ISPCAN Child Maltreatment Medical Curriculum
Facilitator Manual

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Introduction

Background & Scope of the Curriculum

The International Society for the Prevention of Child Abuse and Neglect (ISPCAN) has developed these curriculum materials to support its mission of creating sustainable child abuse and neglect systems of prevention, protection and treatment throughout the world.

This curriculum has been developed for medical professionals and students in medical fields. Through 28 hours of didactics and case discussions, the curriculum provides an in-depth introduction to skills that medical professionals need in order to provide diagnosis, medical treatment and advocacy for children who have been abused and neglected.

Professionals from social services, law enforcement and the courts are also welcome and encouraged to participate in this curriculum. The scope of the curriculum is medical in nature, so it will not teach these professionals the full range of information and skills they need in their specific roles of children protection, but it will provide a valuable knowledge base of medical and psychosocial issues so they can have a better understanding of how best to help children.

Goals of the Curriculum

- Improve the identification and medical treatment of children who have been abused and neglected
- Increase communication, information exchange and networking among multidisciplinary professionals in local private and public agencies and organizations
- Build and strengthen multi-disciplinary teams
- Strengthen and expand existing services through more qualified professionals
- Increase training of facilitators and number of trainers trained and engaged

The specific objectives for each learning module are listed in two places: the Appendix in this document, and at the beginning of each module.

Learning Theories Employed in the Curriculum

The curriculum employs several learning theories - from Malcolm Knowles's adult learning theory to several non-Western modes of learning. Malcolm Knowles was the first to write about *andragogy* (how adults learn) as opposed to *pedagogy* (how children learn)[1]. Two of his concepts incorporated in this curriculum include[1]:

- Readiness: The learning readiness of adults is internally motivated and closely related to the assumption of new social roles.
- Orientation: As a person learns new knowledge, he or she wants to apply it immediately in problem solving.

[1] Knowles, M. S. (1968). Andragogy, not pedagogy. *Adult Leadership, 16*(10), 350–352, 386.

The curriculum also includes key components found commonly in non-Western modes of teaching: interdependence, community, holism, and informal learning[2]. Through the use of case discussions, the informality of allowing the participants to ask questions and have discussions throughout the presentation, and through addressing the biological, psychological, and social implications of our work on children and on ourselves, the curriculum provides a supportive environment that fosters engagement of participants from a wide range of learning traditions.

Preparing the Curriculum for a Specific Country

Growing Partnerships

To fulfill the goals of the curriculum, develop your training as just one piece of a *sustainable partnership,* an *ongoing exchange of ideas and practices* on how best to help children:

1. Spend more time exploring what local leaders need than telling them what you can offer. Starting with the Baseline Survey, engage the local medical professionals, social services, and law enforcement in informal discussions in which you share with each other the struggles you encounter in your daily work. Be very upfront about the shortcomings in your community's response to child maltreatment, and use these issues to find common ground and specific topics to emphasize during the training.
2. As you grow the partnership, constantly explore how to make the project sustainable – both financially and in terms of institutionalizing the changes in order to maintain the improved clinical practice. Many communities are rightly wary of engaging with outsiders who think it's exciting to visit their country for a week but then are gone and provide no follow-up to help sustain and grow their work. Given the complexity and the sensitivity of the material in this curriculum, long-term engagement is a must. As the partnership takes shape, discuss with the local leaders their thoughts on next steps for ensuring the lasting success of the training and the partnership.

Cultural Sensitivity

In preparing the curriculum for a specific training, the facilitator will need to be mindful of cultural sensitivity at two levels – first, in the differences between the facilitator and the participants in the training, and second, the cultural differences within the host community in which the participants may benefit from increasing their cultural sensitivity to the different cultures, races, ethnicities and classes in their community. In its simplest form, cultural sensitivity is an appreciation that certain issues may have more than one good, ethical resolution. People who practice cultural sensitivity:

1. Start with *cultural competence* - learn as much as possible about the host country and host region – their history, politics, religion, culture, and which specific groups

[2] Merriam, S.B., Caffarella, R.S., Baumgartner, L.M. Learning in Adulthood: A Comprehensive Guide, 3rd Edition. San Francisco: Jossey-Bass, 2007.

have been marginalized and why. The Baseline Survey provides pertinent questions to discuss with your host regarding religions and cultural norms as they relate to child rights.

2. Take time to reflect on the values and assumptions that guide every large and small decision in their everyday work and life – and then make sure to inquire about these issues with their host. This inquiry and appreciation fosters a true exchange between both parties and provides opportunities both parties to learn something valuable they might not have expected to learn.
3. Employ effective conflict resolution skills: affirm the strengths of the person's position; inquire further – in a nonjudgmental tone - in areas of perceived disagreement; re-assess whether there are further areas of common ground; and conclude by politely explaining the basis of your final stance.
4. Do not allow cultural sensitivity to be a reason to not address sensitive topics. For both the facilitator, and for the participants in their communities, it can be easy to avoid certain topics for fear of expressing an opinion that may seem like an "intrusion" on someone's culture. To truly be appreciative of someone's culture is to ask questions on sensitive topics, but in a context of reflection rather than prescription.
5. Pay attention to details of communication and interaction. Are there any cultural taboos? If you do not speak the native language, at least learn the words and phrases to greet someone, to express thanks, and to say goodbye. What are the customs during meals?
6. Thank everyone, often, for allowing you to be a part of their work to help children.
7. Imagine how a typical tourist might act walking through the town, and then do the opposite. If family are traveling with you, remind them: do not point at people. Do not take photos of people unless you have asked their permission. Do not complain about anything. In restaurants it is fine to avoid food rinsed in tap water, but never turn down food offered in someone's home.

The Baseline Survey

The Baseline Survey should be performed at the very beginning of your project development, over a series of phone calls and emails with your host partners. The goals of the Baseline Survey are to:

1. Establish consistency in the assessments being made by physicians in different communities.
2. Bring to light the important details needed in order to tailor culturally-sensitive, capacity-building activities that best meet the community's needs.
3. Provide a benchmark for assessing progress in the future after the capacity-building has been initiated.

How to Use the Learning Modules

Outline of Learning Modules

I. Child Maltreatment Overview

II. The Social and Developmental Impact of Child Maltreatment

III. Taking a Medical History in Child Maltreatment

IV. Child Physical Abuse

V. Child Sexual Abuse

VI. Psychological Maltreatment

VII. Child Neglect

VIII. Human Trafficking

IX. Multidisciplinary Identification and Management of Child Maltreatment

X. Testifying in Court

Speaker's Notes

Speaker's notes are included in the Notes section below each individual slide in PowerPoint. It is assumed that the facilitator is a physician with expertise in child maltreatment; thus, the speaker's notes do not explain all the important points for each slide, just the points that may not be obvious on a particular slide.

Be sure to familiarize yourself the notes for each slide, even if you are very familiar with the material on the slide – the notes may provide important transition or clarifications that improve the strength of the message of that slide.

Modifying Aspects of the Curriculum

This curriculum serves as a foundation for you to prepare the modules in a way that best meets the needs of your partners in the host country. The most common modifications could include, but are not limited to:

- Adding specific information about the host country – incidence rates of different forms of maltreatment, or specific cultural practices that get mistaken for abuse
- Adding information about strong prevention or treatment programs that already exist in the community that some of the participants from other agencies may not know about.
- Condensing or leaving out certain modules based on limited time availability. The participants will not be able to say they have completed the ISPCAN Child Maltreatment Medical Curriculum, but at least they will have learned more than they knew before.

Training of Trainers

This curriculum is designed in a level of detail and in a style that requires that it be delivered *in-person* by a *physician who is recognized as an expert in child maltreatment*. To

only read the modules, or to have them taught by someone who is not a recognized expert in child maltreatment is not sufficient and could lead to a false sense of comfort and possible under- or over-diagnosis of abuse or neglect.

Gaining expertise in child maltreatment requires years of training with a mentor; never the less, if the facilitator identifies a participant who wishes to join their long-term partnership and commit to extra time involvement so that he or she can become proficient in child maltreatment and eventually become a trainer of this curriculum, then ISPCAN will work to foster this mentorship. The mentorship will include regular case review in which the participant sends their written medical assessments of real children suspected of being maltreated, and the mentor provides constructive feedback and guidance.

Assessing Efficacy

In order to assess efficacy, the curriculum includes a Course Survey for each module to assess the facilitator's (your) efficacy in achieving each of the learning objectives for each module. As you prepare the curriculum for your project, think of ways to assess the ultimate goals of the curriculum, which are to *change clinician behavior* and *improve child outcomes*.

Appendix: Complete List of Learning Objectives

I. Child Maltreatment Overview (1 hour)

Authors: Sue Bennett & Aaron Miller

The participant will be able to:

1. Differentiate between various ethical frameworks for addressing child maltreatment.
2. Describe the various forms of child maltreatment within the context of the United Nations and the Convention on the Rights of the Child.
3. Discuss how adverse childhood experiences affect long-term medical, emotional and social problems for the individual and for society.

II. The Social and Developmental Impact of Child Maltreatment (1.5 hours)

Authors: Michael De Bellis, Marilyn Kaufhold & Cynthia Kuelbs

A. Child Maltreatment Interrelationships (1 hour)

The participant will be able to:

1. Discuss the importance and challenges in obtaining accurate research data.
2. Explain the advantages of viewing child victimization in a social ecology model.
3. Describe child/family characteristics associated with various categories of child abuse.

B. Effects of Abuse and Neglect on Brain Development (0.5 hours)

The participant will be able to:

1. Define the term *developmental traumatology*.
2. Summarize the evidence that shows the effect of early life stress on the biologic stress response system in maltreated children.
3. Compare and contrast brain development in healthy versus maltreated children.
4. List circumstances capable of attenuating or accentuating the effects of maltreatment.

III. Taking a Medical History in Child Maltreatment (2.5 hours)

Author: Aaron Miller

A. Speaking with Caregivers (1 hour)

B. Taking a Medical History from Children (1.5 hours)

Both sections should be presented together because they share the same objectives. The participant will be able to:

1. Discuss important logistical issues in speaking with caregivers and with children.
2. Integrate psychosocial history into medical history when interviewing parents to better assess the child's medical, mental health and psychosocial needs.
3. Incorporate evidence-based best practices when asking children about maltreatment.

IV. Child Physical Abuse (5 hours)

A. Physical Abuse (4 hours)

Author: Stephen Boos

The participant will be able to:

1. Recognize historical and physical findings that should cause the learner to include child abuse in the differential diagnosis.
2. Structure an appropriate evaluation for abuse when it is in the differential diagnosis.
3. Make rational diagnoses of abuse based on all the findings.
4. Initiate management of abuse within the systems of the host country.
5. Strengthen medical documentation by writing child abuse in the differential diagnosis, when appropriate, and writing clear recommendations for the child's physical and emotional well-being.
6. Recognize ways in which Social Services and Law Enforcement are helpful partners to engage in the process of diagnosing/identifying abuse or neglect.
7. Discuss with parents the concern of possible abuse/neglect and explain the next steps that need to occur in contacting Social Services and Law Enforcement.

B. Effective Discipline (1 hour)

Author: John Stirling

The participant will be able to:

1. Define corporal punishment (physical discipline).
2. From global studies, summarize information about incidence and attitudes regarding corporal punishment.
3. Contrast characteristics of effective discipline from the practice of physical discipline.
4. Structure a culturally sensitive dialogue between a health care provider and a parent to discuss discipline.

V. Child Sexual Abuse (10 hours)

Author: Marilyn Kaufhold & Sandra Murray

A. Sexual Victimization Overview (0.75 hours)

The participant will be able to:

1. Describe the disclosure process of a young child sexual abuse victim.
2. List features that distinguish sexual abuse of a young child from that of an adolescent.
3. Explain societal attitudes that discourage and complicate victimization reporting by adolescents.

B. Developmental Anogenital Anatomy (1.5 hours)

The participant will be able to:

1. Correctly label the normal anatomic landmarks of female and male genitalia and anus on a diagram or photograph utilizing the APSAC Glossary as a resource.
2. Recognize genital and anal anatomic variants and nonspecific findings.
3. Explain the relationship of estrogen to female genital changes from birth into puberty.

C. Performing a sexual abuse medical exam (1.5 hours)

The participant will be able to:

1. Describe age appropriate strategies for developing rapport with patients of all pediatric ages prior to the sexual abuse examination.
2. Select appropriate examining positions and techniques that enhance examiner visualizing the patient's genitalia.
3. Explain painful procedures to avoid during sexual abuse examinations.
4. Determine appropriate photos to document findings.

D. Findings in acute and nonacute exams of prepubertal children (1.5 hours)

The participant will be able to:

1. State the incidence of acute and non-acute injuries in prepubertal children examined following sexual abuse.
2. Recognize in photographs, injuries typically caused by sexual abuse acts.
3. Recognize abnormal genital findings resulting from accidental trauma or conditions that are not sexual abuse.
4. Explain why genital injuries may not be found when sexually abused children are examined.
5. Formulate a conclusion from a case scenario.

E. Findings in acute and nonacute exams of adolescents (1 hour)

The participant will be able to:

1. Describe genital injury patterns and incidence associated with acute and nonacute adolescent abuse.

2. Identify from photographs normal genital findings that are sometimes mistaken for injuries.
3. Explain why it is not possible to determine consent vs. nonconsent from the genital examination findings.
4. Explain the significance of nongenital injuries resulting from sexual assault.

F. Sexually transmitted infections in the context of sexual abuse (2 hours)

The participant will be able to:

1. Contrast and explain the difference in the incidence of sexually transmitted infections in prepubertal children vs. adolescents.
2. Analyze the risk factors for acquiring a sexually transmitted infection from sexual abuse or assault from case scenarios.
3. Using local public health data and the current World Health Organization Recommendations, establish a protocol for testing, prophylaxis and treatment for patients following sexual abuse and assault.

G. Evidence collection (1.5 hours)

The participant will be able to:

1. List the usual forensic specimens collected from an acute sexual abuse/assault victim for evidence analysis.
2. Explain how sexual assault evidence may be contaminated or lost before collection.
3. Define the concept of "chain of custody."
4. Justify the importance of establishing a collaborative relationship between medical providers and the forensic laboratory.

VI. Psychological Maltreatment (1 hour)

Author: David Corwin

The participant will be able to:

1. Review developing knowledge and consensus about psychological maltreatment/emotional abuse.
2. Recognize the impact of psychological maltreatment by itself and as a component of all physical abuse, sexual abuse and neglect.
3. Incorporate questions about psychological maltreatment when asking children about maltreatment.

VII. Child Neglect (3 hours)

A. Child Neglect: Intervention and Prevention (1.5 hours)

Author: Howard Dubowitz

The participant will be able to:

1. Explain 3 points that validate the importance of understanding child neglect.
2. Know different approaches to defining neglect.
3. List categories of neglect and identify age-characteristic examples of child neglect for each.
4. Describe various reasons why children with disabilities are at increased risk for maltreatment.
5. Discuss poverty as it interacts with child neglect.

B. Failure to Thrive (1 hour)

Author: Premi Suresh

The participant will be able to:

1. Review use of growth charts.
2. Know how failure to thrive is identified.
3. Be familiar with the three broad categories of causes of Failure To Thrive (FTT).
4. List ways in which FTT could result from abuse and neglect.
5. Learn strategies for management of children with FTT.

C. Safety at School (0.5 hours)

Author: Verena Wyvill

The participant will be able to:

1. Identify logistical issues with schools that increase children's susceptibility to abuse and neglect while in school.
2. Recognize the impact of bullying as a form of child maltreatment.
3. Discuss teacher-student dynamics that increase susceptibility to sexual abuse, physical abuse, and psychological maltreatment.

VIII. Human Trafficking (1 hour)

Author: Sarah Kureshi

The participant will be able to:

1. Define human trafficking.
2. Describe the causes and mechanisms of human trafficking.
3. List various approaches to combat human trafficking.
4. Explain the health consequences of human trafficking.
5. Identify tools for medical providers to use for victim identification and assessment.

IX. Multidisciplinary Identification and Evaluation of Child Maltreatment (2 hours)

A. Multidisciplinary Identification and Evaluation of Child Maltreatment (1 hour)

Author: Aaron Miller

The participant will be able to:

1. Explain the different roles and responsibilities of medical and other health professionals, social services, law enforcement, education/schools, NGOs and other key agencies.
2. Discuss the medical, psychosocial and safety benefits of interagency coordination.
3. List common barriers to interagency coordination and consider effective steps to create lasting improvements in coordination.
4. Recognize the signs and symptoms of *compassion fatigue/secondary trauma*.

B. Child Fatality Review (1 hour)

Author: Michael Durfee

The participant will be able to:

1. Explain the components and processes of effective child fatality review teams.
2. Compare the relative benefits of active case review versus retrospective case review.
3. Consider how child fatality review might be implemented in the host country given the level of resources and interagency coordination.

X. Testifying in Court (1 hour)

Author: Ann Botash

The participant will be able to:

1. List important legal elements of medical documentation in child abuse.
2. Explain the steps in working with attorneys to prepare for court.
3. Describe how to testify in court.