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An Examination of the Knowledge and Screening Practices for Child Maltreatment among
Primary Care Providers

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College of Nursing

Fall, 2018

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Dedication

I dedicate this DNP project to my husband Joe, my children Jaydon, Luca, and Giada, my parents Joe and Nancy, my extended family, my classmates, my friends, and all those who have helped me through this journey. To my husband and children who picked me up when I was tired and understood if I had to say no, this journey was long and difficult, but you always made me smile and laugh. To my parents who encouraged me to go back to school and broaden my horizons. To my classmates who I cried with and had lots of laughs with, class after class. To my brothers and their families for their support and guidance, and my friends who always checked on me and said it would be ok. To all of you, thanks for all the love and support.

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In addition, I would like to thank the University of Kentucky and Norton Healthcare for selecting me to pursue my dreams and it was a privilege to be part of such a prestigious program. This Doctor of Nursing Practice project and program of the study was fully funded through the University of Kentucky and Norton Healthcare academic-practice partnership. I would also like to thank Amanda Wiggins (statistician) for helping me through this process.

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Abstract

Background: Child maltreatment can affect any race, economic status, gender, and age.

Primary care providers have contact with children and their caretakers daily and develop bonds that encourage open communication. Screening for child maltreatment risk factors can help discover those in danger and decrease abuse rates.

Purpose: The purpose of this study was to examine provider's knowledge of child maltreatment risk factors and assess screening and documentation practices.

Methods: This was a descriptive study that included an electronic survey to primary care providers to assess current knowledge and practices for child maltreatment risk factors. Second, a retrospective chart review was done to assess providers' documentation of risk factors.

Results: Seventy-eight percent of provider's surveyed screen for child maltreatment risk factors at all visits and with parents in the room. Providers surveyed do not feel Kentucky and Indiana have enough resources available to prevent child maltreatment. Providers are fearful to ask difficult questions to caregivers about substance abuse and domestic violence in the home but did not agree as to whether they needed more training on substance abuse or domestic violence.

Conclusion: Providers are knowledgeable when it comes to child maltreatment risk factors. To adequately screen for child maltreatment risk factors, providers must ask specific key questions of patients and their caregivers. Using a standardized set of questions can ensure that all providers in the organization are screening the same.

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Introduction

“Child maltreatment (or child abuse) can be physical, sexual, and emotional mistreatment or neglect of a child, more specifically as an act, or failure to act, on the part of a parent or caretaker that results in the death, serious physical or emotional harm” (The Free Dictionary, 2018, p. 12). Primary care providers have frequent contact with children, especially during the critical years of infancy and toddlerhood when children are at greater risk for abuse. Primary care offices are an ideal location to screen, diagnose, and began treatment of child abuse. Primary prevention regarding child abuse incorporates identifying at risk families, offering resources and interventions aimed at treating the family before an incident occurs. The purpose of this study was to assess the current child maltreatment screening practices of providers (identify risk factors), and to assess if these practices were being documented in a patient’s chart.

Background

Child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child’s health, development or dignity (World Health Organization, 2017). The Center for Disease Control and Prevention estimates that 1 in 4 children experience some form of child maltreatment in their lifetime (CDC, 2016). Children under 4 years of age are at greatest risk for severe injury and death from abuse (CDC, 2016). In 2011, there were over 700,000 confirmed cases of child abuse out of 3.4 million referrals that were made to Child Protective Services (CPS) (Child Maltreatment, 2011). Young children are

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the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves (CDC, 2016). Several risk factors have been associated with an increased probability of child abuse. Contributing factors include young age of the parent, history of domestic violence in the family, and history of substance abuse or mental illness within the family (Hornor, 2011). Negative effects on a child's developing brain, emotive difficulties, intellectual delays, depression, anxiety, and the potential to lead a person to smoke, abuse drugs and alcohol, or potential food binging, are among the many physical and psychological consequences of child maltreatment (Net Wellness Consumer Health Information, 2017).

As of 2012, the total lifetime cost of child abuse and neglect is \$124 billion each year in the United States (CDC, 2012). Each case of abuse is predicted to cost each victim approximately \$210,000 over his or her lifetime of receiving care (Sheets, et al., 2013). In 2016, Kentucky had 52,424 cases of child neglect that met the definition of child maltreatment; 15,378 of those had abuse or neglect findings (Cabinet for Health and Family Services, 2016). Of those 15,378 cases, 76 were fatalities or near fatalities (Cabinet for Health and Family Services, 2016).

Primary care practitioners can help identify those families with risk factors that can lead to child maltreatment. Providers work closely with patients and families in an office setting and can formulate a trusting bond with open communication. If a screening tool in the primary care setting can identify risk factors more consistently, then potential early interventions could reduce the risk of child maltreatment (Murray & Lewin, 2014). Currently there are assessment tools available to be used, but a facility must use one tool to be able to show trends in abuse and to be

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able to accurately gather data. Identification and reporting of abuse are inconsistent and highly dependent on the clinician's awareness and training (Nygren, Nelson, & Klein, 2004). The CDC, Child Welfare Information Gateway, and the American Academy of Pediatrics all have different resources available to help screen for child maltreatment (Child Welfare Information Gateway, 2018). The CDC has research and programs that advocate for the understanding of child abuse and neglect and to prevent it before it begins (Centers for Disease Control and Prevention, 2017). Child Welfare Information Gateway's mission is to help professionals with resources to help protect children and strengthen families (Child Welfare Information Gateway, 2018). The American Academy of Pediatrics and the Council on Child Abuse and Neglect published a policy, *The Pediatrician's Role in Child Maltreatment Prevention*, which educates providers on identifying risk factors, provide guidance to families, and refers families to programs and other resources with a goal to help families thrive (American Academy of Pediatrics, 2018).

When assessment for risk factors occurs, early interventions that reduce the threat of child maltreatment could be offered to the family, thus potentially reducing incidence or minimizing the long-term effects of abuse or neglect (Murray & Lewin, 2014). Early intervention programs mitigate both short term and long-term effects of child maltreatment. The importance of identifying risk factors is foundational to the development of secondary prevention services. The availability of a concise rapidly scored, reliable, and valid screening instrument would enable clinicians to evaluate risk and make referrals to early intervention programs and family support services (Murray & Lewin, 2014).

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The purpose of this study was to assess child maltreatment screening practices (identify risk factors) in primary care providers, and to assess if these practices were being documented in the patient's chart. The specific objectives of this study were to 1) Assess providers' current knowledge of child maltreatment. 2) Assess provider practices regarding screening (identify risk factors) for child maltreatment. 3) Identify what risk factors are documented by primary care providers in the medical record.

Theory

Communication is important in developing a strong bond with a patient or caregiver, in hopes of being able to work collectively to solve any real or potential problems. Hildegard Peplau's theory of interpersonal relationships is the guiding framework for this study. Without a strong relationship between patient and provider it is difficult to establish trust and productive communication. In each of Hildegard Peplau's phases communication is used, particularly the identification phase, where the bond between the provider and patient/caregiver begins. When a provider develops a bond with a patient and their caregiver, important details about a patient or caregiver's history can be identified and documented. Effective verbal and nonverbal communication are an important part of the provider-patient interaction, as well as providing care in a manner that enables the patient to be an equal partner in achieving wellness (Pullen & Mathais, 2010).

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Methods

Design

This study used a descriptive design with an electronic retrospective chart review and an electronic survey to providers (See Appendix A).

Sample and Setting

The sample for the electronic survey was drawn from the population of 74 primary care providers who see pediatric patients within the system. These providers are physicians, nurse practitioners, and physician's assistants, and are from pediatric practice settings and family practice settings. The inclusion criteria were those providers who served children from birth to 18 years of age within a primary care practice. Exclusion criteria included providers that saw children in a specialty care practice and providers that saw only patients over 18 years old.

The study also consisted of a retrospective electronic chart review. Ten medical charts were randomly selected to be reviewed from each of the 20 offices that have a pediatric population for a total of 200 medical records. Inclusion criteria included male or female subjects less than 5 years of age, who were seen for an annual exam at the designated offices from January 1, 2017 to December 31, 2017, and the exclusion criteria were those in the designated population that were seen for an episodic visit.

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Measures

Provider knowledge of child maltreatment was assessed using an electronic survey. The survey was developed in Qualtrics (Qualtrics, 2018), and consisted of 17 questions in Likert scale format. Questions involved knowledge of consequences of child maltreatment, and 3 scenarios where the provider described how they would deal with the situations. The survey was adapted from the World Health Organization (World Health Organization, 2012) and the SEEK (University of Maryland School of Medicine, 2018) questionnaire for providers. Demographic questions asked for credentials, years of experience, the number of child maltreatment cases seen in the last 5 years, training received on child maltreatment.

For the electronic chart review, demographic data was collected consisting of race and gender. Child maltreatment risk factors were also collected from the electronic chart such as insurance carrier, whether the parent was employed parent, biological caregiver, parents married, immunizations up-to-date, CPS involvement, CM documented in chart, and any referrals made.

Procedures

Email addresses were obtained from the organizations' Data Analytics team and, an email was sent out to 74 providers. The email contained an informed consent letter with a link to the survey. Those consenting and agreeing to participate simply clicked on the link to access the survey. An email reminder was sent to the providers at two and four weeks.

For the electronic chart review, a random sample of medical record numbers was

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requested from Data/IT for 10 children from each of the primary care/pediatric offices aged 5 years or below who were seen from January 1, 2017 to December 31, 2017 for annual/well child visit. Two hundred (200) medical record numbers were obtained and stored in a crosswalk table kept in a separate file on the password protected H drive. The data collection tool was numbered 1 to 200 and each study number corresponded to a (MR) medical record number in a crosswalk table. These two spreadsheets will be stored in separate files. Information that was obtained from the medical records was insurance, gender, age, race/ethnicity, parents married, immunizations up-to-date, biological caregiver, documentation of child maltreatment, acknowledge by provider of risk factors identified, referrals made, and employed parent.

Human subject approval was obtained from the University of Kentucky Institutional Review Board (IRB) and Norton Healthcare Office of Research Administration (NHORA).

Data Analysis

Descriptive statistics, which included standard deviation (sd), means, percentages and frequency distributions, were applied to adequately describe all data analysis.

Results

Provider Survey

Seventy-four providers met the criteria for the study. Nine (12.1%) responded to the survey within the dedicated timeframe. Sixty-six percent (n=6) of the participants were female providers and with an average age of 44 and an average of 11.6 years in practice. Seven (77.8%)

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were Doctor of Medicine (MD), one (11.1%) was a Nurse Practitioner (NP), and one (11.1%) was a Doctor of Osteopathic Medicine (DO). Providers responded that more continuing education and training was needed on domestic violence and how to deal with substance abuse in a parent or those in the household.

Providers responded they helped manage an average of 23.6 cases of child maltreatment over the last five years with a range of 5-50 cases. Providers reported encountering specific subjects in the office over the last five years with social problems that impact child maltreatment risk. For example, a mean of 318 hours was spent on major parental stress, 179 hours on parental substance abuse, 64 hours on parental depression, and 15 hours on domestic violence.

Eighty-seven percent of providers (n=7) responded they screen for child maltreatment during all visits and while the caregiver is present in the room. Eighty-eight percent of providers responded that they do not believe Kentucky and Indiana have enough resources available to prevent child maltreatment; 44.4% (n=4) responded neither adequate nor inadequate, 44.4% (n=4) responded inadequate, and 11.1% (n=1) said it was adequate. Providers reported developmental delays, mental health issues, future substance abuse, and high-risk behaviors as the consequences of child maltreatment. Providers reported parents with a history of substance abuse, poverty, mental health issues of the parent, having a child with developmental delays, and not having support were risk factors that led to child maltreatment.

The second part of the survey described three different scenarios and asked for the provider's response. Scenario one depicted a sleepy mother who seems "cranky" when asked

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questions by the provider. All providers responded they would ask about family stressors (mean 4.22, sd 0.42), but providers were concerned if they asked about stressors they could hinder the patient/provider relationship (mean 2.11, sd 0.57). The last question asked providers to state whether training was adequate for substance abuse but there was a variation in their responses (mean 3.33, sd 1.05).

Scenario two depicted a fussy child and the provider speaking with the mother about dealing with her baby's crying. Providers agreed that counseling the mother on dealing with a crying baby is important (mean 4.22, sd 0.42), and crying was a major trigger for abusive head trauma (mean 4.44, sd 0.68). A surprising variance was seen in that 33.3% would not express concern to the mother about her irritation with questions.

Scenario three depicted a baby that cries a lot at home and the mother's partner gets angry with the situation. Providers responded that asking about social support during a visit is important (mean 4.11, sd 0.74), as is asking about domestic violence (mean 2.56, sd 0.57). The Providers disagreed that parents often feel their children do not realize there is violence in the home (mean 3.89, sd 0.57), and providers agree that children are aware of parents fighting (mean 1.44, sd 0.50). Similar to scenario one, provider responses varied as to whether they needed more training on domestic violence (mean 3.22, sd 1.12).

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Retrospective Chart Review

For the second part of the study, 200 electronic medical charts were reviewed. Of the 200 patients, 53.5% were male (n=117). The race analysis for these 200 patients was 63% (n=126) were white, 16.5% (n=33) were African American, 8% (n=16) were Hispanic, 8% (n=16) were of other decent, 4.5% (n=9) were Asian. Fifty-nine percent (n=117) had public insurance versus private. Immunizations not being up-to-date is a risk factor for child maltreatment, and this chart review showed 95.5% (n=191) were up-to-date. A single-family household is also a risk factor for child maltreatment. The review showed 54.5% (n=109) were single parent households, 38.5% (n=77) were married and living in the same household, and 1 was unknown. A further breakdown of the dynamics of the household arrangement was 96% (n=192) were biological caregivers and 4% (n=8) were non-biological caregivers. Another risk factor for child maltreatment is income level for the household and caregiver employment status. In this study, 63.5% (n=127) caregivers were employed, 4.5% (n=9) were not employed according to the chart, but 68% (n=136) had no documentation in the patient's chart related to caregiver employment. See Table 1.

Out of the 200 reviewed electronic medical records, 7.5% (n=15) had child maltreatment reported in the patient's chart. Specific risk factors that were documented in the chart revealed; 100% (n=15) had Child Protective Services (CPS) involvement, 2.5% (n=5) had substance abuse by the parent, 1% (n=2) had child maltreatment documented, 0.5% (n=1) had domestic violence.

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Discussion

The responsibility lies with providers to recognize and treat cases of child maltreatment at first presentation to prevent significant morbidity and mortality (McDonald, 2007). This study was able to assess providers' current knowledge of child maltreatment, provider practices regarding screening for child maltreatment, and provider documentation of child maltreatment risk factors.

Providers agreed on worrisome situations, for example, an inconsolable child, a boyfriend's irritation with a crying infant, and stressors in the home. This is a positive finding in that providers had the knowledge of risk factors that could put a child in danger. Identifying risks involves the attentiveness on the provider's part as well as a familiarity with the historical, physical, and mental clues to abuse (Herrman, Banascak, Csorba, Navratil, & Dettmeyer, 2014). Providers also agreed on teaching coping techniques for a crying infant but also were concerned with asking about difficult situations and damaging the provider/patient bond. Providers were also hesitant to ask about domestic violence and substance abuse for fear of harming the provider/patient/caretaker relationship. Research shows that providers have a fear of an incorrect diagnosis, the possible impact of a report on the provider's relationship with the family, fear of not spending enough time with other patients and, lastly, financial repercussions (Regnaut, Jeu-Steenhouwer, Manaouil, Gignon, & Maxime, 2015). Parents are understandably frightened and concerned when physicians raise the issue of child abuse. There are no clear guidelines for effective communication strategies, although development of an initial rapport with the child and

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the family is important and beneficial during further discussions (McDonald, 2007). The fact that providers have these worries can have a negative impact on the care they provide to those at risk of child maltreatment.

Another key finding from this study was that providers felt that more training was needed on domestic violence and substance abuse in the household. One of the more important contributors to physicians' discomfort with the management of child and family violence is their lack of education and training about the problem (Christian, 2008). In the state of Kentucky, nurses are required to complete 3 hours of continuing education related to domestic violence (one-time requirement), and 1.5 hours on pediatric abusive head trauma (one-time requirement) for their licensure (Kentucky Board of Nursing, 2018). According to the Kentucky Medical Board of Medical Licensure, every 3 years primary care physicians are required 1 hour of Pediatric abusive head trauma training and 3 hours of domestic violence training (Kentucky Medical Board of Licensure, 2018). There are no requirements for substance abuse training or identification of child maltreatment risk factors other than that gained during abusive head trauma education.

Providers should routinely screen for abuse and neglect during office visits by asking questions of both parents and children (McDonald, 2007). Research shows there are key risk factors that lead to child maltreatment such as special needs that may increase caregiver burden (e.g., disabilities, mental health issues, and chronic physical illnesses), parents' lack of

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understanding of children's needs, child development and parenting skills, parental history of child abuse and or neglect, substance abuse and/or mental health issues, parental characteristics such as young age, low education, single parenthood, and low income, and non-biological, transient caregivers in the home (e.g., mother's male partner) (Centers for Disease Control and Prevention, 2017).

All charts reviewed had a physical assessment documented which is one aspect of CM screening. However, more than 90% of abused children have no abnormal findings on physical examination (Herrman, Banascak, Csorba, Navratil, & Dettmeyer, 2014). The rate of specific CM screening in this study was 7.5%, compared to the national average of 9.1% (United States Children's Bureau, 2018). Given the discrepancy in authoritative bodies about screening, it is understandable that providers are confused. The USPSTF concludes that evidence is insufficient to assess the balance of benefits and harms of interventions delivered in primary care to prevent child maltreatment (U.S. Preventive Task Force, 2013). In 2010, the American Academy of Pediatrics published a clinical report advocating for a prominent role of pediatricians in prevention of maltreatment and provided specific guidelines and information on risk factors and protective factors (Flaherty & Stirling, 2010).

Some research shows that providers would like a short and meaningful screening tool to use in the office. The availability of a concise rapidly scored, reliable, and valid screening instrument would enable clinicians to evaluate risk and make referrals to early intervention

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programs and family support services (Murray & Lewin, 2014). A provider can alternate between questions that could uncover abuse, and questions about more conventional subjects, can keep the interview positive and informational (Monroe County Department of Human Services, 2018). Having a tool may cause providers to think more about screening and could potentially increase vigilance (Herrman, Banascak, Csorba, Navratil, & Dettmeyer, 2014).

The chart review revealed narrative comments like ‘no risk factors’ without any reference to what questions were asked. Without information regarding the specific question’s providers asked, it is unknown if the assessment was adequate or not adequate. Without more specific documentation there is no way to conclude if this was appropriate screening. It was interesting to note the way two providers screened. They asked two clear and distinct questions and the caretaker was to answer whether the statement was “often true, sometimes true, or never true.” Within the past 12 months we worried whether our food would run out before we got money to buy more and within the past 12 months the food we bought just didn’t last and we didn’t have money to get more (Hager ER, Quigg AM, et al., 2010). After further research these were part of what is called Hunger Vital Signs (Hager ER, Quigg AM, et al., 2010). Just these two easy questions helped focus on a caretaker’s concern for money and the ability to care for their children at home. But these questions only address one risk factor for child maltreatment. Other concerns are physical abuse in the home, substance abuse, no support at home, and other stressors that can place a child at risk.

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Practice Implications

From the findings in this study, some practice implications are clear. Developing key short questions to ask the parent or caretaker are essential to address the issues. Questions that are direct and open-ended can help a provider get real answers about potential risk factors in the household. Primary prevention programs raise awareness among the public, service providers, and policymakers about the scope of issues involved in child maltreatment (Child Welfare Information Gateway, 2018). Proper training programs such as Safe Environment for Every Child (SEEK), Connected Kids: Safe, Strong, Secure, and Practicing Safety are all programs that have been developed and have been researched. One primary focus of these programs is to educate providers and the public on screening for risk factors of child maltreatment.

Another implication could be a Best Practice Alert when key questions are answered in a way that increases risk. If a few key questions were asked and then scored, a provider could get an alert that potential risks exist. An alert could be a warning for the provider they are with a caregiver that needs potential support.

Another implication could be a Tool Kit for providers could be implemented to highlight risk factors for child maltreatment and how to ask the right questions to help identify these in the office setting. Part of the tool kit could be example questions to start the conversation with the caretaker and develop a rapport with them, so they feel safe to answer these delicate questions. Also included in the tool kit could be risk factors for child maltreatment and resources providers can give a family.

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Future Research

As stated earlier the USPSTF does not feel like there is enough research to support screening for risk factors in the primary care setting. The USPSTF reviewed risk assessment instruments used to identify children for whom preventive interventions might be indicated and found limited and inconsistent evidence on the validity and reliability of these tools (U.S. Preventive Task Force, 2013). Clearly more research is needed because identifying those at risk is the essential first step. USPSTF suggests primary care programs designed to identify high-risk patients/caregivers and refer them to community resources, parent education to improve nurturing and increase the use of positive discipline strategies, and psychotherapy to improve caregivers' coping skills and strengthen the parent-child relationship. These interventions can be delivered in a primary care clinic setting but research as to the benefit will be needed.

Limitations

Limitations to the study are the lack of participation in the electronic survey. With only a 12% participation rate, not enough data was collected to generalize the results. A larger response rate could have more clearly shown what providers agree or disagree on, and where there is potential for improvement.

Another limitation was the unknown factor of what or how well providers asked key questions about risk factors for child maltreatment. Two providers asked key questions about

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lack of food in the household, but this still only acknowledges one risk factor that could lead to child maltreatment.

Conclusion

In conclusion, primary care providers are knowledgeable when it comes to child maltreatment risk factors. To adequately screen for child maltreatment risk factors, providers must ask specific key questions of patients and their caregivers. Using a standardized set of questions can ensure that all providers in the organization are screening the same. Documentation of these risk factors is also a key finding from this study. All providers did a physical assessment on their patients, but this is only one small portion of assessing for child maltreatment.

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Table 1. *Chart Review Demographics*

Characteristics	n= 200 (%)
Gender	
Male	107 (53.5%)
Female	93 (46.5%)
Race/Ethnicity	
White	126 (63%)
African American	33 (16.5%)
Hispanic	16 (8%)
Other	16 (8%)
Asian	9 (4.5%)
Immunizations Up-to-date	
Yes	192 (96%)
No	8 (4%)
Parents Married	
No	109 (54.5%)
Yes	77 (38.5%)
Biological caregiver	
Yes	192 (96%)
No	8 (4%)
Insurance	
State	117 (58.5%)
Private	83 (41.5%)
Employed Caregiver	
Yes	127 (63.5%)
Unknown	36 (18%)
No	9 (4.5%)

EVALUATION OF CHILD MALTREATMENT

Appendix A

Provider Survey

Thank you for agreeing to participate in this study.

Before we start, could you please provide some basic background information about yourself. This will be **completely confidential**.

Sex: Male Female Other

Years in practice:

Title (MD, NP, DO, PA):

Age:

In the past 5 years, approximate number of **cases of child maltreatment** you helped manage:
_____ cases

In the past 5 years, how much **training** have you had on the following topics?

- a. domestic violence _____ hour(s)
- b. parental substance abuse _____ hour(s)
- c. parental depression _____ hour(s)
- d. major parental stress _____ hour(s)

In the past 5 years, how many **times** did you encounter these problems in your patients?

- e. domestic violence _____ time(s)
- f. parental substance abuse _____ time(s)
- g. parental depression _____ time(s)
- h. major parental stress _____ time(s)

EVALUATION OF CHILD MALTREATMENT

When do you screen for child maltreatment?

Well child visits All visits NA

When you screen, who is present when you screen?

Parents in room Provider alone with child NA

In Kentucky/Indiana, do you think that measures so far to prevent child maltreatment have been adequate?

- Adequate
- Neither Adequate nor inadequate
- Inadequate

In your opinion, what are the main types of consequences of child maltreatment? Please list as many types as you can think of.

What do you think are the main risk factors for child maltreatment? Please list as many types as you can think of.

Can you list the names of any institutions currently involved in child maltreatment prevention? Please list any you can think of.

For each scenario, please choose the response that best reflects your level of agreement or disagreement with each of the following statement.

EVALUATION OF CHILD MALTREATMENT

You walk in to an exam room to find Ms. G asleep with her head on the desk, and her baby, AG, crying. When you wake Ms. G, she is somewhat cranky. She tells you how tired she is from working the night shift at the factory.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. I usually inquire about family stressors during well child visits.					
b. I don't usually ask parents about drug or alcohol use.					
c. There isn't enough time in a routine visit for me to ask Ms. G about her own problems.					
d. I'm concerned that asking Ms. G about stressors in her life might interfere with the doctor-patient relationship.					
e. I'd feel comfortable asking Ms. G if she used drugs or alcohol.					
f. If Ms. G disclosed a problem with drugs or alcohol, I know of resources to help her.					
g. I'd like to have more training in dealing with issues like substance abuse.					

You're seeing 3-month old SK for a checkup. He's quite fussy, and his mom seems a bit irritated with him. She says, "He's not easy like my other two." You suggest how she could care for him and she responds, "We'll be fine!"	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. I'm quite worried about this situation					
b. I'd normally express concern to the mother that she seems irritated					
c. It's important to try to motivate parents to accept recommendations					
d. It's understandable that she's irritated; I would not interfere					
e. I usually counsel parents on normal infant crying patterns					
f. If a parent does not want to be helped, there's not much I can do					
g. I usually counsel parents on how to manage infant crying.					
h. My office has reading materials or other resources on infant crying.					
i. I know how to motivate parents who may be resistant to suggestions					
j. Crying is a major trigger of abusive head trauma					
k. Most parents easily figure out how to handle their infant's crying					
l. I really don't have time to try to motivate resistant parents					

EVALUATION OF CHILD MALTREATMENT

<p>Ms. B is in with her 1 year old (LB) for a check-up. Mother feels LB is doing well, but he “cries a lot and sometimes that makes my partner angry.” No other problems are noted, including on exam.</p>	<p>Strongly Disagree</p>	<p>Disagree</p>	<p>Neutral</p>	<p>Agree</p>	<p>Strongly Agree</p>
<p>a. I usually ask families about their social support during well child care visits</p>					
<p>b. I usually don't ask mothers like Ms. B about how family members are getting along⁵</p>					
<p>c. There's no clear basis for asking about domestic violence (DV) in this situation</p>					
<p>d. I feel uncomfortable asking Ms. B about the possibility of DV</p>					
<p>e. I just don't have the time to probe possibilities like DV</p>					
<p>f. I don't really know how to talk to Ms. B about DV</p>					
<p>g. I'm concerned that asking Ms. B about DV might irritate her</p>					
<p>h. I'm not sure what to do if DV turned out to be a problem</p>					
<p>i. Parents often think that their children are not aware of the violence in their relationship</p>					
<p>j. I think that very few middle-class families have problems with DV</p>					
<p>k. Young children don't usually realize that their parents are fighting</p>					
<p>l. I need more training to help address DV</p>					