in all member countries...(3)

Physical abuse of children should be a international priority for several reasons. It occurs in both developing and developed countries. There exists a large literature and research foundation,(11-24) and a great number of experts and organizations (such as ISPCAN, IPA, UNICEF, WHO, DCI, Save the Children) already internationally concerned about the subject. The paediatric community is uniquely suited to addressing this form of child maltreatment, since many physically abused children come into contact with health providers, and resources for diagnosis, treatment and follow up are often more readily available than in other settings.

Future international research efforts will undoubtedly expand the spectrum of maltreatment. It is worth noting that many forms of child maltreatment at the societal level--such as child labour, sexual exploitation, and the plight of street children--are already the focus of national and international attention (25-31).

DEMONSTRABLE HARM AND ACTS OF COMMISSION

There is another important reason for targeting physical abuse: the relative ease of establishing a clear, standardized definition for data-gathering purposes. Compared to the controversies surrounding the definition of emotional neglect and sexual abuse, the standard of "observable physical harm" can be applied reasonably consistently and with good inter-observer reliability.(5)

Certain kinds of adult behaviours may not produce obvious harm to a child, but may seriously endanger the physical health or safety of the child. For example, a parent who heavily abuses cocaine and is "high" for many hours of the day places his or her child in danger of injury or impairment. The 1986 U.S. National Incidence Study therefore adopted an "endangerment" standard to include this form of maltreatment. However, whether a child is endangered or not is a judgement that is both subjective and variable. In contrast, a "demonstrable harm" standard provides a clear and coherent definition of what constitutes "countable" instances of child abuse.

Similar problems of subjectivity occur in the diagnosis of "child neglect". "Neglect" may be intentional (depriving a child of food as a punishment, for example) or unintentional (leaving a child alone for many hours because both parents must work outside the home). In situations of extreme poverty, physical, nutritional, and medical "neglect" is more often societal in nature than the result of intra-familial maltreatment.

Therefore, this protocol counts only acts of commission ("abuse") and excludes all forms of omission ("neglect"). It requires "demonstrable harm" and excludes cases where children may have been endangered, but not actually injured.

Of course, the great disadvantage to such a restrictive standard of "countability" is that many other forms of abuse and neglect (in fact, a large majority of the cases) are likely to be excluded. Nevertheless, for the purposes of an initial international research effort--where there will be wide variations in available resources for research and action, and dramatic differences in local norms and practices--the advantages of this approach far outweigh the drawbacks.

PERPETRATOR REQUIREMENT: Who injured the child?

A very important aspect of studies on child abuse is the spectrum of potential perpetrators that are included. Many studies focus exclusively on abuse that occurs within families. This is because the dynamics of intrafamilial violence, its impact on the child, and the management differ from violence that is perpetrated by individuals outside the family. Thus, the WHO Draft Multiaxial Classification of Child Psychiatric Disorders defines physical abuse (Appendix B) as "incidents in which the child has been injured by <u>any adult in the household</u> to an extent that is medically significant or that involves forms of violence that are abnormal in form for the subculture." (Emphasis added.)(<u>32</u>) An "adult in the household" can be interpreted to include the child's natural or foster <u>parents</u>, step-parents, adoptive parents, or other legal guardians regardless of their age; <u>parent substitutes</u>, such as grandparents or other relatives, regardless of their age, who have temporary responsibility for the welfare of the child because of parental illness, incarceration, or other separation; adults (18 years of age or older) who lived at or <u>regularly visited</u> the child's home (such as adult siblings, grandparents, a parent's friend, etc.); and any <u>adults in the household who were responsible for the child's care</u> (such as an adult babysitter or a divorced/separated parent who was not living in the child's home.)

Targeting "adults in the household" excludes injuries inflicted by employers, caretakers outside the home (e.g., teachers and day care workers), and employees of residential facilities, such as orphanages. Many child protection laws address injuries inflicted by any person--within or outside the household--who has responsibility for a child's welfare for even brief periods of time. The disadvantages of this approach (including

perpetrators of abuse outside the household) are that it relies on a subjective determination of whether a person (such as an employer) is "responsible for a child's well-being"; it can detract attention from the difficult task of identifying intra-familial abuse; and it results in a pooling of data on intra- and extra-familial cases (although this can be addressed in the data analysis).

Another difficulty arises concerning the age of the perpetrator. Obviously, injuries inflicted by siblings or peers in the course of an argument do not qualify as child abuse. Therefore, some studies set an arbitrary age limit for the perpetrator, such as 18 years or older. Of course, this excludes instances where the child's parent or caretaker is under 18 years old, a situation not uncommon in many communities.

Because this protocol identifies cases on the basis of observable injuries, it includes instances of abuse inflicted by other adults in the household; by caretakers of any age inside or outside the home (such as employers, babysitters, teachers, and day care workers); and by other adults (soldiers, police) who intentionally harm a child. Table 5 is a list of potential perpetrators.

SEVERITY: How much harm is required?

A distinction must be made between the severity of injury and the severity of abuse. The severity of an injury depends on the type of injury (burn, laceration, fracture, etc.), the body part affected (head, trunk, limb, genitals, etc.), the extent of injury (degree of burn, compound vs. simple fracture), and the threat to life and physical well-being posed by the injury. Although detailed scaling systems are available,(33) a simple scheme requires less training to apply and should provide adequate information (Table 4). Only injuries of moderate or severe degree will be included in the study. By excluding mild injuries--such as minor erythema from a spanking--the controversy about whether limited forms of corporal punishment in the home constitute abuse can be largely avoided.

The severity of abuse which a child suffers is determined not only by the severity of the specific injuries, but also by the child's age, the forms of abuse, their chronicity, and the perpetrator's relationship to the child. It is a more subjective measure and is not specifically rated in this protocol.

SUMMARY OF CRITERIA FOR INCLUSION

- Age of child: Birth until 18 years of age.

  Excludes acts occurring during pregnancy or delivery.

- Nature of Maltreatment: Physical abuse only, i.e., injuries resulting from intentional acts of commission (battering, burns, etc.).

  Excludes all forms of neglect, sexual and emotional abuse.

- Level of maltreatment: Interpersonal and institutional.

  Excludes societal abuse.

- Standard of Harm: Demonstrable harm only.

  Excludes endangerment.

- Severity of injury: fatal, moderate, or severe

  Excludes mild injuries: pain or physical signs lasting under 48 hours.

- Perpetrator: parent, parent substitute, other adult in the household, or caretaker (person with responsibility for the child, even temporarily); other adults (e.g., soldiers, police) who intentionally harm a child.

IDENTIFYING PHYSICAL ABUSE

For this study, physical abuse is defined as the intentional, non-accidental use of physical force - on the part of a parent or other caretaker interacting with a child in his or her care - aimed at hurting, injuring or destroying a child. This includes:

- the non-accidental use of a weapon, foreign object or foreign substance;

- slapping, spanking, punching, or biting;

- any other physical assault - e.g., shoving, burning, immersing, dropping, shaking, or throwing a child.

The injury may occur as a result of physical punishment carried to excess or from malicious maltreatment. The demonstrable harm is physical, not emotional or behavioural.

A major problem in any study of abuse is the difficulty in distinguishing intentional from unintentional injuries (34-43). Important factors in confirming - or at least raising the possibility of abuse - are:

1. Injuries or patterns of injuries that are inconsistent with the explanation offered:

   - spiral fractures

   - subdural hematoma and retinal hemorrhage (with or without a skull fracture)

   - metaphyseal injury

   - circumferential injuries about the wrists or ankles

   - marks from choking

2. A previous history of abuse documented in the medical record;

3. Injuries whose very appearance points to abuse: bite marks, bruises or lacerations in the shape of belt buckles or looped cords, erythema in the pattern of an open hand, immersion burns from scalding water, etc.;

4. Admission of involvement by the perpetrator;

5. Reports from witnesses of abuse: child, siblings, parents, etc.

Just as the diagnosis of abuse can be missed, conditions can be misdiagnosed as abuse when they are not. For example, multiple bruises can occur from bleeding disorders or diseases (e.g., Henoch-Schonlein purpura). Multiple fractures can result from osteogenesis imperfecta. These latter conditions are very uncommon.

Many physicians have not had a great deal of training or experience in diagnosing child abuse (44-45). To increase the likelihood of diagnosis, and reduce physician's uneasiness about becoming involved with this emotionally-charged issue, an orientation programme should be offered to study participants. Also, data forms should be completed for children who are <u>suspected</u> to be victims of abuse, rather than only in cases where the physician is <u>certain</u> that abuse has occurred. Data forms must clearly indicate that all information is confidential, and not linked to any official (i.e., legal) reporting system.

OUTLINE OF RESEARCH PLAN

There are many excellent publications describing the steps in undertaking a research effort of sort proposed (45-46). Briefly, these are:

1. Finalize the study design:

   - select project director and coordinators

   - select sampling technique for hospitals and physicians: representative sample vs. sample of convenience

   - establish the time frame

   - design quality controls

2. Finalize the data-collection form.

3. Pilot the form.

4. Revise the form based on results of the pilot study.

5. Obtain cooperation of hospitals and physicians.

6. Prepare a protocol manual describing terms and procedures for the study.

7. Orient participants to the study purposes and design using the protocol manual; provide updated information on the diagnosis and management of child abuse.

8. Implement the study.

9. Monitor for completeness and quality of data collection.

10. Input the data and analyze results.

11. Interpret results and publish the final report.

A draft of the data-collection form - adapted from the U.S. National Incidence Survey (6) - appears in appendix C.

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TABLE 1: LEVELS OF MALTREATMENT

International:

- war and preparations for war
- trade practices
- environmental destruction
- nuclear weapons testing
- world debt and international aid policies

Societal:

- government-sanctioned violence, family separation, internment and detention
- apartheid
- national budget priorities (e.g., military vs. social expenditures)
- conscription of children into the military
- child labour
    - unorganized sector
    - domestics
- sexual exploitation: pornography, prostitution, sex tourism
- civil war/internal conflicts
- kidnapping and/or trafficking of children for sale
- cultural practices:
    - clitoridectomy/infibulation
    - physical discipline/corporal punishment
    - "sandbagging" infants
    - contract marriages
    - infanticide

Institutional:

- orphanages, foster care
- residential facilities for children who are mentally ill, physically impaired, or developmentally delayed
- day care centers
- schools: corporal punishment
- hospitals
- prisons: incarceration of children with adults
- detention centers for delinquent or "unruly" children

Interpersonal abuse and neglect:

- intra-familial
- extra-familial

TABLE 2: TYPES OF INTERPERSONAL ABUSE/NEGLECT

Physical abuse

- violent acts: e.g., battering, shaking, burning
- child homicide
- "Munchausen-by-proxy"

Physical neglect

- abandonment
- psychosocial failure-to-thrive
- inattention to health care
- inattention to avoidable hazards
- inattention to child's personal hygiene leading to illness or infestation
- deprivation of necessities: food, clothing or shelter
- inadequate supervision
- permitting or condoning maladaptive behavior (delinquency, substance abuse, prostitution)

Sexual abuse

- contact:
    - with intrusion
    - fondling of genitals only
- non-contact:
    - exhibitionism
    - pornography
    - deliberate exposure of children to adult sexual material or activity

Educational neglect

- failure to enroll a child in school
- failure to respond to chronic truancy
- inattention to special educational needs

Emotional abuse or neglect

- verbal assault: belittling, scapegoating, humiliation
- psychological unavailability of the parent
- chronic role reversal
- excessive non-physical discipline
- verbal threat of other forms of abuse
- close confinement: tying or locking a child in a room
- refusal of or delay in psychological care

TABLE 3: THE NATURE AND INCIDENCE OF CHILD MALTREATMENT

TYPES OF STUDIES

A. Descriptive reports:

- summaries by knowledgeable professionals or key informants
- newspaper reviews
- case studies

B. Analysis of data from centralized registries:

- death certificates
- child protection reporting registries

C. Analysis of case files:

- hospitals, clinics, physicians' offices
- medical examiners/coroners
- legal system
- police
- social service and mental health agencies

D. Prospective data collection:

- at centralized protective agencies
- involving community professionals:
  - physicians and other health care workers
  - lawyers
  - police officers
  - social workers
  - teachers and day care workers

E. Cross-sectional surveys:

- by phone, personal interview, or mailed questionnaires
- of professionals, older children, or the general public
- to establish prevalence data and/or obtain information about attitudes, beliefs, practices

F. Case-comparison studies:

- to identify preventable risk factors
- to improve diagnosis/identification

G. Action research: to evaluate approaches to prevention, identification, and treatment.

TABLE 4: SEVERITY OF HARM

1 = Fatal: Child died; physical abuse suspected as a major contributing cause of death.

2 = Serious: Life-threatening condition; or an injury or impairment serious enough to cause significant long-term impairment or to require professional treatment aimed at preventing significant long-term impairment.

Examples:

- Loss of consciousness, seizures, fractures;
- Any physical condition serious enough to require hospitalization;
- All third-degree burns and second-degree burns covering at least 10% of body surface area;

3 = Moderate Injury/Moderate Impairment: Physical condition with observable symptoms (pain or impairment) expected to last at least 48 hours.

Examples:

- Any second degree burn covering less than 10% of body surface area.
- Multiple bruises, welts, or abrasions
- First-degree burn covering more than 10% of body surface area.
- Laceration into subcutaneous tissue.

TABLE 5: POTENTIAL PERPETRATORS

Parent(s)/Substitute(s):

- natural (biological) mother
- natural (biological) father
- step-father
- step-mother
- foster mother
- foster father
- adoptive mother
- adoptive father

Other household members:

- mother's partner
- father's partner
- grandmother
- grandfather
- older sibling
- other relative: uncle, aunt, cousin
- babysitter or live-in domestic worker

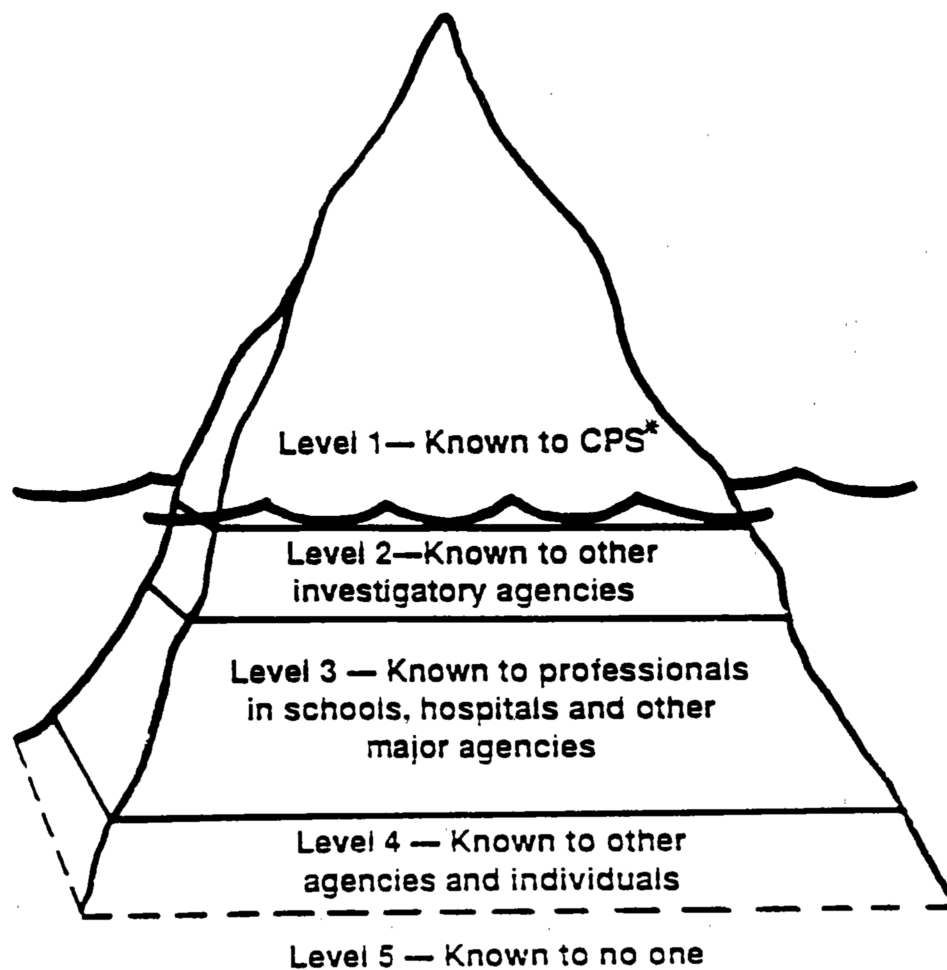
Other caretakers:

- teacher
- day care worker
- child's employer
- child sitter
- in-home domestic worker
- sibling at least 5 years older than the child
- employee of institution/residential facility
- other (Specify)

Other adults inflicting intentional harm:

- police
- soldiers
- other military or paramilitary persons
- other adults

FIGURE 1: LEVELS OF RECOGNITION OF CHILD ABUSE AND NEGLECT



Source: Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988. National Center on Child Abuse and Neglect, USDHHS, Washington, D.C.

* CPS = Children's Protective Services.

APPENDIX A: EXAMPLES OF STUDIES

A. Descriptive reports and case studies:

1. *Okeahialam TC: Child abuse in Nigeria. CAN 1984; 8(1):69-73.*

Issues of child abuse and neglect in Nigeria include traditional child-rearing practices (such as the neglect or abandonment of severely handicapped children or twin births, female circumcision, severe corporal punishment for minor offenses, and scalding of the feet as a method of controlling convulsions), abandonment of normal infants by unmarried, very poor mothers in cities, child labour, exploitation (including sexual abuse) of children from rural areas in urban elite families, and abuse of children in urban nuclear families by childminders (often a live-in female from a village aged 7 to 12 years).

2. *Liao HB, Hwang RC, Chi YW, et al: Child abuse: report of three cases [Chinese]. Acta Paediatrica Sinica 1989; 30(3):216-22.*

Three cases of child abuse are reported with two resulting in death. A 7-year-old boy suffered from abdominal pain for 3 days after being beaten by his mother for "inadequately learning his lessons." A 4-year-old girl became semicomatose "after her father impulsively struck her with a chair."

3. *Muhler E: Sonographic follow-up of pronounced brain concussion in a 3-week-old infant following trauma caused by shaking [German]. Klinische Padiatrie 1986; 198(1):49-52.*

Cerebral sonography was performed in a 3-week-old whiplash-shaken-baby who had no external marks of injury and no skull fracture. On the day of admission, increased echogenicity in the white matter could be correlated with hypodense contusional lesions in the cranial computerized tomography. In all infants with open anterior fontanel presenting with unexplained clouding of consciousness and/or external marks of child abuse, cerebral sonography should be a basic diagnostic method.

4. *Nazer H, Daradkeh T, Mohamed S, et al: A diagnostic dilemma in Jordan: Two child abuse case studies. Child Abuse Negl 1988;12:593-599.*

This is the first report of child abuse in Jordan.

B. Analysis of data from centralized registries:

1. *Creighton SJ: An epidemiological study of abused children and their families in the United Kingdom between 1977 and 1982. Child Abuse & Neglect 1985;9:441-448.*

Between 1977 and 1982 there were 6532 children placed on the child abuse registers maintained by the National Society for the Prevention of Cruelty to Children (NSPCC) in England. Unlike the US, the UK does not have a system of mandatory reporting of cases of suspected child abuse. The rate of physical injury increased over the last four years of the study from 0.43 to 0.63 per thousand children under 15 in the NSPCC register areas, but the percentage of fatal and serious injuries decreased.

2. *Daro D and Mitchel L: Current trends in child abuse reporting and fatalities: The results of the 1989 Annual Fifty State Survey. National Committee for Prevention of Child Abuse (NCPCA), Chicago, March 1990.*

A total of 2.4 million reports of child abuse and neglect were registered in 1989 in the U.S. An estimated 1237 child abuse and neglect fatalities were reported. Approximately 27% of all reports involved charges of physical abuse, 16% sexual abuse, 8% emotional maltreatment, and 55% child neglect. A large number of cases involved extreme poverty; high levels of family violence; and parental substance abuse, particularly crack/cocaine.

3. *Sachers P: The problem of child abuse in East Germany. A 5-year analysis [German]. Padiatrie Und Grenzgebiete 1989; 28(4):219-22.*

All cases of ill-treatment of children registered in an area of newly-built houses in the G.D.R. were analyzed.

C. Analysis of case files:

1. *Bitsch-Christensen M, Mikkelsen BG: Children and domestic fights. A review of 105 social reports [Danish]. Ugeskrift For Laeger 1989; 151(15):932-4.*

Information on the condition of children in families with "domestic rows" was analyzed based on 105 social reports made by the Copenhagen police during a period of one year. A total of 162 children were involved in the domestic rows. In 14% of the cases, the domestic rows were reported by the child. Violence to the women occurred in just under half of the cases and to the children in 6%. In 77% of the cases, at least one of the adults was under the influence of alcohol/medicine/narcotics. Children were primarily the victims of passive violence.

2. *Merrick J: Child abuse and the lack of care (2): An epidemiologic and social pediatric study of fatal child abuse and neglect in Denmark in 1970-1979 (Danish]. Ugeskrift For Laeger 1989; 151(14):874-7.*

A total of 38 children aged 0-13 years were registered in this retrospective study from all Danish forensic offices, pediatric departments, institutes of forensic medicine and the medico-legal council. At least 21% of the children had a history of failure to thrive and at least 21% had a chronic disease or handicap. At least 1/3 had been subjected to previous abuse. The primary cause of death was head injury and, in order of frequency, intra-abdominal injury,

strangulation, drowning and neglect. This study showed an incidence of 0.8 child deaths from fatal child abuse per million inhabitants per year in Denmark.

3. *Caplan PJ, Watters J, White G, et al: Toronto multi-agency child abuse research project: the abused and the abuser. CAN 1984;8:343-351.*

Data from 422 Toronto child welfare agency and children's hospital child mistreatment cases filed for 1973-77 were compared with data from previous studies in Canada, England and the United States.

4. *Larsson G, Ekenstein G, Rasch E: Are the social workers prepared to assist a changing population of dysfunctional parents in Sweden? CAN 1984; 8(1):9-14.*

Families whose infants were admitted to institutional care in 1980 had more complex forms of parental dysfunction--including mental disorders, criminality, alcohol abuse, and drug addiction--than in previous years.

5. *Farinatti FAS, Fonseca NM, Dondonis M, et al: Child abuse and neglect in a developing country. Child Abuse and Neglect 1990; 14;133-134.*

Sixty-three families whose children were diagnosed as suffering from child abuse or neglect at a 300-bed children's hospital in Brazil. Age, sex, type of maltreatment (physical or sexual abuse, or neglect), caretakers, age of caretaking adults, marital history of caretakers, education, family history of drug/alcohol abuse, employment status, perpetrators (mothers, parent's current partner, father, both parents, others), disposition at hospital discharge. The authors note the scarcity in developing countries of resources and services for therapy, conflict resolution, and the provision of basic family needs.

6. *Johnson CF and Showers J: Injury variables in child abuse. CAN 1985; 9:207-215.*

The child abuse reporting records of 616 children seen by the child abuse team in a metropolitan children's hospital were analyzed. The types of injury, injury site and types of instruments used varied with the age and race, but not the sex of the child. The wide variety of instruments used to perpetrate child abuse resulted in a broad spectrum of injury types.

D. Prospective data collection:

1. *Study Findings: Study of national incidence and prevalence of child abuse and neglect: 1988. National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services, 1988.*

Data were collected concerning cases of child maltreatment which were reported to the study by "community professionals" in a national probability sample of 29 counties through the United States. They included local Child Protective Services staff and respondents in a variety

of other agencies (schools, hospitals, police departments, juvenile probation authorities). Only those cases which fit standardized criteria were counted.

E. Cross-sectional Surveys:

1. *Schools and Child abuse: A national survey of principals' attitudes, beliefs, and practices. Working Paper #851. NCPCA, Chicago, 1990.*

This mailed survey sought information from school principals about their attitudes toward child abuse prevention and reporting; types of identification, counseling, and prevention activities; prevalence of corporal punishment; and procedures for reporting, counseling and social service referrals.

2. *Straus, Gelles, and Steinmetz: Behind Closed Doors: Violence in the American family. Doubleday, Garden City, 1980.*

In a national survey, family members were asked about their experiences with child and wife abuse. Four percent of the parents admitted to having used severe violence against their child in the previous year and 28% reported a violent incident in the course of their marriage.

3. *Kim K and Ko B: An incidence survey of battered children in two elementary schools of Seoul. Child Abuse & Neglect 1990;14:273-276.*

Over 1000 third- and fourth-grade students (boys and girls) completed questionnaires under the supervision of class teachers at two schools in November 1986. 8.2% reported being beaten severely (kicking, biting, hitting by the fist, beating, threatening with or striking with a knife or gun) more than 12 times in the previous year. Another 58% were beaten less severely or less often.

4. *Payne MA: Use and abuse of corporal punishment: A Caribbean view. Child Abuse & Neglect 1989; 13:389-401.*

A sample of 499 Barbarian adults, aged 20 to 59 years, completed a written questionnaire regarding corporal punishment in child rearing. Approximately 70% "generally approved" of corporal punishment, although a majority disapproved when parents resorted to punishment in an unsystematic, excessive, or self-serving manner.

F. Case-Comparison studies:

1. *Benedict MI and White RB: Selected perinatal factors and child abuse. Am J Public Health 1985;75:780-781.*

A matched pair case-control study was conducted to compare birth weights, gestations, and length of hospital stay (LOS) of 532 children subsequently reported as physically abused with comparable data from a group of control children matched on age, sex, race, and maternal

education. There was a moderate association between physical abuse and both low birthweight and very short gestation.

2. *Leventhal JM: Risk factors for child abuse: Methodololgic standards in case-control studies. Pediatrics 1981; 68:684-690.*

The author suggests seven standards to reduce bias or distortion of results in case-control studies examining risk factors for child abuse. His review of 22 case-control studies of prematurity/low birthweight or young maternal age of the mother as risk factors found that none of the studies met all seven standards.

G. Action-Research:

1. *Job-Spira N, Lamour M, Gabel M, et al: Action-research on the prevention of abuse in the very young child. Methodology and initial results [French]. Archives Francaises De Pediatrie 1988; 45(4):277-85.*

Teams of pediatricians and psychiatrists are conducting an action-research to develop and evaluate original modes of prevention of abuse and grave neglect of infants with medico-psychosocial high-risk factors. The framework of this study is a randomized controlled trial comparing an intervention group of infants with a group receiving only traditional surveillance. The research is longitudinal and is centered on the study of mother-infant interactions at 3 months, 1 year, 2 years and 3 years of age.

2. *Loredo-Abdala A, Oldak-Skvirsky D, Carbajal-Rodriguez L, et al: Algorithm of battered children at entrance to a third-level pediatric hospital center [Spanish]. Boletin Medico Del Hospital Infantil De Mexico 1990; 47(2):91-5.*

A protocol was established at the Department of Internal Medicine of the National Institute of Pediatrics (INP) that indicates the steps to be followed when a patient with suspicion of maltreatment is hospitalized. The patients were compared with others children who were hospitalized in other services with the same diagnoses.

3. *Soumenkoff G and Marneffe C: Evaluation in primary prevention: an obligation, I. The obstetrical point of view. [French]. Child Abuse & Neglect 1986; 10(1):45-52.*

Evaluation of research in primary prevention is often complicated by the imprecise definition of the child abuse syndrome, ambiguous definitions of primary prevention, a scarcity of epidemiological data, and the existence of ethical problems. Obstetrical models of evaluation are proposed: evaluation of screening methods, postpartum follow-up and contraception, action against prematurity, and lack of prenatal care. Results of a four-year antenatal program are presented.

4. *Olds DL, Henderson CR, Chamberline R, et al: Preventing child abuse and neglect: A randomized trial of nurse home visitation. Pediatrics 1986;78:65-78.*

A programme of prenatal and infancy home visitation by nurses was tested as a method of preventing health and developmental problems in children born to primiparas who were either teenagers, unmarried, or of low socioeconomic status. Among the women at highest risk for caregiving dysfunction, those who were visited by a nurse had fewer instances of verified child abuse and neglect during the first 2 years of their children's lives.

APPENDIX B: WHO DRAFT CLASSIFICATION SYSTEM[1]

PHYSICAL CHILD ABUSE

Physical abuse includes any clear examples of incidents in which the child has been injured by any adult in the household to an extent that is medically significant or that involves forms of violence that are abnormal in form for the subculture.

Diagnostic Guidelines

Cultures vary considerably in the extent to which it is regarded as acceptable to use corporal methods as a means of punishing children. Nevertheless, physical abuse may be considered to have occurred when:

a) the punishment has been sufficiently severe to result in lacerations, fractures, dislocated joints or marked bruising;

or

b) punishment has involved hitting the child with hard or sharp implements such as sticks or belts with buckles (hitting with a slipper or a leather strap may amount to abuse but in some subcultures it need not necessarily do so if moderate in degree and well controlled);

or

c) the punishment has involved a clear and severe loss of control, as shown by throwing the child against a wall or pushing the child downstairs;

or

d) the violence has involved unusual and unacceptable forms of physical trauma, as shown by burning or scalding the child, tying up the child or holding the head under water.

Physical abuse may occur either as a consequence of physical punishment that has been carried to excess as a result of loss of self-control or of deliberate malicious maltreatment.

Excludes: - physical abuse by someone outside the household.

[1]Source: WHO, 1988, reference 33.

APPENDIX C.1: INTENTIONAL PHYSICAL ABUSE OF CHILDREN PROTOCOL

IMPORTANT: Information provided on this form is confidential and will be used for research purposes only. Return of this form does not constitute an official report of suspected child abuse.

PART A. THE INITIAL DESCRIPTION

PLEASE GIVE THE INITIAL DESCRIPTION OF WHAT HAPPENED, AND WHO WAS INVOLVED, SPECIFICALLY, AS IT WAS STATED BY THE CHILD OR REPORTING ADULT:

PART B. THE CHILD

1. Child's initials:_______ 2. Date of birth (day/mo/yr):__________

*3. Child's age:_____ years and/or) ______ months

*4. Child's sex: 1 - male 2 - female

5. Child's Ethnic group:____________________

6. Child's Religion______________

7. Does child work outside of the home?
1- No 2-Yes (Specify type of work):__________________________

8. Does child attend school?
1- Full time 2- Part time 3- Not at all 4- Not of school age

PART C: The Child's Household and Social Demographics

*9. Where child is living:

1__In home with biological parents
2__In home with biological mother and step-father
3__In home with biological father and step-mother
4__In home with mother present and father absent
5__In home with father present and mother absent
6__In home with adoptive parent(s)
7--In home with relatives (both parents absent)
8--In home of employers
9--On the streets or in street shelters
10__Residential facility (specify):________________
11__Other (specify):_______________________________

10. Place of residence (Name of city, town or village): __________________

*11 Is the place of residence considered urban or ural? 1- Urban 2- Rural
Please specify criteria used________________________________

*12-14 For children living with a family (not alone on the street or at an institution):

*12. ESTIMATED FAMILY INCOME:
1: LOW 2: MIDDLE 3: HIGH 9: UNKNOWN

13. Number of children under 18 years of age in the home:______

14. Type of housing: 1: City flat (apartment) 2: City house
3: Rural house 4: Tent/caravan/mobile home 5: Slum
6: Homeless 7: Other_________________ 9: UNKNOWN

15. Child's birth order rank:______________________
(First born = 1, Second born = 2, etc.,)

PART D: THE PARENTS

16. Mother's age ________years (9=unknown)

17. Father's age ________years (9=unknown)

18. Is mother employed? 1-Yes 2-No

19. Is father employed? 1-Yes 2-No

20. Have parents been recently (within the last year) separated or divorced? 1-Yes 2-No.

PART E: MEDICAL INFORMATION:

*13. Severity of injury: 1: Fatal 2: Serious 3: Moderate

*14. Type of injury or injuries (Circle all that apply):

1__Pain/Tenderness ONLY (Subjective) 2__Abrasion/Scratches
3__Bruise/Ecchymosis/Hematoma 4__Swelling
5__Laceration 6__Burn
7__Other internal bleeding 8__Puncture wound
9__Erythema, other marks 10__Bite
11__Fracture/dislocation 12__Retinal Hemorrhage
13__Other internal trauma 14--Other (Describe)

23. Location of injury:

1__Mouth/teeth 2__External head/scalp 3__Brain/skull contents

4__Face 5__Eye(s) 6__Nose
7__Ear(s) 8__Neck 9__Back/Shoulder(s)
10__Chest/breast 11__Abdomen (internal) 2__Abdomen (external)
13__Buttocks/anus 14__Arm(s) or hand(s) 15__Hips
16__Thigh(s) 17__Genitalia/groin 18__Leg(s) or feet
19__Other (Specify)____________________

*24. Likely mechanism of injury: (Circle all those that apply)

1__Open hand (choked, grabbed, pinched, slapped, suffocated)
2__Propelled (thrown, dropped, pushed, pulled, dragged)
3__Burned by iron/heater/stove/lighter/arson
4__Hit with fist 5__Hit with switch/stick/paddle/board
6__Kicked 7__Hit with belt/strap/cord
8__Stabbed/cut 9__Poisoned
10__Hanged 11__Gunshot
12__Shaken 13__Immersion in hot water
14__Bitten 15__Burned by cigarette
16__Other (Specify)________________

25. Relevant Lab data including radiological findings:

		Normal	Abnormal (Describe)
Radiology:	1__Skull films	___	______________
	2__Chest x-ray	___	______________
	3__Long bones	___	______________
Other Lab:	4__________	___	______________
	5__________	___	______________
	6__________	___	______________

26. Medical risk factors for abuse (Check all that apply):

1__Chronic illness: 1-No 2-Yes (Describe):________________
2__Disability or Disfigurement 1-No 2-Yes (Describe):________________

3__Multiple birth (e.g., twin): 1-No 2-Yes 9-Unknown
4__Other (Describe):______________________

*27. Basis for suspicion: Indicate the information or reasoning which leads you to suspect that the above injury is the result of physical abuse. (Circle all that apply)

1__Obvious from type or pattern of injury (e.g., cigarette burn)
2__Child reports abuse
3__Perpetrator admits abuse
4__Parent or caretaker witnessed the abuse
5__Parent could give no explanation of how injuries occurred
6__Explanation of how injury occurred is not consistent with nature, severity, and/or pattern of injuries

7__Documented previous abuse of child or sibling
8__Other:

*28 Level of certainty that injury was intentional (non-accidental):

1__ Beyond any doubt 2__ Strongly convinced
3__ Very suspicious 4__ Somewhat suspicious

29. Where did injury occur? (Circle all that apply)

1__ Usual place of residence 2__ School/Day care
3__ Work place 4__ Relative's home
5__ Unrelated caregiver's home 6__ Other (Specify)__________
9__ Unknown

*30. DISPOSITION: Circle all that apply:

1__Hospitalized
2__Discharged to usual place of residence
3__Discharged elsewhere for child's safety (Where)__________
4__Died
5__Other (Describe)______________________________

*31. REPORTING (Circle all that apply):

1__No report made (Why?)______________________________________
2__Reported to child protection agency
3__Report to other social service agency or social worker
4__Reported to police
5__Other (Specify)__________________________________

*32 The Perpetrator(s)

Known or suspected perpetrator(s) Circle all that apply):

1__Mother 2__Father
3__Other relative (Specify_________ 4__Parent's partner/friend
5__Other person (Specify)__________ 9__Unknown

*33 Perpetrator's: Age:___ Years Age_____years
Sex: 1-Male___ 2-Female___ 1-Male___ 2-Female___

34 Does the Perpetrator have a (Circle all that apply):

1__History of being physically abused as a child
2__History of physically abusing children
3__Criminal past
4__History of mental illness
5__History of drug or substance abuse

6__Other (Specify)__________________
9__Unknown

PART G: THE DATA FORM

*35. DATE FORM COMPLETED: _____/___/____ Day/Month//Year

*36. NAME OF FACILITY:________________________________

NAME OF CITY/TOWN:________________________________

*37. OCCUPATION OF PERSON PROVIDING INFORMATION ON THIS DATA FORM:

1: Physician 2: Nurse
3: Social worker 4: Psychologist
5: Other

NOTE: Protocol items preceded by a "*" are considered essential for core data collection.

APPENDIX C.2: GUIDELINES FOR THE INTENTIONAL PHYSICAL ABUSE OF CHILDREN PROTOCOL

The following is an ordered list of guidelines for completing the Intentional Physical Abuse of Children Protocol (APPENDIX C.1). For items which require no further explanation, the item number will be followed by the term "as specified".

Note: Protocol items preceded by an "*" are considered essential for core data collection.

PART A: THE INITIAL DESCRIPTION

The description should be written in the specific words and terms used by the child or reporting adult.

PART B: THE CHILD

1,2,*3,*4 As specified

5 Group which child or reporting adult identifies as child's ethnicity

6 Group which child or reporting adult identifies as child's religion

7 Excludes work on family farm or other family business based in home or surrounding property.

8.1 FULL-TIME = Time spent in school is greater than or equal to the expected, by custom, or the required, by law, time for children of injured child's age.

8.2 PART-TIME = Time spent in school is less than the expected, by custom, or required, by law, time for children of injured child's age.

8.3 As specified

8.4 Child is not of school age as defined by custom or law.

PART C: THE CHILD'S HOUSEHOLD AND SOCIAL DEMOGRAPHICS

*9.1-10 As specified

*9.11 Use this space to specify homes in which child is considered to have more than two parents (e.g. homes with multiple wives or husbands and/or shared child care responsibilities)

*11.1 Urban = As defined in your area. Please specify the criteria which you are using (e.g. population/square kilometer, industrial versus farm community, etc.) to distinguish urban and rural.

*11.2 Rural = As defined in your area. Please specify the criteria which you are using (e.g. population/square kilometer, industrial versus farm community, etc.) to distinguish urban and rural.

*12.1 Low = income less than .75 times average family income for area

*12.2 Middle = income .75 to 2 times average family income for area

*12.3 High = income greater than 2 times average family income for area

FOR EXAMPLE: If average family income for area equals US$ 100/month then
LOW income is equal to 100 x .75 or less than US$ 75/month
MIDDLE income is equal to US$ 75 to 100 x 2 or US$200/month
and **HIGH** income is equal to greater than US$200/month.

*12.9 For instances where it is not possible to determine income

13 Include parents of injured child if parents under 18 years old

14.1-7,9 As specified

15 As specified

PART D: THE PARENTS

16-20 As specified

PART E: MEDICAL INFORMATION

*21.1 **FATAL** = Resulting in death

*21.2 **SERIOUS** = Considerable damage or permanent physical injury is done; usually requiring hospitalization. Exclude hospitalization solely for psycho-social reasons (e.g. removal of child from dangerous situation).

*21.3 **MODERATE** = Hospitalization is not needed to treat the child's injuries but signs or symptoms (bruises, pain) will persist at least 48 hours. **MILD** injuries are not included in the study

Note: See Table 4, Severity of Harm, for more specific examples.

*22.1-14 As specified

*23.1-19 As specified

*24.1-16 As specified

25.1-3 If abnormal, briefly describe abnormality

25.4-6 List any relevant lab data, include name of test (e.g. HCT). If abnormal, briefly describe abnormality (i.e. high, low, etc).

26.1-4 As specified

*27.1-8 As specified

*28.1-4 Level of certainty is your subjective assessment based on the explanation, nature, severity and/or pattern of injuries

29.1-6,9 As specified

*30.1-5 As specified

*31.1 If no report was filed, please briefly explain why.

*31.2-5 As specified

PART F: THE PERPETRATOR(S)

*32.1-5,9 For a more complete listing of potential perpetrators, please refer to Table 5.

*33 As specified

34.1-6,9 As specified

PART G: THE DATA FORM

*35,*36,*37 As specified

PLEASE EXPLAIN BELOW ANY DIFFICULTIES YOU HAD IN ADMINISTRATION OF THE PROTOCOL:

1.

2.

3.

4.

5.

6.

7.

APPENDIX C.3: INTENTIONAL PHYSICAL ABUSE OF CHILDREN PROTOCOL - SHORT FORM

IMPORTANT: *Information provided on this form is confidential and will be used for research purposes only. Return of this form does not constitute an official report of suspected child abuse.*

INITIAL DESCRIPTION OF WHAT HAPPENED - AND WHO WAS INVOLVED - AS OBTAINED FROM THE CHILD OR REPORTING ADULT:

1. CHILD'S INITIALS:_______ 2. DATE OF BIRTH (DAY/MO/YR):__________

3. CHILD'S AGE:_____ Years (OR) ______ Months

4. CHILD'S SEX: 1 - Male 2 - Female

5. ECONOMIC STATUS: 1: POOR 2: MIDDLE 3: WEALTHY 9: CAN'T SAY

6. WHERE CHILD IS LIVING:

__In home with both parents/step-parents
__In home with mother only
__In the home of employers
__On the streets or in street shelters
__Residential facility (specify):_______________
__Other (state):______________________________

7. PLACE OF RESIDENCE (Name of city, town or village): _________________

8. SEVERITY OF INJURY: 1: Fatal 2: Serious 3: Moderate

9. TYPE OF INJURY OR INJURIES (Check all that apply):

__Stab/Puncture Wound
__Abrasion/Scratches
__Swelling
__Laceration
__Burn
__Other internal bleeding
__Bruise/Ecchymosis/Hematoma
__Erythema, Other marks
__Bite
__Fracture/Dislocation
__Retinal Hemorrhage
__Other Internal trauma
Other (Describe):

10. LIKELY MECHANISM OF INJURY:

__Hit with belt/strap/cord
__Hit with fist
__Hit with switch/stick/paddle/board

__Open hand (choked, grabbed, pinched, slapped)
__Propelled (thrown, dropped, pushed, pulled, dragged)
__Kicked
__Shaken
__Bite
__Immersed in hot water
__Burned by cigarette
__Burned by iron/heater/stove
Other (state):____________________

11. BASIS FOR SUSPICION: Indicate the information or reasoning which leads you to suspect that the above injury is the result of physical abuse. Check all that apply:

__Obvious from type or pattern of injury (e.g., cigarette burn)
__Child reports abuse
__Perpetrator admits abuse
__Parent or caretaker witnessed the abuse
__Parent could give no explanation of how injuries occurred
__Explanation of how injury occurred is not consistent with clinical findings
__Documented previous abuse of child or sibling
Other:

12. LEVEL OF CERTAINTY THAT INJURY WAS INTENTIONAL (NON-ACCIDENTAL):

__ Beyond any doubt
__ Strongly convinced
__ Very suspicious
__ Somewhat suspicious

13. KNOWN OR SUSPECTED PERPETRATOR:

1: Mother
2: Father
3: Other relative
4: Parent's partner/friend
5: Other person:

AGE:___ Years
SEX: Male___ Female___
Relation to victim:______________________________

14. DISPOSITION: Check all that apply:

__Hospitalized
__Died
__Discharged to usual place of residence
__Discharged elsewhere for child's safety (e.g., to foster home)

15 REPORTING (Check all that apply):

__No reports made

__Reported to child protection agency
__Reported to other social service agency or social worker
__Reported to police

24. ADDITIONAL COMMENTS OR EXPLANATIONS:

25. DATE FORM COMPLETED: _____/___/____ Month/Day/Year

26. NAME OF FACILITY:____________________________________

CITY OR TOWN:____________________________________

*27. OCCUPATION OF PERSON PROVIDING INFORMATION ON THIS DATA FORM:
1: Physician 2: Nurse
3: Social worker 4: Psychologist
5: Other

APPENDIX C.4: INTENTIONAL PHYSICAL ABUSE OF CHILDREN - ONE PAGE PROTOCOL

IMPORTANT: *Information provided on this form is confidential and will be used for research purposes only. Return of this form does not constitute an official report of suspected child abuse.*

INITIAL DESCRIPTION OF WHAT HAPPENED - AND WHO WAS INVOLVED - AS OBTAINED FROM THE CHILD OR REPORTING ADULT:

1. CHILD'S INITIALS:_______ 2. DATE OF BIRTH (DAY/MO/YR):__________

3. CHILD'S AGE:_____ Years (OR) ______ Months

4. CHILD'S SEX: 1 - Male 2 - Female

5. ECONOMIC STATUS: 1: POOR 2: MIDDLE 3: WEALTHY 9: CAN'T SAY

6. WHERE CHILD IS LIVING:
   __In home with both parents/step-parents
   __In home with mother only
   __In the home of employers
   __On the streets or in street shelters
   __Residential facility (specify):_______________
   __Other (state):______________________________

7. SEVERITY OF INJURY: 1: Fatal 2: Serious 3: Moderate

8. BASIS FOR SUSPICION: Check all that apply:
   __Child reports abuse
   __Perpetrator admits abuse
   __Parent or caretaker witnessed the abuse
   __Parent could give no explanation of how injuries occurred
   __Explanation of how injury occurred is not consistent with clinical findings
   __Documented previous abuse of child or sibling Other:_____________

9. LEVEL OF CERTAINTY THAT INJURY WAS INTENTIONAL (NON-ACCIDENTAL):
   __ Beyond any doubt
   __ Strongly convinced
   __ Very suspicious
   __ Somewhat suspicious

10. KNOWN OR SUSPECTED PERPETRATOR:
    1: Mother 2: Father 3: Other relative
    4: Parent's partner/friend 5: Other person:
    AGE:___ Years SEX: Male___ Female___
    Relation to victim:______________________________

11. DATE:__________________ 12:Person completing the form:________