Child Abuse: Know It When You See It

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How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

   Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. **COMPLETE THE COURSE EXAM**

   After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

   Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation**. At this point, you should print the certificate and keep it for your records.

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Course Objectives

Upon completion of this course, the learner will be able to:

- Distinguish among various behavioral and environmental characteristics of abusive parents or caregivers.
- Identify physical and behavioral indicators of physical abuse, maltreatment and neglect.
- Contrast the physical and behavioral indicators of sexual abuse.

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Introduction

This course presents an overview of the signs and symptoms of a serious problem too often confronting nurses - child abuse. There is no classic case; child abuse occurs in all settings, all socioeconomic classes, and all kinds of families. Accidental injury is a leading cause of childhood death and nurses are often in key positions to recognize when injuries may or may not be accidental.

BEING AN ABUSIVE PARENT MEANS:

- Trusting no one because you have been burned too many times.
- Believing that raising your kids is your business and no one else's.
- Verbally attacking your child because you think that is better than hitting.
- Hating yourself for being abusive, but feeling that it is part of yourself that cannot be changed.

BEING AN ABUSED CHILD MEANS:

- Being careful not to do anything that brings you into someone's attention.
- Hoping that the teacher, doctor, or nurse won't believe your parent's/caregiver's story this time.
- Never knowing for sure the consequences of a simple request, facial expression or gesture. Sometimes you are praised and comforted and sometimes you are berated, punished and belittled - you just never know.

BUT MOST OF ALL, ABUSED CHILDREN:

- Wish that they knew what was wrong with them.
- Wish that there was someone gentle who cared, that they could talk to.
- Defend their parents loyally, because they love them and, in spite of everything, they need to believe that their parents love them too.

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Overview

It shouldn't hurt to be a child. Child abuse and neglect are seen in many arenas of practice. The content for this course uses the hospitalized child as a specific model. It is important when reviewing the information that nurses realize the indicators of child abuse, maltreatment and neglect can be applied to all practice settings in which professionals interact with children and their families/caregivers. As child abuse is not limited to one setting, neither is its identification or reporting.

Pediatric nurses often encounter abused/neglected children in emergency rooms, ambulatory clinics and inpatient units. School nurses have the opportunity to observe the abused/neglected child in classroom settings, physical education activities and school health clinics.

Public/community health nurses, who have prior relationships with at-risk families, have the unique opportunity to focus on the prevention of abuse and neglect by providing early intervention services. Psychiatric-mental health nurses have similar opportunities.

However, regardless of the professional's area of specialty practice, it is important to understand the responsibility of all professionals in being able to recognize child abuse/neglect and to participate in appropriate nursing interventions.

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Frequently Asked Questions

How many children are reported and investigated for abuse or neglect?

For calendar year 2002, an estimated 1,800,000 referrals alleging child abuse or neglect were accepted by State and local child protective services (CPS) agencies for investigation or assessment. The referrals included more than 3 million children, and of those, approximately 896,000 children were determined to be victims of child abuse or neglect by the CPS agencies (HHS-ACF, 2002).

CPS agencies respond to the needs of children who are alleged to have been maltreated and ensure that they remain safe. The rate of children who received a disposition by CPS agencies was 43.8 per 1,000 children in the national population. This yields an estimate of 3,193,000 children who received investigations or assessments during 2002 (HHS-ACF, 2002).

An estimated 896,000 children were found to be victims, which was approximately 28.1 percent of all children who received an investigation or assessment. The national rate of victimization was 12.3 per 1,000 children (HHS-ACF, 2002).

The rate of all children who received an investigation or assessment increased from 36.1 per 1,000 children in 1990 to 43.8 per 1,000 children in 2002, which is a 21.3 percent increase (HHS-ACF, 2002).

Approximately 30 percent of the reports included at least one child who was found to be a victim of abuse or neglect. Sixty-one percent of the reports were found to be unsubstantiated (including intentionally false); the remaining reports were closed for additional reasons (HHS-ACF, 2002).

In 2001, the NYS Central Register of Child Abuse and Maltreatment (the Child Abuse Reporting Hotline) received 152,671 reports of suspected child abuse or neglect, 32.6 reports for every 1,000 children in the State. Out of those reports 31%, or 45,298, were confirmed as cases of child abuse and neglect. The number of reports increased by 1% compared to 2000, when the Central Register received 143,712 reports (PCA-NY, 2003).

How many children are victims of maltreatment?

An estimated 896,000 children were determined to be victims of child abuse or neglect in 2002. The rate of victimization per 1,000 children in the national population has dropped from 13.4 children in 1990 to 12.3 children in 2002 (HHS-ACF, 2002).

Is the number of abused or neglected children increasing?

Although the rate of child abuse and neglect appears to have dropped from 1990 to 2002 (from 13.4 per 1,000 children in 1990 to 12.3 per 1,000 children in 2002--a 7.5 percent decrease), the rate of child abuse and neglect fatalities reported by National Child Abuse and Neglect Data System (NCANDS) has increased. Over the last several years there has been a slight increase in fatalities from 1.84 per 100,000 children in 2000 to 1.96 in 2001 and 1.98 in 2002. However, experts do not agree whether this represents an actual increase in child abuse and neglect fatalities, or whether it may be attributed to improvements in reporting procedures. For example, statistics on approximately 20 percent of fatalities were from health departments and fatality review boards for 2002, compared to 11.4 percent for 2001, an indication of greater coordination of data collection among agencies (HHS, 2004).

What are the most common types of maltreatment?

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Neglect is the most common form of child maltreatment. During 2002, 60.5 percent of victims experienced neglect (including medical neglect); 18.6 percent were physically abused; 9.9 percent were sexually abused; and 6.5 percent were emotionally or psychologically maltreated. In addition, 18.9 percent of victims experienced such "other" types of maltreatment as "abandonment," "threats of harm to the child," and "congenital drug addiction." States may code any maltreatment type that does not fall into one of the main categories— physical abuse, neglect, medical neglect, sexual abuse, and psychological or emotional maltreatment— as "other". The maltreatment type percentages total more than 100 percent because many children were victims of more than one type of maltreatment and were coded multiple times (HHS-ACF, 2002).

Who are the child victims?

For 2002, 48.1 percent of child victims were boys, and 51.9 percent of the victims were girls. The youngest children had the highest rate of victimization. The rate of child victimization for the age group of birth to 3 years was 16.0 per 1,000 children of the same age group. The victimization rate of children in the age group of 4-7 years was 13.7 per 1,000 children in the same age group (HHS-ACF, 2002).

Overall, the rate of victimization was inversely related to the age of the child. The youngest children accounted for the largest percentage of victims. Children younger than 1-year-old accounted for 9.6 percent of victims, and children age 1-9 years accounted for approximately 6.0 percent for each single-year age (HHS-ACF, 2002).

American Indian or Alaska Native children and African-American children had the highest rates of victimization at 21.7 and 20.2 per 1,000 children of the same race or ethnicity, respectively. White children and Hispanic children had rates of approximately 10.7 and 9.5 per 1,000 children of the same race or ethnicity, respectively. Asian-Pacific Islander children had the lowest rate of 3.7 per 1,000 children of the same race or ethnicity (HHS-ACF, 2002).

One-half of all victims were White (54.2%); one-quarter (26.1%) were African-American; and one-tenth (11.0%) were Hispanic. American Indians or Alaska Natives accounted for 1.8 percent of victims, and Asian-Pacific Islanders accounted for 0.9 percent of victims (HHS-ACF, 2002).

How many children die from abuse or neglect?

Child fatalities are the most tragic consequence of maltreatment. The National Child Abuse and Neglect Data System (NCANDS) reported an **estimated 1,400 child fatalities in 2002**. This translates to a rate of 1.98 children per 100,000 children in the general population. NCANDS defines "child fatality" as the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect were contributing factors (HHS, 2004).

Research indicates very young children (ages 3 and younger) are the most frequent victims of child fatalities. NCANDS data for 2002 demonstrated children younger than 1 year accounted for 41 percent of fatalities, while children younger than 4 years accounted for 76 percent of fatalities. This population of children is the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves (HHS, 2002; HHS, 2004).

Children age 4 to 7 years old were fatal victims of abuse or neglect in 12 percent of cases; 6 percent were 8 to 11 years old; and 6 percent were 12 to 17 years old (HHS, 2002).

Infant boys (younger than 1 year old) had the highest rate of fatalities, nearly 19 deaths per 100,000 boys of the same age in the national population. Infant girls (younger than 1 year old) had a rate of 12 deaths per 100,000. The overall rate of child fatalities was 2 deaths per 100,000

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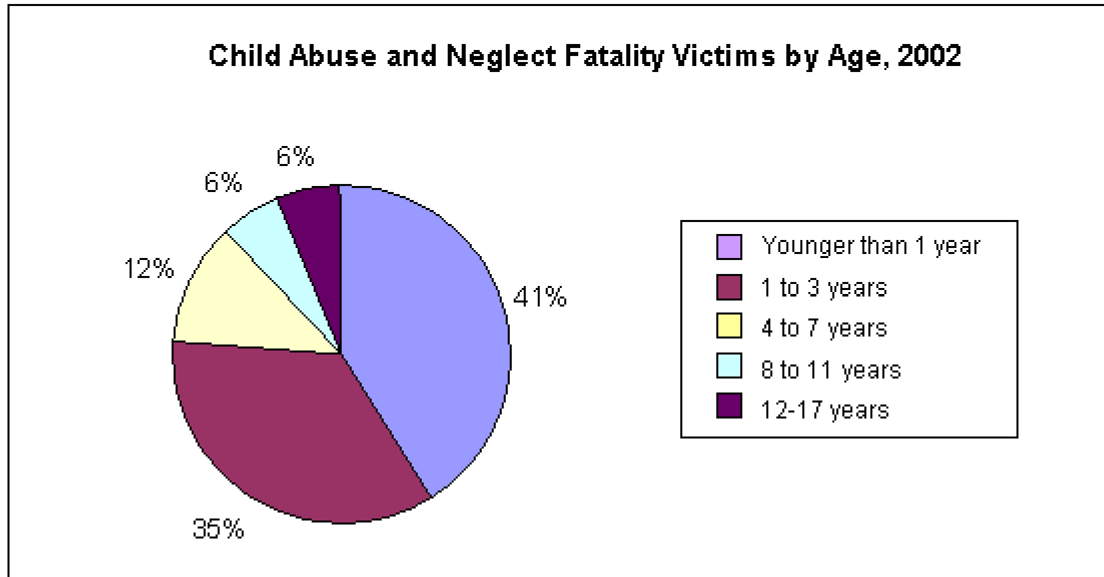
children. One-third of child fatalities were attributed to neglect. Physical abuse and sexual abuse also were major contributors to fatalities (HHS, 2002).



US Department of Health and Human Services (2004).

Many researchers and practitioners believe child fatalities due to abuse and neglect are underreported. States' definitions of key terms such as "child homicide," "abuse," and "neglect" vary (therefore, so do the numbers and types of child fatalities they report). In addition, some deaths officially labeled as accidents, child homicides, and/or Sudden Infant Death Syndrome (SIDS) might be attributed to child abuse or neglect if more comprehensive investigations were conducted or if there was more consensuses in the coding of abuse on death certificates (HHS, 2004).

Studies in Colorado and North Carolina have estimated as many as **50 to 60 percent** of deaths resulting from abuse or neglect are not recorded (Crume, DiGuiseppi, Byers, Sirotnak, Garrett, 2002; Herman-Giddens, Brown, Verbiest, Carlson, Hooten et al., 1999). These studies indicate that neglect is the most under recorded form of fatal maltreatment (HHS, 2004).

In New York State in 2000, 140 fatalities reported to the NYS Central Register alleged the death of a child resulted from abuse or maltreatment. Of these fatality reports, 60% or 72 children were confirmed to have died of as a result of child abuse and neglect (PCA-NY, 2003).

Who abuses and neglects children?

For 2002, 58.3 percent of the perpetrators were women and 41.7 percent were men. Female perpetrators were typically younger than male perpetrators. The median age of perpetrators was 31 years for women and 34 years for men. More than 40 percent (42.5%) of women who were perpetrators were younger than 30 years of age compared to one-third of the men (32.4%) who were younger than 30 years (HHS-ACF, 2002).

By far, the largest percentage of perpetrators (81.0%) was parents, including birth parents, adoptive parents, and stepparents. Other relatives accounted for an additional 6.6 percent. Unmarried partners of parents accounted for 2.9 percent of perpetrators (HHS-ACF, 2002).

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More than one-half (53.3%) of all perpetrators were found to have neglected children. Slightly more than 10 percent (11.0%) of perpetrators physically abused children, and 6.9 percent sexually abused children (HHS-ACF, 2002).

There were variations in these overall patterns when the relationship of perpetrator to the child victim was considered. Less than 3 percent (2.5%) of parents committed sexual abuse; however, 28.9 percent of other relatives, 19.3 percent of daycare providers, 16.4 percent of residential facility staff, and 11.2 percent of unmarried partners of parents committed sexual abuse. More than one-third (36.9%) of perpetrators who were in "other" types of relationships to the child victims—including camp counselors, school employees, and hospital staff—committed sexual abuse (HHS-ACF, 2002).

In cases of fatal abuse, one fact of great concern is that the perpetrators are, by definition, individuals responsible for the care and supervision of their victims. In 2002, one or both parents were involved in 79 percent of child abuse or neglect fatalities. Of the other 21 percent of fatalities, 16 percent were the result of maltreatment by no parent caretakers, and 5 percent were unknown or missing. These percentages are consistent with findings from previous years (HHS, 2004).

There is no single profile of a perpetrator of fatal child abuse, although certain characteristics reappear in many studies. Frequently the perpetrator is a young adult in his or her mid-20s without a high school diploma, living at or below the poverty level, depressed, and who may have difficulty coping with stressful situations. In many instances, the perpetrator has experienced violence first-hand. Most fatalities from *physical abuse* are caused by fathers and other male caretakers. Mothers are most often held responsible for deaths resulting from *child neglect* (HHS, 2004).

Who reports child maltreatment?

In 2002, an estimated total of 2.6 million referrals concerning the welfare of approximately 4.5 million children were made to CPS agencies throughout the United States. Of these, approximately two-thirds (an estimated 1.8 million) were accepted for investigation or assessment; one-third were not accepted (HHS, 2002).

Professionals submitted more than one-half (56.5%) of the reports. "Professional" indicates that the report source came into contact with the alleged victim as part of the reporter's occupation. State laws require most professionals to notify CPS agencies of suspected maltreatment. The categories of professionals include educators, legal and law enforcement personnel, social services personnel, medical personnel, mental health personnel, child daycare providers, and foster care providers. The three most common sources of reports in 2002 were from professionals— educational personnel (16.1%), legal or law enforcement personnel (15.7%), and social services personnel (12.6%) (HHS-ACF, 2002).

Nonprofessional report sources submitted the remaining 43.6 percent of reports. These included parents, other relatives, friends and neighbors, alleged victims, alleged perpetrators, anonymous callers, and "other" sources. Anonymous (9.6%), "other" sources (9.0%) and other relatives (8.0%) accounted for the largest groups of nonprofessional reporters (HHS-ACF, 2002).

Based on data from 38 States for a 5-year timeframe, the percentage of reports made by nonprofessionals decreased from 47.4 percent in 1998 to 43.4 percent in 2002, with an accompanying increase in professional reporters from 52.6 percent to 56.6 percent (HHS-ACF, 2002).

Are victims of child abuse more likely to engage in criminality later in life?

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According to a 1992 study sponsored by the National Institute of Justice (NIJ) maltreatment in childhood increases the likelihood of arrest as a juvenile by 53 percent, as an adult by 38 percent, and for a violent crime by 38 percent. Being abused or neglected in childhood increases the likelihood for arrest for females by 77 percent. A related 1995 NIJ report indicted that children who were sexually abused were 28 times more likely than a control group of non-abused children to be arrested for prostitution as an adult.

Is there any evidence linking alcohol or other drug use to child maltreatment?

A 1999 study by the National Center on Addiction and Substance Abuse found that children of substance abusing parents were almost 3 times likelier to be abused and more than 4 times likelier to be neglected than children of parents who are not substance abusers. Other studies suggest that an estimated 50 percent to 80 percent of all child abuse cases substantiated by CPS involve some degree of substance abuse by the child's parents.

What is HIPAA and does it affect or limit my responsibility as a mandated reporter of suspected child abuse, neglect or maltreatment?

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The privacy provisions contained in this regulation do not affect the responsibilities of mandated reporters, as they are defined in the New York State Social Services Law (NYSOCFS, 2003).

Information concerning the provisions of HIPAA may be found at www.hhs.gov/ocr/hipaa.

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Definitions

Abuse encompasses the most serious harms committed against children. An abused child is defined as one who is under eighteen years of age whose parent or other person legally responsible for his/her care:

- inflicts or allows to be inflicted upon such child physical injury by other than accidental means;
- creates or allows to be created a substantial risk of physical injury to such a child by other than accidental means which would be likely to cause death or serious or protracted disfigurement or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ;
- committed or allowed to be committed a sex offense against a child;
- allows, permits, or encourages such child to engage in any act described in article 263 of the penal law (e.g., obscene sexual performance, sexual conduct, prostitution);
- committed any of the acts described in section 255.5 of the penal law (e.g., incest).

Maltreatment

Maltreatment means that a child's physical, mental, or emotional condition has been impaired or placed in imminent danger of impairment, by the parent's or legal guardian's failure to exercise a minimum degree of care.

A maltreated child includes a child:

- less than eighteen years of age defined as a neglected child by the Family Court Act;
- who has had serious physical injury inflicted upon him/her by other than accidental means;
- is eighteen years of age or older, is neglected and resides in one of the special residential care institutions previously listed.

Neglect

A neglected child is defined as a child less than eighteen years of age whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his/her parents or other person legally responsible for his/her care to exercise a minimum degree of care:

- in supplying the child with adequate food, clothing, shelter, or education, or medical, dental, optometric or surgical care, though financially able to do so or offered financial or other reasonable means to do so;
- in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment;
- by misusing a drug, drugs, or alcohol to the extent that he or she loses self-control of his/her actions;
- by any other acts of similarly serious nature requiring the aid of the court;
- whom his/her parents or other person legally responsible for the child's care has abandoned.

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Poverty or other financial inability to provide for the child is **not** maltreatment.

Definition of Person Legally Responsible

A legal caregiver or person legally responsible is a:

- Parent
- Guardian
- Foster parent
- Custodian
- Any other person responsible for the child's care at the relevant time

It is important to emphasize that abuse or maltreatment can result from the acts of the parent or person legally responsible for a child's care, and suspected incidents should be reported accordingly. In accordance with Sec. 1012(g) of the Family Court Act:

"*Person legally responsible*" includes the child's custodian, guardian, or any other person responsible for the child's care at the relevant time. Custodian may include any person continually or at regular intervals found in the same household as the child when the conduct of such persons causes or contributes to the abuse of neglect of the child.

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Behavioral and Environmental Characteristics

Characteristics of abusive parents or caregivers can be identified by careful assessment that includes:

- Parent/Caregivers History
- Parent/Child History
- Environmental Factors

It is important to remember that child abuse and neglect is a family problem. It is a disease of parenting; it is deviant parenting. Child abuse should receive the same logical, step-wise diagnostic work-up, treatment, and management as any other serious condition.

The challenge is to recognize the potential for child abuse early and to intervene on a primary, rather than secondary, level.

American culture, on the whole, accepts and condones the use of physical discipline as normal practice in the adult-child relationship.

There is definitely room for learning in parenting styles. However, the message from the caregiver to the child must be "it is safe, you can trust me, come out, experiment, you will not be destroyed."

An abusive/neglecting parent does not fit a simple mold. Child abuse/neglect covers a broad continuum of behaviors. Abuse/neglect can run the gamut from an isolated explosive episode to psychotic behavior. However, most abusive parents are not psychotic; they are frequently adults who were abused/maltreated children. Their parenting model was an abusive one. They know no other way of acting. We all essentially parent the way we were parented. Each of us has the potential to abuse. We are saved by our coping mechanism, our own positive experience as children, and/or our intact social supports such as spouses, family and friends.

It should be noted that these indicators are clues but not conclusive proof. They may exist in situations where a child is not suspected to be abused or maltreated. However, they are useful to remember when dealing with the parent/caregiver or child. Clues rarely appear as single entities. Typically, several clues will appear regarding the child and his/her family. Except for the obvious, single clues should be treated as "flags" which indicate that the professional needs to look further, more closely, and methodically.

<u>Parent/Caregiver History</u>

Items in the personal history of the parent/caregiver that should be seen as “red flags” include:

- parent was abused or neglected as a child;
- lack of friendships or emotional support, isolated from supports (such as friends, relatives, neighbors, community groups), lack of self-esteem, feelings of worthlessness;
- marital problems of the parents (and grandparents), may include intimate partner violence;
- physical or mental health problems or irrational behavior;
- life crisis, for example:
    - financial debt
    - unemployment/underemployment
    - housing problems
    - other significant life stressors

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- alcohol/substance abuse of parents or grandparents;
- adolescent parents.

Parent-Child History

- Parents have unrealistic expectations of child's physical and emotional needs -
    - mentally/developmentally disabled children are particularly vulnerable.

- Parent's unrealistic expectations for child to meet parent's emotional needs -
    - role reversal,
    - children viewed as "miniature adults."

- Absence of nurturing child-rearing skills -
    - violence/corporal punishment is accepted as unquestioned child-rearing practice within the parent's culture,
    - violence is accepted as a normal means of personal interaction.

- Delay or failure in seeking health care for child's injury, illness, routine checkups, immunizations, etc.
- Parent views child as bad, evil, different, etc.

Environmental

- Lack of social support
    - Note: there may be an inability to ask for and receive the kind of help and support parents need for themselves and their children.

- Homelessness

Behaviors of Parent/Caregivers of Abused Children

- Contradictory histories
- Cannot explain the child's injury or condition
- Reluctant to give information
- Blame the child's injury on siblings or others
- Hospital "shop", delay in getting care
- Refuse to give consent for diagnostic workup
- Exhibit loss of control
- Overreact or under react to child's condition
- Complain about issues unrelated to child's condition
- Have unrealistic expectations of the child
- Cannot be located
- Present a history of family discord

Both the abusing and non-abusing parent are ultimately responsible.

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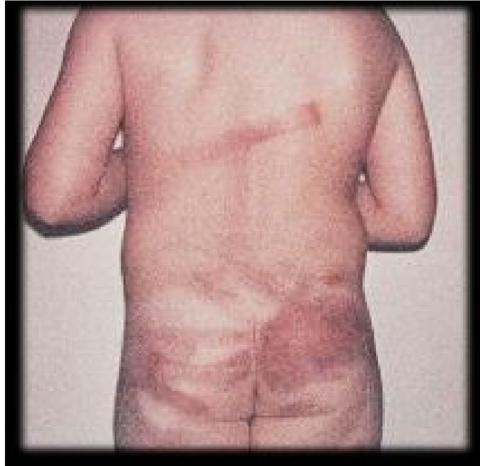
Physical Abuse

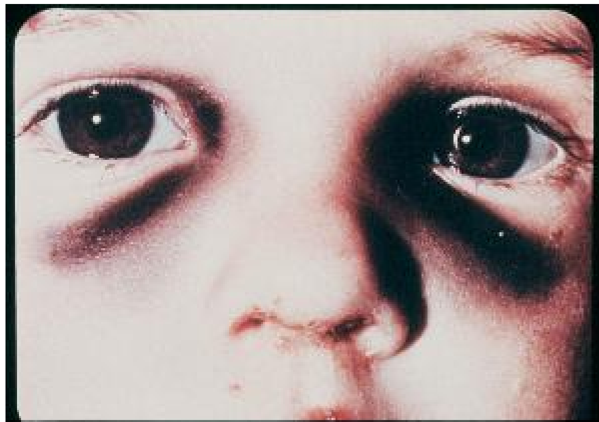
Note: Special attention should be paid to injuries that are unexplained or are inconsistent with the parent(s)/caretaker's explanation and/or the developmental stage of the child. This section will describe physical and behavioral signs that could indicate abuse.

Bruises, welts, and bite marks

- On face, lips, mouth, neck, wrists, and ankles
- On torso, back, buttocks, and thighs



- Both eyes or cheeks - always of suspicious origin because only one side of the face is usually injured as the result of an accident.



- Clustered, forming regular patterns reflecting shape of article used to inflict i.e. electric cord, belt buckle, etc.
- Grab marks, on arms or shoulders

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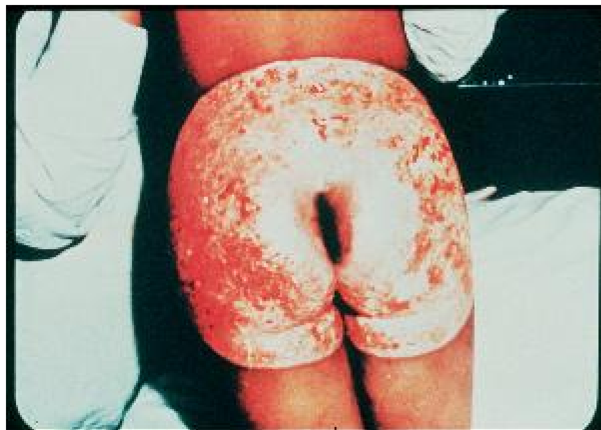
- On several different surface areas
- Evidence of human bite - human bite compresses the flesh, animal bite tears flesh and has narrower teeth imprint
- In various stages of healing
- Regularly appear after absence, weekend, or vacation

Lacerations or abrasions:

- to mouth, lips, gums, eyes,
- to external genitalia,
- on backs or arms, legs or torso.

Burns:

- Cigar, cigarette burns, especially on soles, palms, back, or buttocks
- Immersion burns by scalding water (sock-like, glove-like, doughnut- shaped on buttocks or genitalia - "dunking syndrome")



- Patterned like electric burner, iron, etc.

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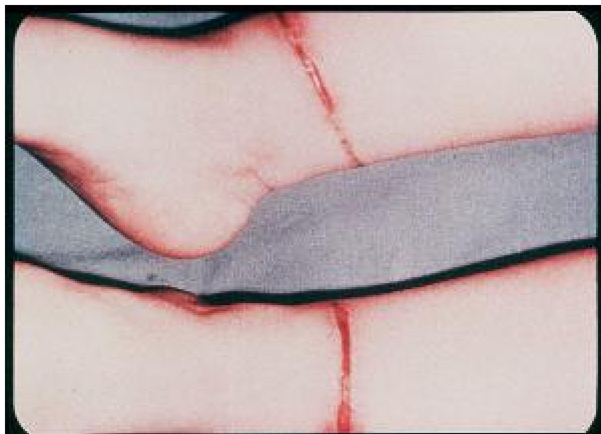
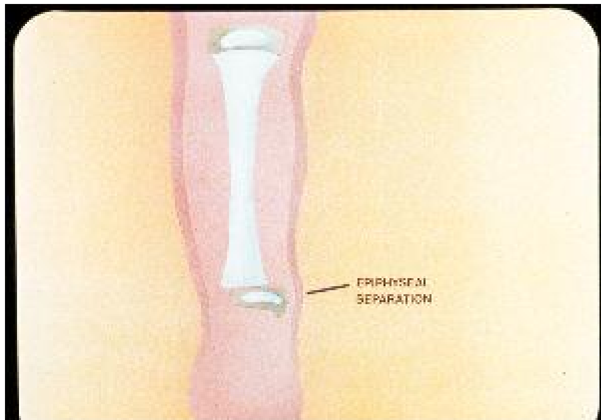
- Rope burns on arms, legs, neck, or torso



Fractures:

- To skull, nose, facial structure
- Skeletal trauma accompanied by other injuries, such as dislocations



- Multiple or spiral fractures

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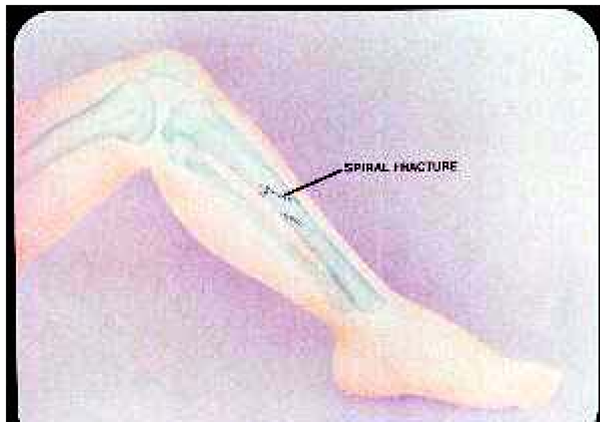
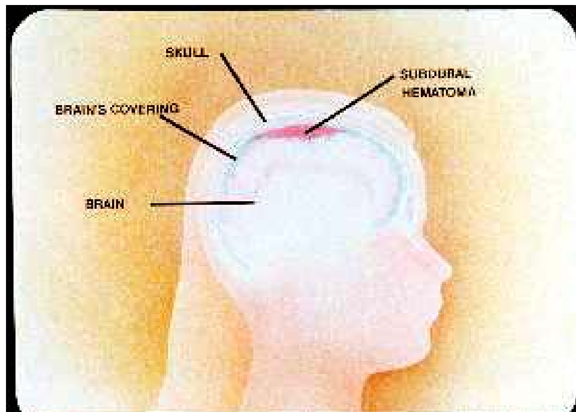


- In various stages of healing
- Fracture "accidentally" discovered in the course of an exam

Head Injuries

- Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling
- Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking)



- Retinal hemorrhage or detachment, due to shaking
- "Whiplash shaken infant syndrome"

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- Eye injury
- Jaw and nasal fracture
- Tooth or frenulum injury

Symptoms suggestive of parentally - induced or fabricated illnesses:

- sometimes know as Munchausen Syndrome by Proxy (MSP) - an example might be repeatedly causing a child to ingest quantities of laxatives sufficient to cause diarrhea, dehydration, and hospitalization.

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Assessing Behavioral Symptoms

- Wary of contact with other adults
- Apprehensive when other children cry
- Exhibits behavioral extremes:
    - aggressiveness,
    - destructiveness,
    - withdrawal,
    - emotionless behavior,
    - extreme mood changes.
- Is afraid to go home, has repeated incidents of running away
- Fear of Parents
- Reports injury by parents:
    - sometimes blames self, e.g., "I was bad and I was punished."
- Has habit disorders:
    - self-injurious behaviors,
    - psychological reactions (obsessions, phobias, compulsions, hypochondria).
- May wear long sleeves or other concealing clothing to hide physical indicators of abuse:
    - often inappropriate for season.
- Manifests low self-esteem
- Attempts suicide

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Maltreatment and Neglect

Just as when observing for physical abuse, professionals must be alert and aware for signs of possible maltreatment and neglect.

Physical Signs

- Obvious Malnourishment
- Failure to thrive (physically or emotionally)
- Drug withdrawal symptoms in newborns
- Lags in physical development
- Poor hygiene/inappropriate seasonal dress, consistent hunger
- Speech disorders
- Chronic lack of supervision, especially in dangerous activities or for long periods
- Unattended physical problems/medical needs
- Untreated need for glasses, dental care
- Chronic truancy
- Abandonment

Remember that not all of these symptoms are present in all abusive/neglectful situations. Look for patterns, clues, or a combination of indicators.

Behavioral Indicators

- Begging for, or stealing food
- Extended stays at school (early arrival or late departure)
- Constant fatigue/listlessness
- Alcohol or drug use/abuse
- Delinquency (e.g., thefts)
- Runaway behavior
- Habit disorders (sucking, biting, rocking, head banging)
- Conduct disorders (antisocial, destructive)
- Neurotic traits (sleep disorders, inhibited play)
- Psychological reactions (hysteria, phobias, hypochondria)
- Behavioral extremes (compliant, passive, aggressive, demanding)
- Lags in mental and/or emotional development
- Suicide attempts

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Sexual Abuse

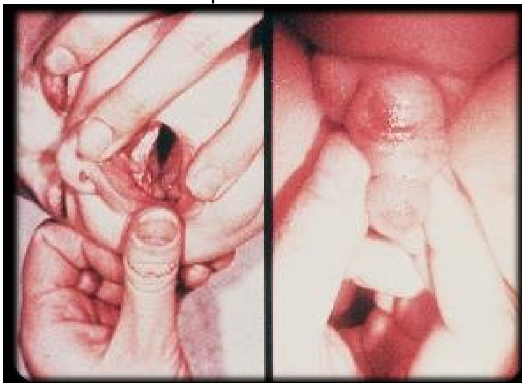
Because most sexual abuse cases do not present overtly apparent physical evidence or indicators, identification and recognition are often very difficult. To compound the problem of detection and identification, the many legitimate fears which child victims of sexual abuse experience make it extremely difficult for them to report the abuse, even to a very trusted adult or friend since their trust has been so violated.

The fact that the vast majority of child molesters are family members or friends of the child or his/her family makes disclosure of the abuse very difficult for the child. Victims of child sexual abuse experience the fear of betraying a loved one and possibly losing affections forever if they disclose the abuse. Child victims fear the overwhelming shame and guilt that such disclosure may cause, and they fear that family members and other significant people in their lives will blame them for the abuse. They also fear the common threats of being hurt or even killed if they disclose the abuse. Even after disclosing sexual abuse, a child may retract the disclosure as the family system may begin to place pressure. For these and other reasons, sexually abused children often decide to live in quiet and devastating isolation with their "secret" rather than risk the realization of their fears.

It is very important to keep in mind that the overwhelming majority of child sexual abuse occurs within the child's immediate or extended family. Most perpetrators of child sexual abuse are known to the child before the abuse. They are usually trusted family members who have easy physical access to their child victims, not the stereotypical strangers in raincoats who wait for children on street corners with lures of candy or money. Child sexual abuse is not a problem uniquely found in only certain geographic areas or among people of certain economic conditions, races, or occupations. There is absolutely no profile of a child molester or of the typical victim. Do not assume that because an alleged offender has an unparalleled reputation for good works in the community or holds a certain job, he or she could not also be a child molester.

Physical Indicators

- Difficulty in walking, sitting
- Torn, stained, bloody clothing or underwear
- Genital pain, itching
- Bruises, bleeding or any injury in genital, vaginal or anal areas
- Bruising, injury to the hard or soft palate



- Sexually transmitted diseases, especially in preteens, including venereal oral infections
- Pregnancy, especially in early adolescent years
- Painful urination or urinary tract infections
- Presence of foreign bodies in vagina or rectum

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Remember, the lack of physical evidence makes identification and recognition difficult. Since the vast majority of child molesters are family members or friends, admitting the abuse is very difficult for the child.

Behavioral Indicators

- Low self esteem
- Refusal to participate in/or change for gym
- Infantile behavior
- Withdrawn/elaborate fantasy life
- Sexually suggestive, inappropriate, or promiscuous behavior or verbalization
- Expressing age-inappropriate knowledge of sexual relations
- Sexual victimization of other children
- Prostitution
- Extreme fear of being touched
- Poor peer relationships
- Delinquency, truancy, running away
- Self-injurious activities/suicide

Components of a Sexual Abuse Examination

- Full history and physical examination
- Psychosocial/developmental evaluation
- X-rays and photographs as indicated
- Genital examination
- Appropriate specialty examinations
- Daycare and school reports

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Hospitalization and the Abused Child

In instances where an abused child is hospitalized, in addition to the treatment of injuries, hospitalization can provide benefits for the abused child and family:

- respite for all involved parties;
- exposure to predictable and trustworthy adults;
- opportunity for the child to develop a positive self image;
- interaction of the child and parent in a controlled environment;
- opportunity for parents to form relationships with supportive professionals.

During hospitalization caregivers must adhere to professional responsibilities:

- the child's safety is the healthcare worker's responsibility;
- parents should be told that New York State law requires that, when the cause of a child's injuries cannot be explained, the child and family is referred to the child protection agency for investigation;
- parents should be informed that the cause of the child's injuries is uncertain and that further studies and evaluation are necessary.

The following information can be very useful in dealing with an abused child:

<u>Assessment</u>

Key Points

- Physical and emotional trauma to child
- Relationship of parents/caregiver and child

Objectives: Outcomes of Care

- Physiological and psychosocial well-being of child
- Freedom from further abuse/neglect
- Positive parent-child interactions

<u>Intervention: Specific Professional Actions</u>

- Verify that the case has been reported to appropriate agencies according to state law
- Promote a trusting relationship with the child:
    - insure consistent professional care givers,
    - Provide a non-threatening atmosphere,
    - Provide frequent contact (note that cuddling/holding may not be appropriate).
- Integrate child into normal daily routine as tolerated
- Observe closely all interactions between parents/caregivers and child
- Remove parent/caregiver from unit if she/he is attempting to harm child
- Participate in multidisciplinary treatment meetings regarding the child's progress and status
- Allow parents/caregivers to verbalize; listen non-judgmentally
- Avoid asking threatening questions about specific incident of abuse

<u>Teaching and Discharge</u>

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- If the child is to be discharged in the custody of parents/caregivers, provide guidance in:
    - specific stages of growth and development to foster realistic expectations of behavior at home,
    - appropriate child-rearing practice within the framework of the individual family's cultural background,
    - proper use and methods of discipline (consistency, positive reinforcement).
- If the child is to be placed outside of the home, assist parents in accepting that the decision has been made for the benefit of the child/family
- Encourage parents to comply with professional guidance/treatment
- Collaborate with other healthcare professionals in discharge planning

<u>Document</u>

- All objective evidence of abuse/neglect
- Child's responses to professional interventions
- Behavior of parent/caregiver with child:
    - time, number, and length of visits and their effects on the child,
    - parent/caregiver's response to child (e.g., eye contact, ignoring child, physical contact),
    - child's response to parent (e.g., crying, no eye contact, clinging, avoidance).
- Parents/caregivers level of comprehension of all instructions/teaching

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Handling Disclosures of Abuse

Recognizing Disclosures

Very seldom will a child disclose abuse immediately after the first incident has occurred. Victimized children often experience a great sense of helplessness and hopelessness and think that nobody can do anything to help them. Also, victimized children may try to make every attempt to protect an abusive parent or they may be extremely reluctant to report any abuse for fear of what the abuser may do to them. Typically, a child may not report abuse for months and even years, particularly if the abuser is someone close to the child.

Sometimes an outcry may not be verbal but portrayed in a drawing left behind inadvertently for the teacher, the counselor, or a trusted relative to see. Another form of outcry may be seen in a child who will frequently go to the school nurse complaining of vague, somatic symptoms, often without organic basis, hoping that the nurse will guess what has happened. This way, in their minds, they have not betrayed, nor will they be punished since they did not directly report the abuse. Some children, while totally reluctant to report or discuss the abuse, may be more willing to express their apprehensions and anxieties about the perpetrator or the home situation. In some cases, abused children will make an outcry, which may take the extreme form of a suicide gesture or attempt.

Children may disclose abuse in a variety of ways. They may blurt it out to you, especially after you have created a warm nurturing environment. They may come privately to **talk directly and specifically** about what is going on. But more common ways include:

> ***Indirect Hints:*** "My brother wouldn't let me sleep last night." "My babysitter keeps bothering me." A child may talk in these terms because he/she hasn't learned more specific vocabulary, feels too ashamed or embarrassed to talk more directly, has promised not to tell, or for a combination of these reasons.
>
> ***Appropriate responses*** would be invitations to tell you more, such as "How did that make you feel?" and open-ended questions such as "Can you tell me more?" or "What do you mean?" Gently encourage the child to be more specific. It is important that the child use his/her own language, and that no additional words are given to the child.
>
> ***Disguised Disclosure****:* "What would happen if a girl told someone her mother beat her?" "I know someone who is being touched in a bad way." Here the child might be talking about a friend or sibling, but is just as likely to be talking about her/himself. Encourage the child to tell you what he/she knows about the "other child." It is probable that the child will eventually tell you about whom he/she is talking.
>
> ***Disclosure with Strings Attached:*** "I have a problem, but if I tell you about it, you have to promise not to tell anyone else." Most children are all too aware that some negative consequences will result if they break the secret of abuse. Often the offender uses the threat of these consequences to keep the child silent. Let the child know you want to help him/her. Tell, from the beginning, that there are times when you too may need to get help with the problem. In order to help, it may be necessary to get some special people involved. The fact that the child has chosen this particular moment to disclose is important. Usually they will agree to seek help if you talk about it ahead of time. Assure the child that you will respect his/her need for confidentiality by not discussing the abuse with anyone other than those directly involved in getting help. And, if you can explain the process, it may help with initial fear.

Responding to Disclosures

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In school, if a child discloses during a lesson, acknowledge the child's disclosure and continue the lesson. Afterward, find a place where you can talk with the child alone. It is best to present child abuse curricula before a playtime or recess so that you have a natural opportunity to talk with children privately if they come forward.

Before notifying anyone outside of your school or agency, you or another designated person should sit down in a quiet room without interruptions and speak with the child. If a child has chosen you as the person in whom to confide, you should take the time to speak with the child about the problem. If that is not possible, ask the child if she/he would feel comfortable discussing it with someone else. If the child indicates that he wants to tell you, you must make every effort to listen and support the child. She/he may not trust another enough to tell.

Multiple interviews should be avoided. The child will have to share the story with many others. When you speak with the child, sit down together, assure him/her that you are concerned and want to know more and that it's okay to tell you. Go slowly, allowing the child to explain as much as he/she can. Do not suggest in any way that any particular person may have done something to him/ her or that the child was touched in any particular way. Let the child talk as much as possible. Explain, in age appropriate language, that the law requires you to make a report if any child discloses abuse and that the law is there to protect them. Describe for them who will be involved, for example, the social worker, principal and the CPS caseworker.

When Talking to the Child

DO:

- Find a private place to talk with the child
- Sit next to the child, not across a table or desk
- Use language the child understands; ask the child to clarify words you don't understand
- Express your belief that the child is telling you the truth
- Reassure the child that it is not his/her fault, and that he/she is not bad and did nothing to deserve this
- Determine the child's immediate need for safety
- Let the child know you will do your best to protect and support him/her
- Tell the child what you will do, and who will be involved in the process

DO NOT:

- Disparage or criticize the child's choice of words or language
- Suggest answers to the child
- Probe or press for answers the child is unwilling to give
- Display shock or disapproval of parent(s), child, or the situation
- Talk to the child with a group of interviewers
- Make promises to the child, about "not telling" nor about how the situation will work out

<u>Supporting the Child After the Report Has Been Made</u>

If it is necessary for Child Protective Services or a Law Enforcement official to interview the child at the school or agency, you should cooperate and assist by providing access for such an interview. Unless there are compelling reasons against it, a staff member the child trusts should be present during the interview to provide support for the child. (This situation may also arise when the report did not originate from your school or agency.)

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Conclusion

Although child abuse and neglect have strong historical roots, it is time to stop the suffering of children. The greater the awareness of this issue among nurses, the more likely that the nurse will be able to identify children who have been abused or neglected and then take appropriate steps to intervene.

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Resources - Compendium of Local, State and National Organizations and Agencies

American Humane Association
Children's Division
63 Inverness Dr. East
Englewood, CO 80112-5117
(303) 792-9900
http://www.americanhumane.org/

This is a national center promoting responsive child protection services in every community through program planning, training, education, and consultation. It operates the National Resource Center on Child Abuse and Neglect. Please contact for free general information.

C. Henry Kempe National Center for the Prevention & Treatment of Child Abuse & Neglect
1825 Marion St.
Denver, CO 80218
(303) 864-5320
http://naccchildlaw.org

The center emphasizes the development of treatment programs for abused children, conducts training and consultation programs, and offers technical assistance. A catalog of materials and services is available upon request.

Center for the Prevention of Sexual and Domestic Violence
936 North 34th St.
Suite 200
Seattle, WA 98103
(206) 634-1903
www.cpsdv.org

This educational and training center is designed to train clergy and lay leaders about family violence and concerns that arise for both the victims and offenders.

Child Welfare League of America (CWLA)
440 First St. NW
Suite 310
Washington, DC 20001
(202) 638-2952
www.cwla.org

This organization is comprised of public and private direct service agencies throughout the United States and Canada. CWLA offers a variety of publications and audiovisual materials for professionals.

Children's Defense Fund (CDF)
25 E. St. NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org

This national advocacy organization focuses on the education, care, welfare, and health of children, and on federal legislation affecting children and families. CDF offers numerous publications on important issues in child health and family welfare.

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Children of the Night
14530 Sylvan St.
Van Nuys, CA 91411
(818) 908-4474
www.childrenofthenight.org

Provide protection and support for street children, usually runaways, ages 11 – 17 who are involved in pornography or prostitution. Provides shelter, a 24-hour hotline, and a street outreach program.

Family Support America
20 North Wacker Dr.
Suite 1100
Chicago, IL 60606
(312) 338-0900
www.frca.org

This membership organization is comprised of social services, agencies concerned with family issues and preventive programs. FSA maintains a clearinghouse of information on family resource programs throughout the United States and Canada.

National Center for Missing and Exploited Children
699 Prince St.
Arlington, VA 22314
(703) 235-3900
www.missingkids.com

This nonprofit corporation operates a national resource and technical assistance center to deal with child abduction and exploitation.

National Clearinghouse on Child Abuse and Neglect (NCCAN)
U.S. Dept. of Health and Human Services
P.O. Box 1182
Washington, DC 20013
1-800-FYI-3366
www.childwelfare.gov

The NCCAN was established by the Child Abuse Prevention and Treatment Act in 1974. Its activities include conducting research, collecting and analyzing information, and providing assistance to states and communities for activities on the prevention of child abuse and neglect.

National Coalition Against Domestic Violence (for members)
119 Constitution Ave. NE
Washington, DC 20002
(202) 544-7358
www.ncadv.org

The coalition is a national organization that works to end violence in the lives of battered women and their children. The coalition provides information, technical assistance, publications, newsletters, and resource materials. Call or write for membership information.

National Network For Youth
1319 F St. NW.
Suite 401

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Washington, DC 20004
(202) 783-7949
www.nn4youth.org

Works to ensure that young people can be safe and grow up to lead healthy and productive lives. Provides Community Youth Development (CYD) services to members and communities. CYD is an approach that models the best practice in youth work and focuses on lifelong learning in which youth develop skills and competencies.

New York State Council on Children and Families
5 Empire State Plaza
Suite 2810
Albany, NY 12223
(518) 474-6294
www.ccf.state.ny.us

The NYS Council on Children and Families is dedicated to reducing child abuse and neglect through development and support of programs and educational materials designed to help families cope successfully with the stresses of family life. Members include professionals, child advocates, local coalitions on child abuse and neglect, and commissioners and directors of relevant state agencies.

New York State Federation on Child Abuse and Neglect
134 S Swan St.
Albany, NY 12210
1-800-children
1-800-342-7472 (Parent information and help line.)
www.preventchildabuseny.org

In its capacity as the New York State Chapter of the National Committee for Prevention of Child Abuse, the Federation supports the activities of regional task forces throughout the state that assist communities in their efforts to prevent child abuse and neglect.

New York State Office of Children and Family Services
Capital View Office Park
52 Washington St.
Rensselaer, NY 12144
800-635-1522
www.ocfs.state.ny.us

New York State Office for the Prevention of Domestic Violence (OPDV)
Capital View Office Park
52 Washington St.
Rensselaer, NY 12144
(518) 486-6262
www.opdv.state.ny.us

Created in 1983 as the Governor's Commission on Domestic Violence, this agency studies all aspects of domestic violence and develops recommendations for ways the state can more effectively help victims and their families. The office has initiated a diverse range of projects and produces a number of publications to help victimized family members.

Prevent Child Abuse America
200 South Michigan Ave. 17th Floor

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Chicago, IL 60604
(312) 663-3520
www.preventchildabuse.org

This organization is committed to the reduction of child abuse and neglect through public awareness, education, research and advocacy. PCAA coordinates chapters at the state level and is a primary resource for local child abuse and neglect prevention efforts. A number of publications on the prevention of child abuse and neglect are produced by PCAA.

Prevent Child Abuse New York
134 S. Swan St.
Albany, N& 12210
www.preventchildabuseny.org

This is the New York State Chapter of Prevent Child Abuse America (discussed above). Programs include The Prevention Information Resource Center and Parent Helpline (24 hour hotline), Healthy Families New York, public awareness and education, advocacy, and annual Legislative and Prevention Conferences. The programs are an integrated whole, offering prevention services that begin with the needs of the child, the family, and the community they live in; expand to the human services and volunteer community that supports them, and reach out to the public officials and public policy makers who have ultimate responsibility to assure that every child has a protected childhood and people who can guide them to a successful future in safe communities.

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Child Abuse: Know It When You See It
Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, login using the username and password you created, click on the "Go to Course" link, and proceed to the course exam.

1. Child abuse may be considered which of the following?
   A. Physical abuse
   B. Neglect
   C. Sexual activity with a consenting 14 year old
   D. Hiring a 15 year old prostitute
      a. (A) only
      b. (A) and (B)
      c. (A), (B) and (C)
      d. all of the above

2. Children are most often physically abused by:
   A. Strangers
   B. Other children
   C. Relatives
   D. Teachers

3. Physical signs that almost always indicate child abuse are:
   A. Lacerations
   B. Injuries to both eyes or cheeks
   C. Bruises
   D. Persistent diaper rash

4. Burns which are physical indicators of child abuse are all of the following EXCEPT:
   A. Cigarette or cigar burns
   B. Immersion-type burns
   C. On one arm only
   D. Burns with patterned designs

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5. Special attention should be paid to injuries that are:
    A. Easily explained by parent/caretaker
    B. Consistent with the explanation given
    C. Inconsistent with developmental stage
    D. Consistent with developmental stage

6. Which behavioral sign is **LEAST** likely to indicate that a child has been physically abused?
    A. Scared when other children cry
    B. Wears only short sleeved shirts
    C. Manifests low self-esteem
    D. Has extreme mood changes

7. Which of the following is **LEAST** likely a physical indicator of maltreatment and neglect?
    A. Chronic truancy
    B. Use of profanity
    C. Unattended physical problems
    D. Slow physical development

8. Family histories can reveal clues that suggest further investigation is warranted if child abuse is suspected. Which of the following is **NOT** such a clue?
    A. Marital problems of spouses
    B. Single parent family
    C. Parent abused as a child
    D. Alcohol/substance abuse

9. Which of the following parent/child interactions warrants further assessment for a possible report of abuse?
    A. Parent's verbalization of mental limits of a child who is developmentally disabled
    B. Child appears to care for or nurture parent
    C. Parent frequently attends school activities with child
    D. Parent appears nurturing

10. Environmental factors which seem to contribute to abusive behavior are all of the following except:
    A. Homelessness
    B. Frequent moves
    C. Extended family present
    D. Lack of social support

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11. Which of the following behaviors demonstrated by a 15-year-old boy is most likely a sign of maltreatment and neglect?
    A. He has a huge appetite
    B. A “C” average in school
    C. He plays violent video games
    D. He is always compliant and passive

12. Which of the following behaviors is the **LEAST** likely sign of sexual abuse?
    A. A 16 year old girl who is sexually active
    B. Unwillingness to change for gym
    C. Unusual sexual knowledge or behavior
    D. Reports of sexual assault by a caregiver

Use the following situations for questions 13 – 15:

A. A 4-year-old girl with gonorrhea

B. A 4-week-old infant who fractured his skull falling out of his crib

C. A 3-year-old and her 3-month-old brother who stay alone while their mother works.

D. 12-year-old with a fractured collarbone, and leg which he says he injured on a friend’s skateboard

13. Which of the situations indicates possible neglect?
    a. A
    b. B
    c. C
    d. D

14. Which of the situations indicates possible physical abuse?
    a. A
    b. B
    c. C
    d. D

15. Which of the situations indicates possible sexual abuse?
    a. A
    b. B
    c. C
    d. D

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16. An individual over eighteen years of age, with a handicapping condition, and residing in a specific state approved residential care facility may be classified as an abuse child.

    A. True

    B. False

17. Nursing assessment of potential child abuse should include physical signs as well as parent/child relationships.

    A. True

    B. False

18. Parenting courses are often essential to help eliminate child abuse.

    A. True

    B. False

19. Documentation of nursing care given to hospitalized abused children must include which of the following?

    1. Child's behavior when parent it present.
    2. Parent's reaction to child's crying.
    3. Child's reaction to nursing staff.
    4. Lack of Visits by parents.

    A. 1 and 2

    B. 1,2, and 3

    C. 1,2, and 4

    D. All of the above.

20. Nursing assessment can aid in identifying child abuse that might go undiagnosed.

    A. True

    B. False

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