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Contact Hours: **3**

Child Abuse, Neglect, and Maltreatment

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COURSE OBJECTIVE: The purpose of this course is to enable healthcare professionals and mandated reporters to identify and report child maltreatment, including child abuse and child neglect.

LEARNING OBJECTIVES
Upon completion of this course, you will be able to:

- Define child maltreatment, child abuse, and child neglect according to the Centers for Disease Control and Prevention.
- Explain the risk factors contributing to child maltreatment.
- Recognize physical and behavioral indicators of child maltreatment.
- Differentiate situations in which mandated reporters must report suspected cases of maltreatment.
- List procedures for placing a child into protective custody.
- Discuss the legal protections afforded mandated reporters as well as the consequences for failing to report.

INTRODUCTION

The government has a responsibility to protect children when parents fail to provide proper care and to intervene in cases of child maltreatment. Likewise, healthcare professionals have a responsibility to recognize and report suspected child abuse and maltreatment.

Parents have the primary responsibility for their children and the legal right to raise them as they see fit. This right falls under the 14th Amendment of the United States Constitution, which states "no state [shall] deprive any person of life, liberty, or property without due process of law." The Supreme Court states that "liberty" as referred to in the amendment denotes not merely freedom

from bodily restraint but also the right of the individual to establish a home and bring up children (USDHHS, 2014).

Although the constitution upholds the rights of parents, initially there were no laws to protect children. The first organization established with the purpose of protecting children from abuse and neglect was a nongovernmental agency; in 1874, the Society for the Prevention of Cruelty to Children was established in New York. A federal Children's Bureau was not founded until 1912, demonstrating that Congress officially acknowledged the government's obligation to protect children from maltreatment.

The Child Abuse Prevention and Treatment Act (CAPTA) of 1974 was signed into law many years later and was the first legislative effort of the federal government to improve the response to child abuse and neglect. In 1996, the Office on Child Abuse and Neglect (OCAN) was created to provide national leadership for child abuse and neglect policy and programs. In the year 2000, the Child Abuse Prevention and Enforcement Act (P.L. 106-77) was enacted. This legislation authorized law enforcement to enforce child abuse and neglect laws, promote child abuse prevention programs, and develop a system to track suspected offenders.

The goal of governmental child abuse laws and programs today is to develop a comprehensive child welfare system that supports children, families, and communities in ways that will prevent the occurrence of maltreatment in the future.

WHAT IS CHILD MALTREATMENT?

The Centers for Disease Control and Prevention (CDC) defines **child maltreatment** as "any act or series of acts of commission or omission by a parent or other caregiver (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child." Under the CDC's definition, child abuse is considered an act of commission and child neglect is considered an act of omission.

Acts of commission (**child abuse**) include physical, sexual, and psychological abuse. These acts are deliberate even though harm to a child may not be the intended outcome. Intention only applies to the actions of the caregiver and not to the result of the act. For example, a parent may intend to hit a child as a form of punishment but not intend for the child to suffer from a concussion. The act of hitting the child is deliberate and intentional and is not accidental.

Acts of omission (**child neglect**) fail to provide for the child's basic physical, emotional, and educational needs. Neglect also includes failure to protect the child from harm or potential harm. As with acts of commission, harm may not be an intended consequence of neglect.

The CDC promotes the use of a consistent definition because it assists in monitoring the incidence of child maltreatment trends over time and across jurisdictions (CDC, 2015a).

By **federal** law, each state is responsible for providing definitions of child abuse and neglect in accordance with minimum standards set in the Child Abuse Prevention and Treatment Act

(CAPTA), 42 U.S.C. §5101, as amended by the CAPTA Reauthorization Act of 2010, which defines child abuse and neglect as, at a minimum:

> Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm.

Most **states** identify four major types of maltreatment: neglect, physical abuse, sexual abuse, and psychological maltreatment. Any of the forms of child maltreatment may occur separately or in combination.

Typically, state definitions that refer to child maltreatment may be found in two places within the state statutory code:

- Civil Statutes: These laws provide guidance for mandatory reporters and determine the grounds for intervention for child protection and services and civil courts.

- Criminal Statutes: These laws provide definitions of child maltreatment that can lead to offender arrest and prosecution in the criminal justice system.
  (Child Welfare Information Gateway, 2015b)

All 50 states, the District of Columbia, and U.S. territories have mandatory child abuse and neglect reporting laws. These laws require certain professionals and institutions to report suspected maltreatment to a child protective services (CPS) agency (USDHHS, 2015a).

CHILDREN IN RESIDENTIAL CARE

Residential care and group homes, both public and private, provide a structured environment for children who have specific needs. These children may have behavioral health issues or disabilities. The definition of a maltreated child in residential care settings is comparable to the definition of abuse occurring in a family setting, but the age limit may be extended up to 21 years old in some states if the child has a disabling condition and resides in a private residential school, a school for the deaf or blind, or other special institution.

Child Abuse

The following types of maltreatment involve acts of commission and are considered child abuse:

- Physical abuse
- Sexual abuse
- Psychological abuse

PHYSICAL ABUSE

Physical abuse is the most obvious form of child abuse. It is the **intentional use of physical force** against a child that results in or has the potential to result in physical injury. Physical abuse includes physical acts ranging from those which do not leave a physical mark on the child to those which cause permanent disability, disfigurement, or death. Physical abuse can result from discipline or physical punishment, regardless of the caregiver's intent to harm or injure the child (CDC, 2014a).

Physical abuse is nonaccidental physical injury and can range from minor bruises to severe fractures and even death. These injuries are a result of shaking, punching, kicking, beating, biting, throwing, stabbing, strangling, burning, or otherwise harming a child by a caregiver, parent, or someone who is responsible for the child (Child Welfare Information Gateway, 2013a).

SEXUAL ABUSE

Child sexual abuse is defined as the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct: or the rape, and in cases of a caretaker or interfamilial relationships, statutory rape, molestation, prostitution of children, or incest with children (CAPTA, 42 U.S.C.A. § 5106g(4)).

Contact Forms

Sexual acts are those in which contact involves penetration, however slight, between the caregiver and the child. A caregiver can also force or coerce a child to commit a sexual act on another individual (either adult or child).

Abusive sexual contact also includes acts in which penetration is not attempted but intentional touching occurs, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks. Sexual contact can be performed by the caregiver on the child, by the child on the caregiver, or by the child on another adult or child through force or coercion by the caregiver. Sexual contact does not include touching required for normal care or attention to day-to-day needs of the child.

Noncontact Forms

Sexual abuse also includes noncontact forms of inappropriate sexual activity, sexual harassment, or exploitation of a child. Noncontact sexual abuse does not require physical contact of a sexual nature between the caregiver and the child. However, it does include acts which expose a child to sexual activity, such as filming of a child in a sexual manner, sexual harassment of a child, or prostitution of a child (Basile et al., 2014).

PSYCHOLOGICAL/EMOTIONAL ABUSE

The CDC defines emotional abuse as behaviors that harm a child's self-worth or emotional well-being. The National Center of Child Abuse and Neglect defines emotional or psychological child abuse as abuse that results in impaired psychological growth and development. Emotional or psychological abuse is sometimes called "invisible" abuse because it does not leave any physical marks. The unseen scars of emotional abuse can leave devastating effects.

Emotional abuse includes parent or other caretaker behaviors that cause or have the potential to cause serious cognitive, affective, or other behavioral health problems. Emotional abuse is a repeated pattern of damaging interactions between parent(s) or caregiver(s) and the child that becomes typical of the relationship and conveys to the child that he or she is flawed, unloved, or unwanted. The pattern may be chronic or triggered by alcohol or other potentiating factors.

The resulting emotional impairment must be clearly attributable to the unwillingness or inability of the parent or other person legally responsible for the child to exercise a minimum degree of care toward the child. Examples include name calling, shaming, rejection, isolating, ignoring, overpressuring, withholding love, and threatening.

Children can also be harmed by exposure to the abuse of others. Some state laws include the exposure of children to domestic violence as a form of abuse or neglect. Children who witness violence in the home experience changes in the anatomic and physiological make up of their central nervous system.

Children who witness domestic violence may develop posttraumatic stress disorder (PTSD) if there is no intervention and may develop permanent changes to their personality as well as their ability to interact effectively in society as an adult. These children may demonstrate sleep disorders, irritability, repetitive play themes, and disorganization. Interventions before the age of seven are the most successful, so it is important to recognize the symptoms and intervene as early as possible (Tsavoussis, 2014).

The developing brain of a child is highly sensitive, and the chronic state of fear and stress that these children experience prevents the brain from developing normally. Instead, the brain is influenced adversely by abnormal patterns of neurological activities and brain chemicals. A violent environment will have the greatest adverse effects on the brains of the youngest children (Gaskill & Perry, 2012).

CASE

Beginning at age 8, Riley, the youngest of four children, has spent every other week at his father's apartment without his siblings so that he and his father can have "one-on-one time." When Riley's parents divorced, and although the judge was aware that Riley's father was possibly abusive, it was the philosophy of the court that children suffer more damage when they have no contact at all with their parents.

At age 9, Riley was developing obvious signs of anxiety, such as running away from Little League baseball games because he did not enjoy playing while people watched. His father

ridiculed him and physically picked him up and put him back on the field in anger in the middle of the game. The coach tried to intervene, but the father prevailed, and Riley stood motionless in the field.

By age 10, Riley was resisting visitation with his father, and a neighbor called 911 after observing Riley's father yelling at him and forcing him into the car, followed by Riley trying to jump out of the moving vehicle. Riley's teacher also reported to the authorities that he arrived late to school 10 days in a row following a visitation to his father and requested to go home to his mother on a daily basis because he had a "stomach ache."

An investigation revealed that Riley was having severe separation anxiety from his mother and siblings and that the apartment where he stayed with his father was filled with storage items, leaving little room for the child. There was no bed at the residence for Riley, who slept on a mat on the floor, nor was there food in the refrigerator. Riley's father said that the child was "fat" and that he did not want to keep any food around for that reason.
Riley was screened in to CPS because he was diagnosed with a severe anxiety disorder by the school psychologist. A multidisciplinary team helped Riley and his family. Riley began seeing the school counselor, and at the recommendation of CPS, his visitation schedule was amended to exclude overnights with his father. In addition, his father was ordered by the court to attend parenting classes. Riley's symptoms improved within a few months after counseling, treatment with anti-anxiety medication, and the revised visitation schedule.

ACE STUDY

Many children suffer multiple types of abuse, which increases their risk of serious health consequences as adults. The Adverse Childhood Experience (ACE) study, published in 2009, investigated the association between childhood maltreatment and later-life health and well-being.

The findings suggest that certain negative experiences in childhood are major risk factors for illness, poor quality of life, and death later in life. The more adverse childhood experiences that were experienced by an individual, the greater the risk of developing alcoholism, chronic obstructive pulmonary disease (COPD), depression, illicit drug use, intimate partner violence, sexually transmitted infections, criminality, and smoking.

Source: CDC, 2014d.

Child Neglect

Child neglect is an act of omission and includes the failure or a parent, guardian, or person responsible for a child to provide for the child's basic needs. Neglect may be physical, medical, educational, or emotional.

- **Physical** neglect is the failure to provide a child with adequate food, shelter, clothing, hygiene, and/or supervision needed for normal growth and development.

- **Medical** neglect is the failure to provide a child with necessary medical or mental health treatment. Some states make provisions for parents who choose not to seek certain forms of medical care for a child due to religious beliefs.

- **Educational** neglect is the failure to educate a child or attend to special education needs.

- **Emotional** neglect includes parent or other caretaker behaviors that cause or have the potential to cause serious cognitive, affective, or other behavioral health problems. These behaviors may include failure to provide love, affection, security, and emotional support; failure to provide psychological care when needed; and spouse abuse in the presence of the child.

Abandonment is also defined as a form of neglect in many states. A child is generally considered to be abandoned when a parent's whereabouts are unknown, the child has been left alone and suffers serious adverse consequences, or the parent fails to maintain contact with or provide reasonable support for a specified period of time.

Substance abuse, such as harm due to prenatal exposure, manufacture of methamphetamine in the presence of a child, providing illegal drugs or alcohol to a child, or use of a controlled substance by the caregiver so that the caregiver is impaired and unable to adequately care for the child may be defined as neglect in some states (Child Welfare Information Gateway, 2013a).

SAFE HAVEN LAWS

Another form of neglect is abandonment (discarding) of an infant. In order to help prevent tragic consequences resulting from unwanted babies, all 50 states have enacted some version of a "safe-haven" law that allows parents to relinquish an newborn infant to the state by leaving the newborn in a safe location such as a hospital, fire department, or police station.

The purpose of these statutes is to decriminalize leaving unharmed infants anonymously in a safe location in order to save the lives of these unwanted infants. Safe-haven laws also protect parents who feel that they have no choice other than abandonment and want to protect their newborn from harm.

In some states, infant abandonment is considered to be a felony. In all states, infant abandonment must be reported by mandated reporters.

Source: Child Welfare Information Gateway, 2013b.

CASE

Robert attends fifth grade at a public school with his childhood friend Kevin. Robert's mother provides him with lunch money or prepares a lunch for him to bring to school. Recently, Robert began to come home from school hungry every day and told his mother that he had given his lunch or his money to Kevin. He also let Kevin borrow a jacket, and it was never returned. His

mother queried him as to why he was doing this, and Robert denied any bullying behavior on Kevin's part; he said Kevin was just really poor and hungry and cold every day. Robert's mother contacted the school about Kevin.

The school counselor called Kevin into the office, and a sensitive discussion revealed that Kevin's parents were separated and that he was living with his father in a hotel room. His father was unemployed and drinking and using drugs daily, leaving little money for food or clothing to care for Kevin's needs. The counselor contacted CPS, who determined Kevin was the victim of neglect. He was placed in the care of his mother, whose income was also below the poverty level, and social services assisted her in obtaining assistance in order to care for Kevin.

PREVALENCE AND RISK FACTORS

Nationally, an estimated 3,188,000 children received a CPS response in 2013, and the estimated number of child victims in 2013 was 679,000, or 9.1 victims per 1,000 children. It is estimated that 1,520 children nationally died as a result of abuse and neglect in that year. Investigations have determined that:

- 79% were victims of neglect
- 18% suffered physical abuse
- 9% suffered sexual abuse
- 8.7% suffered psychological abuse
- 10% were victims of other forms of maltreatment such as abandonment, threats of harm, or parental drug abuse
  (USDHHS, 2015a)

Victim Demographics

The youngest children are the most vulnerable to maltreatment. In 2013, states reported that:

- The victimization rate was highest for children younger than 1 year (23.1 per 1,000 children in the population of the same age).
- More than one quarter of victims were younger than 3 years.
- Twenty percent of victims were ages 3 to 5 years.
- The percentages of child victims were similar for both boys and girls.

There appears to be a racial disparity in the incidence of child fatalities. African American children had the highest fatality rate within their group, with a recorded number of 4.52 deaths per 100,000 children. This is approximately three times higher than the rates of white (1.53 per 100,000) or Hispanic (1.44 per 100,000) child fatalities (USDHHS, 2015a).

Risk Factors

Health professionals need to be alert for risk factors that may increase the likelihood of child abuse and maltreatment. Risk factors may be either characteristics of a caregiver or of a child and may go undetected.

The CDC (2015b) cites the following **caregiver risk factors**:

- Parents' lack of understanding of children's needs, child development, and parenting skills
- Parents' history of child maltreatment in family of origin
- Substance abuse and/or mental health issues, including depression in the family
- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income
- Nonbiological, transient caregivers in the home (e.g., mother's male partner)
- Parental thoughts and emotions that tend to support or justify maltreatment behaviors

The following characteristics of **children** were determined to be risk factors:

- Children younger than 4 years of age
- Special needs that may increase caregiver burden
- Physical disability
- Intellectual disability
- Mental health issues
- Chronic physical illnesses

Additional risk factors include:

- Social isolation
- Family disorganization, dissolution, and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships, and negative interactions
- Community violence
- Concentrated neighborhood disadvantage (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol sales outlets)
- Poor social connections

(CDC, 2015b)

Presence of these factors signals the need for the professional to examine the situation more closely, carefully, and methodically. These factors seldom appear in isolation but rather in clusters.

PARENTAL SUBSTANCE ABUSE AND CHILD ABUSE

Parental substance abuse greatly increases the incidence of child abuse and neglect.

- Children are three times more likely to be abused and four times more likely to be neglected when they live with parents who abuse drugs and alcohol than children who reside in families where there is no substance abuse.
- Substance abuse is present in 40% to 80% of families in which children are victims of abuse and neglect.
- Children of parents who are substance abusers are likely to remain in foster care longer and return to foster care after being reunited than children of parents who are not substance abusers.
- Children of parents who abuse drugs and alcohol are themselves at risk for high rates of alcoholism and other substance abuse.
- Youth who abuse substances have increased incidence of problems at school, pregnancy, and encounters with the criminal justice system.
- More than 8 million children live with parents who are substance abusers.

Source: NCCAFV, 2015.

Protective Factors to Reduce Child Maltreatment

Protective factors safeguard children from being abused or neglected. There is scientific evidence to support that a supportive family environment and social networks have a protective effect. Several other potential protective factors have been identified. Ongoing research is exploring whether the following factors can buffer children from maltreatment:

- Nurturing parenting skills
- Stable family relationships
- Household rules and child monitoring
- Parental employment
- Adequate housing
- Access to healthcare and social services
- Caring adults outside the family who can serve as role models or mentors
- Communities that support parents and take responsibility for preventing abuse

The CDC reports that evidenced-based programs can abate child maltreatment. The CDC's emphasis on prevention of child maltreatment focuses on community awareness and the importance of developing safe, stable, and nurturing relationships and environments. Programs may be offered to parents in different forums, such as in schools, health clinics, homes, and other community settings. These programs also offer social support to parents (CDC, 2014c).

Some examples of programs that have proven to prevent child abuse are government-sponsored child-parent centers, nurse family visits in the home, skill building through parent-child interaction therapy, and parent screening in the pediatric primary care setting (CDC, 2015b).

RECOGNIZING PHYSICAL ABUSE

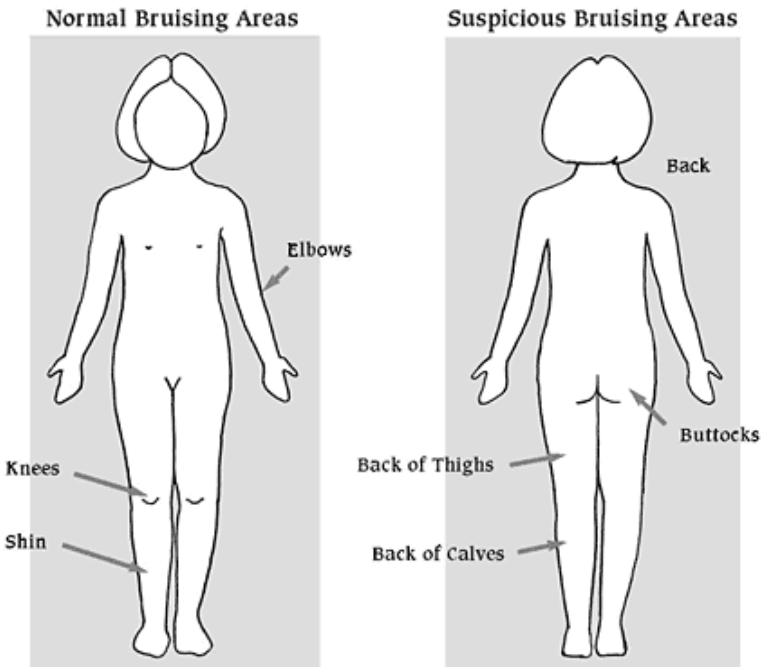
Physical Indicators of Physical Abuse

Healthcare professionals need to be alert for physical injuries that are unexplained or inconsistent with the parent or other caretaker's explanation and/or the developmental state of the child.

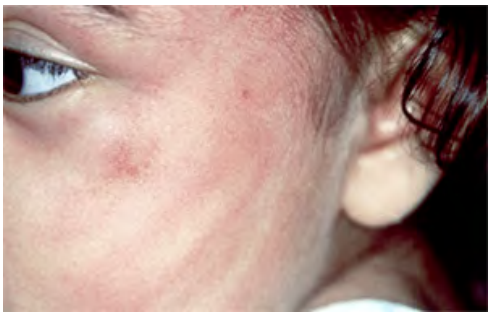
BRUISING

It is important to know both normal and suspicious bruising patterns when assessing children's injuries. Some red flags for non-accidental bruising, if observed, should signal suspicion. In particular, the following injuries are worrisome:

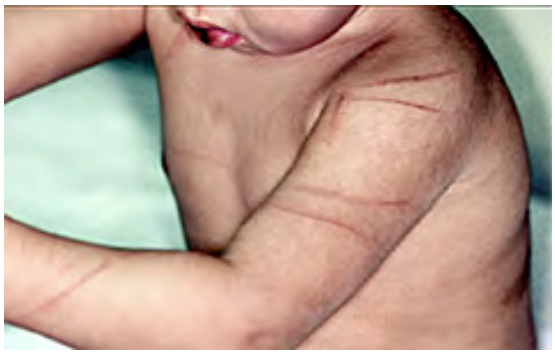
- Bruises in babies who are not yet cruising
- Bruises on the ears, neck, feet, buttocks, or torso (torso includes chest, back, abdomen, genitalia)
- Bruises not on the front of the body and/or overlying bone
- Bruises that are unusually large or numerous
- Bruises that are clustered or patterned (patterns may include handprints, loop or belt marks, bite marks)
- Bruises that do not fit with the causal mechanism described
  (Ward, 2013)



Normal and suspicious bruising areas.
(Source: Research Foundation of SUNY, 2006.)



This pattern signals the blow of a hand to the face of a child.
(Source: NYS OCFS, 2006.)



Regular patterns reveal that a looped cord was used to inflict injury on this child.
(Source: NYS OCFS, 2006.)

CASE

Susan, the school district nurse, was doing routine height and weight measurements for the fifth grade. She valued the opportunity to spend a little time alone with each child. Tommy, small for his age and withdrawn, was in Susan's office for evaluation. He was new this year to the school district, and his records indicated he was already frequently absent.

Susan observed that Tommy was dressed in jeans and a long-sleeved, hooded jacket even though it was 80 degrees out. He also had a black eye as well as a bruise on his opposite cheek. She asked him if he would remove his jacket before stepping on the scale, and when he did so, she noticed four round bruises on the outside of his upper right arm and one round bruise on the inside of his upper right arm. Susan asked Tommy how he had hurt himself, and he said he ran into a door.

Susan believed that the injuries were more consistent with physical abuse and reported her suspicions to CPS. Tommy was interviewed by a social worker, and it was determined that Tommy had been battered by his stepfather. The injury to his eye was the result of being punched. The injury to the right side of his face was sustained when his stepfather struck him as he tried to flee. He incurred the bruises to his right arm when the stepfather grabbed him from behind, causing a patterned injury of four fingers and a thumb.

Tommy's stepfather was arrested and incarcerated. He pleaded no contest to the charges. Tommy and his mother were referred to counseling.

LACERATIONS OR ABRASIONS

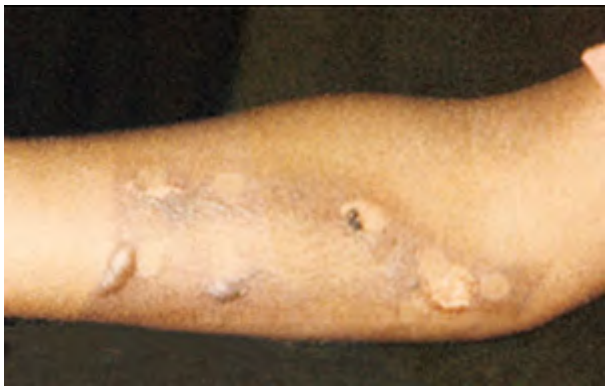
Typical indications of unexplained lacerations and abrasions include:

- To mouth, lips, gums, eyes
- To external genitalia
- On backs of arms, legs, or torso
- Human bite marks (these compress the flesh, in contrast to animal bites, which tear the flesh and leave narrower teeth imprints)

BURNS

Typical indications of unexplained burns include:

- Cigar or 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 an electric burner, iron, curling iron, or other household appliance
- Rope burns on arms, legs, neck, or torso



A steam iron was used to inflict injury on this child.
(Source: NYS OCFS, 2006.)

FRACTURES

Typical indications of unexplained fractures include:

- Fractures to the skull, nose, or facial structure
- Skeletal trauma with other injuries, such as dislocations
- Multiple fractures
- Fractures in various stages of healing
- Swollen or tender limbs

HEAD INJURIES

Typical indications of unexplained head injuries include:

- 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 or pediatric abusive head trauma (see box below)
- Eye injury
- Jaw and nasal fractures
- Tooth or frenulum (of the tongue or lips) injury

PEDIATRIC ABUSIVE HEAD TRAUMA

Abusive head injury is the most common cause of death as the result of child physical abuse. The CDC defines pediatric abusive head trauma (AHT) as an injury to the skull or intracranial contents of an infant or young child (<5 years of age) due to inflicted blunt impact and/or violent shaking. Simply defined, AHT is child physical abuse that results in injury to the head or brain (Parks, 2012).

In 2009, the American Academy of Pediatrics recommended using the term *abusive head trauma* in place of *shaken baby syndrome.* Although the policy statement continued to recognize shaking as a potential cause of serious neurologic injury, the use of *abusive head trauma* includes all mechanisms of inflicted head injury, such as battering and other forms of trauma.

The clinical presentation of infants or children with AHT can vary, and non-accidental injury should be considered in all children with neurologic signs and symptoms, especially if no other injuries are observed. Subdural and retinal hemorrhages are the most common findings (Narang, 2014).

Other possible findings associated with AHT may include:

- Lethargy/decreased muscle tone
- Extreme irritability
- Decreased appetite, poor feeding, or vomiting for no apparent reason
- Absence of smiling or vocalization
- Poor sucking or swallowing
- Rigidity or posturing
- Difficulty breathing
- Seizures
- Head or forehead appears larger than usual
- Fontanel (soft spot) bulging
- Inability to lift head
- Inability of eyes to focus or track movement; unequal size of pupils
- Vomiting
- Apnea

Source: Fingarson & Pierce, 2012.

CASE

Elizabeth is a nurse at the WIC (Women, Infants, and Children) clinic. Her first patient of the day was a 17-year-old single mother cradling a 6-month-old boy. The mother said she was worried about the baby because he had been vomiting and was very sleepy.

The baby was arousable but appeared lethargic on exam. He did not seem interested in feeding when the mother offered him a bottle. Elizabeth weighed the baby and noted that the baby had gained weight appropriately since the last visit. He did not seem to be feverish or have any breathing problems.

Recent history per the mother revealed that the baby had been "colicky" the night before and was crying a lot, but she had not noticed any signs of illness. The mother said she had left the baby with her boyfriend for 20 minutes while she went to the store to buy diapers, and when she returned, the baby was quiet and slept through the night, which was unusual. The mother said she could not get him to wake up enough to take a bottle and that he had been vomiting all morning.

Elizabeth was concerned and sent the mother and child to the emergency department for an examination. The baby was diagnosed with abusive head trauma and admitted. An investigation revealed that the boyfriend had shaken the baby because he was crying and then put him in the crib.

The boyfriend was charged with abuse. The mother voluntarily relinquished custody of the child to her parents until the investigation was completed. The mother was not charged because she was unaware of the boyfriend's abuse and therefore did not knowingly allow it.

Behavioral Indicators of Physical Abuse

Careful assessment of a **child's behavior** may also indicate physical abuse, even in the absence of obvious physical injury. Behavioral indicators of physical abuse include the following:

- Shows fear of going home, fear of parents
- Apprehensive when other children cry
- Exhibits aggressive, destructive, or disruptive behavior
- Exhibits passive, withdrawn, or emotionless behavior
- Reports injury by parents
- Displays habit disorders
    - Self-injurious behaviors (e.g., cutting)
    - Psychoneurotic reactions (e.g., obsessions, phobias, compulsiveness, hypochondria)
- Wears long sleeves or other concealing clothing, even in hot weather, to hide physical injuries
- Seeks affection from any adult

Presence of the following **parent/guardian behaviors** may also indicate an abusive relationship:

- Seems unconcerned about the child
- Takes an unusual amount of time to obtain medical care for the child
- Offers inadequate or inappropriate explanation for the child's injury
- Offers conflicting explanations for the same injury
- Misuses alcohol or other drugs
- Disciplines the child too harshly considering the child's age or what he or she did wrong
- Sees the child as bad, evil, etc.
- Has a history of abuse as a child
- Attempts to conceal the child's injury
- Takes the child to a different doctor or hospital for each injury
- Shows poor impulse control

MUNCHAUSEN SYNDROME BY PROXY

A rare form of child abuse known as Munchausen syndrome by proxy occurs in a medical setting and is characterized by unexplainable, persistent, or recurrent illnesses and discrepancies among the history, clinical findings, and child's general health. This type of abuse is a combination of physical abuse, medical neglect, and emotional abuse.

It is the child's parent (almost always the biological mother) who creates a fictitious illness in the child by giving the child medications, inducing bruising or fever, and often causing the child to become hospitalized. Munchausen syndrome by proxy should be suspected in cases where children have unusual illnesses and/or do not respond to treatment (USDHHS, 2015b).

The characteristics of the parents in this syndrome are predictable. The child's mother frequently has past experience in healthcare and is often a nurse. She gets along well with the hospital staff and appears to be a devoted mother and never leaves the child's side. She may demonstrate a lack of emotion or an inappropriate affect when discussing the child's illness. The mother often reports a history of past abuse and may report falsehoods about her life, such as having earned a law degree. In addition, the mother has both poor relationship and coping skills. If there is a father, he may not ever visit the hospital, and he presents as dependent with a high level of denial and a very supportive attitude towards the mother.

Some of the warning signs of the syndrome are that the signs and symptoms of the child's illness only occur in the mother's presence, the mother never leaves the child alone in the

hospital, and the child is intolerant of the prescribed treatment. The mother may interact more with the medical staff than she does with the child. Diagnosis of Munchausen syndrome by proxy may require a multidisciplinary team approach in the hospital setting.

RECOGNIZING SEXUAL ABUSE

Detecting child sexual abuse can be very difficult. Physical evidence is not apparent in most cases, and victims fear the consequences of reporting their "secret." Most perpetrators of child sexual abuse are people who are known to the victim. In more than half of cases of repeated abuse, the perpetrator is a member of the family. Anyone, even a mother, can be a perpetrator, but most are male.

The fact that such abuse is carried out by a family member or friend further increases the child's reluctance to disclose the abuse, as does shame and guilt plus the fear of not being believed. The child may fear being hurt or even killed for telling the truth and may keep the secret rather than risk the consequences of disclosure. Very young children may not have sufficient language skills or vocabulary to describe what happened.

Child sexual abuse is found in every race, culture, and class throughout society. Girls are sexually abused more often than boys; however, this may be due to boys'—and later, men's—tendency not to report their victimization.

There is no particular profile of a child molester or of the typical victim. Even someone highly respected in the community—the parish priest, a teacher, or coach—may be guilty of child sexual abuse. The majority of perpetrators of child sexual abuse were once victims themselves, but not all victims will become perpetrators.

Negative effects of sexual abuse vary from person to person and range from mild to severe in both the short and long term. Victims may exhibit anxiety, difficulty concentrating, and depression. They may develop eating disorders, self-injury behaviors, substance abuse, or suicide. The effects of childhood sexual abuse often persist into adulthood.

Physical Indicators of Sexual Abuse

Physical evidence of sexual abuse may be not be present or may be overlooked. Victims of child sexual abuse are seldom injured due to the nature of the acts. Most perpetrators of child sexual abuse go to great lengths to "groom" the children by rewarding them with gifts and attention and try to avoid causing them pain in order to insure that the relationship will continue.

If physical indicators occur, they may include:

- Symptoms of sexually transmitted diseases, including oral infections, especially in preteens

- Difficulty in walking or sitting
- Torn, stained, or bloody underwear
- Pain, itching, bruising, or bleeding in the genital or anal area
- Bruises to the hard or soft palate
- Pregnancy, especially in early adolescence
- Painful discharge of urine and/or repeated urinary infections
- Foreign bodies in the vagina or rectum
- Recurring bladder or urinary tract infections
- Painful bowel movements

Behavioral Indicators of Sexual Abuse

Children's behavioral indicators of child sexual abuse include:

- Unwillingness to change clothes for or participate in physical education activities
- Withdrawal, fantasy, or regressive behavior, such as returning to bedwetting or thumb-sucking
- Bizarre, suggestive, or promiscuous sexual behavior or knowledge
- Verbal disclosure of sexual assault
- Being commercially sexually exploited (trafficked)
- Forcing sexual acts on other children
- Extreme fear of closeness or physical examination
- Suicide attempts or other self-injurious behaviors
- Inappropriate sexual behavior
- Inappropriate sexual knowledge for age
- Layered or inappropriate clothing
- Hiding clothing
- Lack of interest or involvement in activities

Sexually abusive **parents/guardians** may exhibit the following behaviors:

- Very protective or jealous of child
- Encourages child to engage in prostitution or sexual acts in presence of the caretaker
- Misuses alcohol or other drugs
- Is geographically isolated and/or lacking in social and emotional contacts outside the family

- Has low self-esteem
  (Prevent Child Abuse New York, 2015)

COMMERICAL SEXUAL EXPLOITATION OF CHILDREN (CSEC)

The crime of sex trafficking of children is defined in the Trafficking Victims Protection Act (18 USC §1591) as "to recruit, entice, harbor, transport, provide, obtain, or maintain by any means a person, or to benefit financially from such action, knowing or in reckless disregard that the person has not attained the age of 18 years and will be caused to engage in a commercial sex act."

CSEC victims are abused physically, psychologically, and emotionally. The perpetrator controls these victims even when they are not physically restrained or confined by their trafficker.

An estimated 80% to 90% of trafficked adolescents were victims of child sexual abuse. Experts suggest that a runaway adolescent is likely to be approached by a pimp or invited to participate in a form of commercial sex within 48 hours of being on the street. The average age of entry into the commercial sex industry is 12 to 14 years.

Impacts of CSEC

Commercially sexually exploited youth frequently suffer from injuries and other physical and mental health issues:

- Anogenital trauma
- Bruises, abrasions, lacerations, burns
- Patterned injuries from belts, ligatures, etc.
- Head injuries
- Injuries resulting from being dragged or run over by a car
- Areas of alopecia due to hair being pulled out
- Pregnancy and abortion
- Fractures
- Sexually transmitted infections
- Tuberculosis
- Pelvic inflammatory disease
- Drug and alcohol addiction or withdrawal symptoms
- Urinary tract infections
- Gastrointestinal and respiratory problems
- Asthma, diabetes, and dental problems that are untreated or not diagnosed
- Headache and back problems

- Malnourishment, dehydration
- Poor hygiene
- Depression and suicidal thoughts
- Anxiety, panic attacks, agoraphobia
- Poor self-esteem, shame, guilt
- Fear for the safety of family
- PTSD and memory loss

Screening for CSEC

Victims of sex trafficking are often accompanied by their pimp, whom they may refer to as their "boyfriend." If trafficking is suspected, the two must be separated by the healthcare professional, for instance, assuring them that privacy for a physical exam is standard practice. Suggested questions when speaking with a child suspected to be a victim of trafficking include:

- Are you able to go to your home or job at will? Are you able to leave when you want to?
- Are you ever locked in at home or at work?
- Has anyone ever hurt you at home or on the job?
- Is anyone making you to do things you do not want to do at home or at work?
- Do you have full access to food, the bedroom, and the bathroom, or do you have to ask permission?
- Has anyone ever taken away your food or water?
- Has anyone ever not allowed you to sleep?
- Have you ever wanted to go the doctor or dentist, but you weren't allowed?
- Has anyone ever threatened your family?
- Has anyone taken your driver's license/passport/papers?

Source: USDHHS, 2013; Becker & Bechtel, 2015.

RECOGNIZING PSYCHOLOGICAL ABUSE

Psychological abuse includes acts that result in serious cognitive, affective, or other behavioral problems. Healthcare providers can recognize such abuse through indicators in both the child and the parent or guardian.

A **child** may demonstrate indicators of serious psychological injury such as:

- Depression
- Self-injurious behaviors

- Antisocial behaviors
- Delinquent behaviors
- Alcohol or drug abuse
- Neurotic traits
- Habit disorders (sucking, nail biting, rocking, etc.)
- Psychoneurotic reactions (hysteria, obsessive-compulsive behaviors, phobias, hypochondria)
- Extreme behavior (compliant or passive, aggressive or demanding)
- Overly adaptive behavior (inappropriately adult, inappropriately infantile)
- Delays in mental and/or emotional development
- Suicide attempt

A **parent or guardian** exhibiting the following indicators may be a perpetrator of psychological abuse:

- Treats children in the family unequally
- Seems not to care much about the child's problems
- Blames or belittles the child
- Is cold and rejecting
- Behaves inconsistently toward the child

(Child Welfare Information Gateway, 2013a)

RECOGNIZING CHILD NEGLECT

Indicators of neglect in a child may be both physical and behavioral:

- Consistent hunger
- Begging or stealing food
- Poor hygiene (skin, teeth, ears, etc.)
- Inappropriate dress for the season
- Failure to thrive (physically or emotionally)
- Positive indication of toxic exposure, especially in newborns, such as drug withdrawal symptoms, tremors, etc.
- Delayed physical development
- Speech disorders
- Consistent lack of supervision, especially in dangerous activities or for long periods of time

- Unattended physical problems or medical or dental needs
- Chronic truancy
- Early arrival to or late departure from school
- Abandonment
- Constant fatigue, listlessness, or falling asleep in class
- Delinquency, such as thefts
- Reports there is no caretaker at home
- Runaway behavior

Additional indicators of emotional neglect may include those listed above under "Recognizing Psychological Abuse."

It is important to be aware that a finding of neglect may not be applied to situations where the caregiver is unable to provide basic needs such as food, shelter, and clothing due to poverty. Child Protective Services should still be notified, however, because they may be able to help the family with resources.

RECOGNIZING AND RESPONDING TO VICTIMS' DISCLOSURES

It is difficult for young children to describe the abuse and they may only disclose part of what happened initially. It is important not to rush the child and to listen to his or her concerns. If a child discloses abuse, the following actions will help the child:

- Remain calm and do not allow the child to see your initial response of shock.
- Thank the child for telling you.
- Use age-appropriate language, and use the terms that the child uses to describe anatomical parts.
- Ask who, what, when, and where so that you will have the information to report to CPS.
- Ask open-ended questions as opposed to leading questions.
- Do not make promises that you cannot keep.
- Explain to the child that he or she may need to repeat this information to someone else.
- Document what the child tells you using the child's own words. Use quotations whenever possible.
  (Botash, 2014a)

Victimized children may cry out in a variety of nonverbal or indirect ways, for example, a drawing left behind for the teacher, the counselor, or a trusted relative to see. Some children report vague somatic symptoms to the school nurse, hoping the nurse will guess what happened.

To the child, this indirect approach is not betrayal of the abuser and therefore not grounds for punishment.

Some children may come to a trusted teacher or other professional and talk directly and specifically about their situation if that person has established a safe, nurturing environment and a sense of trust. More commonly, however, abused children use other, less direct approaches, such as:

- **Indirect hints.** "My brother wouldn't let me sleep last night." "My babysitter keeps bothering me." Appropriate responses would be invitations to say more, such as, "Is it something you are happy about?" and open-ended questions such as "Can you tell me more?" or "What do you mean?" Gently encourage the child to be more specific. Let the child use his or her own language and don't suggest other words 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." An appropriate response would be to encourage the child to state what he or she knows about the "other child." It is probable that the child will eventually divulge who the abused child really is.
- **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 know that negative consequences can result if they break the silence about abuse. Appropriate responses would include letting the child know you want to help him or her and telling the child, from the beginning, that there are times when you too may need to get some other special people involved.

Forensic Interviewing for Sexual Abuse

Sometimes children and adolescents disclose sexual abuse to a trusted adult or there is cause for the adult to suspect sexual abuse. In those cases, the adult should **not** question the child further. He or she should instead contact Child Protective Services or, if the child is in imminent danger, the police. These professionals have protocols in place to interview the child by a child interview specialist while police, prosecutors, and caseworkers observe. Such forensic interviewers are trained to communicate in an age- and developmentally appropriate manner.

This multidisciplinary interview team approach may be utilized for other types of abuse as well. The expectation of this approach is that it will reduce the impact on the child if there is one interview rather than several by different concerned parties (Child First PA, 2014).

Later, the child will most likely need to meet with an investigator and/or a prosecutor. Increasingly, the criminal justice system is implementing the use of "therapy" or "facility" dogs. The child may be introduced to the dog when he or she meets with the investigation team, and in some courts the dog may be allowed to accompany the child when he or she testifies. The presence of a friendly dog can reduce witnesses' fear and anxiety and facilitate a more efficient testimony (CACTX, 2014).

CASE

A mother brought her 12-year-old daughter, Haley, to the emergency department. She said that her daughter had been complaining about painful urination and wanted to check if she might have a bladder infection. The triage nurse, Janelle, asked the mother, who appeared to be in the last trimester of pregnancy, to fill out some paperwork while she took the girl to the bathroom for a urine specimen.

Janelle noticed that the daughter appeared fearful and sat in silence while her mother did all of the talking. When they were alone behind closed doors, Janelle asked Haley if there was anything that she wanted to talk about privately. The child responded by shaking her head no, but the nurse sensed that she was holding something back.

Haley was able to produce a clear, pale yellow urine specimen and then followed the nurse to an exam room. Janelle asked her if she had any pain when she urinated, and Haley said yes. The nurse asked her if she had begun menstruating, and the child said she had not.

Janelle brought the mother into the exam room to wait with her daughter. After obtaining a brief history from the mother, the doctor ordered a urinalysis. The urinalysis was negative. The doctor did an external genital exam that revealed numerous vesicular lesions on her labia. The child denied any sexual activity. The doctor cultured the lesions for herpes and asked the mother to step into his office to discuss his findings.

Once Janelle and Haley were alone again in the room, the child burst into tears and told the nurse that her mother's boyfriend had been rubbing his "private" on her and said that if she told anyone, her mother would go to jail. The nurse stopped questioning the child and reported her suspicion of child sexual abuse to CPS. The nurse knew that victims of child sexual abuse should only be minimally questioned until they can undergo a forensic interview.

On the following day, Haley was interviewed by a child forensic interview specialist in a child-friendly advocacy center. She and her mother, who was also a victim of child sexual abuse, received counseling for over a year. The mother's boyfriend was convicted of sexual abuse.

REPORTING CHILD MALTREATMENT

Each state has a system in place to receive and respond to reports of child maltreatment. Immediate reporting is done by telephone and a written report is also submitted within a designated time frame. Some states utilize an electronic report system.

Who Must Report?

The government has a responsibility to protect children when parents fail to provide proper care and to intervene in cases of child maltreatment. It is the responsibility of all professionals to recognize and report suspected child maltreatment.

Nearly all states designate professions whose members are **mandated** by law to report child maltreatment. Typically, these individuals have frequent contact with children. Such persons may include:

- Social workers
- Teachers and other school personnel
- Physicians, nurses, and other healthcare workers
- Mental health professionals
- Child care providers
- Medical examiners or coroners
- Law enforcement officers

Some other professions include film or photograph processors, computer technicians, substance abuse counselors, probation or parole officers, and attorneys and clergy in certain circumstances. Domestic violence workers, animal control or humane officers, and court-appointed special advocates are also required to report in some states.

It is important that each professional be informed of the laws that pertain to the jurisdiction of his or her practice, as variations exist from state to state. In some states, certain professionals must report, but also **all persons are encouraged to report** suspected abuse or neglect, regardless of profession. All states, territories, and the District of Columbia permit any concerned citizen to report. In a few states, any person who suspects child abuse or neglect is required to report (Child Welfare Information Gateway, 2014b).

What Situations Require That a Report Be Made?

Although the circumstances under which a mandatory reporter must make a report vary from state to state, typically a report must be made when the reporter has **reasonable cause** to suspect that a child whom the reporter sees in his or her professional capacity is abused or maltreated. In some states, the mandatory reporter must report even if the information is third-hand or is not obtained in his or her professional capacity. If the professional has knowledge of or observes a child being subjected to conditions that would reasonably result in harm to the child, a report must also be made (Child Welfare Information Gateway, 2014b).

(For state-by-state information on mandated reporting, see “Child Welfare Information Gateway” in the “Resources” section at the end of this course.)

How Is a Report Made?

In general, a telephone report should be made as soon as possible and then should be followed by a written report. States provide standardized forms for this purpose.

At the time of an oral telephone report, frequently to a state-subsidized 800 number, a CPS specialist will typically request the following information:

- The condition of the child
- Names and addresses of the child and parents or other person responsible for care
- Location of the child at the time of the report
- Child's age, gender, and race
- Nature and extent of the child's injuries, abuse, or maltreatment, including any evidence of prior injuries, abuse, or maltreatment to the child or its siblings
- Name of the person or persons suspected to be responsible for causing the injury, abuse, or maltreatment ("subject of the report")
- Family composition
- Any special needs or medications
- Whether an interpreter is needed
- Source of the report
- Person making the report and where reachable
- Actions taken by the reporting source, including taking of photographs or X-rays, removal or keeping of the child, or notifying the medical examiner or coroner
- Any additional information that may be helpful

A reporter is not required to know all of the above information in making a report; therefore, lack of complete information does not prohibit a person from reporting. However, information necessary to locate a child is crucial.

What Are the Legal Issues Surrounding Mandated Reporting?

FAILURE TO REPORT

Nearly every state enacts penalties, in the form of a fine or imprisonment, on mandatory reporters who fail to report suspected child abuse or neglect. In addition, mandated reporters can be held liable by civil systems for intentionally failing to make a report of suspected abuse that was encountered while acting in their professional capacity (Child Information Gateway, 2014b).

Failure to report also leads to more serious consequences for the child and family. CPS cannot act until child abuse is identified and reported—that is, services cannot be offered to the family nor can the child be protected from further suffering.

IMMUNITY

Individuals who report suspected abuse in good faith are granted immunity from liability. In order to receive federal grants under the Child Abuse Prevention and Treatment Act, states are required to provide immunity from liability for individuals making good-faith reports of suspected or known instances of child abuse or neglect.

CONFIDENTIALITY

Mandatory reporting laws may recognize the right to maintain confidential communications between professionals and their clients, patients, or congregants. In order to provide protection to maltreated children, the reporting laws in most states and territories restrict this privilege for mandated reporters.

There are legal provisions in all states to maintain the confidentiality of abuse and neglect records. In most states, the identity of the reporter is specifically protected from disclosure to the alleged perpetrator (Child Welfare Information Gateway, 2014b).

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) contains privacy provisions that have caused confusion regarding the obligation of a mandated reporter to provide copies of written records that underlie the report. However, these **HIPAA provisions do not affect the responsibilities of mandated reporters.**

CASE

Sharon, a sixth-grade math teacher, stops by her friend Janie's house for coffee on the way to work. While she is there, Janie's 5-year-old son, Bobby, who has been diagnosed with autism, runs into the kitchen and for no apparent reason shoves his 2-year-old sister, who falls to the floor. The sister is not injured, but Janie rages at Bobby, picks him up, and throws him across the kitchen, where he slides into a cabinet, hitting the back of his head.

Sharon takes off her coat and examines Bobby. He too is okay, but Sharon recognizes the importance of taking action for the safety of her friend's young son. Sharon first sits down with Bobby on her lap to talk to Janie. She empathizes with her friend and expresses her concern for the family. She acknowledges how frightening and stressful it must be for Janie to have a child with a serious condition and asks Janie if she could refer Bobby to a program for autistic children that is provided by the school district. Janie tearfully agrees, and Sharon makes a few calls to the school district to gather information about the program.

Sharon also tells her friend that she will put a call in to social services to request some assistance for the family. Since she is a mandated reporter, Sharon also tells Janie she will need to make a report to Child Protective Services even though she has observed the incident outside of her professional capacity. In her report, Sharon describes Janie's desire to help her child and her voluntary interest in a referral to services that can help her. Sharon is confident that her report will be instrumental in helping her friend receive needed services.

Sharon makes a point to call Janie the next day and frequently thereafter, and one month later, Janie tells Sharon that a social worker referred her to a program for parents of children with special needs in which she has learned appropriate new ways of dealing with Bobby's acting-out behaviors. Bobby has also been enrolled in the school district's program for autistic children and is doing much better.

GATHERING FORENSIC EVIDENCE

Whenever there are allegations of suspected child abuse or neglect, the mandated reporter should keep in mind that any records of physical findings may be used as evidence at a trial. Photos, diagrams, and accurate reporting of medical examination findings are invaluable. Photographs and X-rays provide objective visual evidence to substantiate a report of suspected child abuse and are, along with other imaging studies, legally admissible evidence in court proceedings. Photographs are subject to the same guidelines as other medical records.

The mandated reporter should take care to use language that is not open to misinterpretation when documenting findings (Pullido, 2012).

Photographing Evidence

The goal for photographing evidence is to accurately document the findings that serve as a basis for one's opinion. In many states, permission from a parent or guardian is not required prior to taking photographs of suspected child abuse victims.

If photographs will be needed, it is a good idea to inform the child or adolescent and encourage them to participate in the process. Photographs are another form of medical documentation that can provide objective, visual documentation of abuse. There should be a protocol for releasing the photos after a formal request, and a chain of custody may be necessary as well.

Following are practices for taking good forensic photographs:

- Equipment such as a 35 mm digital camera and/or a colposcope with a camera attached produce images that can easily be transferred.
- In order to document bruises and other injuries accurately, a photograph of a color wheel is necessary for comparison.
- The child's face, body, identification number, and the date should photographed first. Use good lighting and an uncluttered background.
- Employ the rule of three: Take at least two photos of full body, mid-range, and close-up. Photograph the injury close-up with and without a scale.
- Photograph clothing if there is transfer evidence such as vegetation, gravel, or dirt. (Botash, 2014b)

PLACING A CHILD IN PROTECTIVE CUSTODY

Although specific laws vary from state to state, a social worker or police officer can generally place a child into protective custody without a court order or parental consent if he or she believes immediate action is needed to protect a child from abuse or neglect. A child taken into protective custody will often be placed into an emergency shelter, a licensed foster home, or with a relative.

Other persons legally authorized to place the child into physical protective custody generally include:

- A law enforcement official
- An agent of a duly incorporated society for the prevention of cruelty to children
- A designated employee of a city or county department of social services
- A person in charge of a hospital or similar institution

When a child is placed in protective custody, the authorized person must generally take the following actions:

- He or she must bring the child immediately to a place designated by the rules of the family court for this purpose, unless the person is a physician treating the child and the child is or soon will be admitted to a hospital.
- He or she must make every reasonable effort to inform the parent or other person legally responsible for the child's care about which facility the child is in and generally must provide some sort of written notice to the parent.
- He or she must make a report of suspected child abuse or maltreatment to Child Protective Services.

CONCLUSION

There is some evidence that the national incidence of child abuse is declining. In its most recent report, the Children's Bureau indicates that national rates of child victimization dropped 3.3%, or approximately 30,000 fewer victims between 2008 and 2012. In addition, the overall rates of CPS response to children increased by 4.7%, from 40.8 to 42.7 per 1,000 children nationally (USDHHS, 2015a).

Research on child abuse and neglect over the past 20 years indicates that the incidence of child maltreatment can be reduced and its harmful effects can be diminished through prevention and treatment. The Institute of Medicine and the National Research Council formed a committee to make recommendations for further research in the area of child maltreatment. This committee advocates a national strategic plan with a coordinated agenda for child abuse and neglect research. They propose the establishment of standardized definitions of child abuse and neglect

and a national surveillance system for data collection (Petersen et al., 2014).

Child maltreatment, abuse, and neglect negatively impact the health and well-being of society. Child victimization is not only a social problem but also a serious public health issue. Child abuse and neglect affect not only the victims while they are children but also shape the adults these children will become. The fundamental goal for prevention of child maltreatment is to stop child abuse and neglect from occurring at all in order to create healthy children who will in turn become healthy adults.

Individuals, communities, and society must change in order to provide safe environments for children. Mandated reporters are obligated to report suspected child maltreatment. Reporting such abuse and neglect is not only a duty for many professionals, but it is also an opportunity to help improve the health and well-being of the nation's children and take part in creating a healthier society.

RESOURCES

Abandoned Infant Protection Act (AIPA) Information Hotline
866-505-SAFE (7233)

American Professional Society on the Abuse of Children
http://www.apsac.org

Child Care, Foster Care, and Adoption Information
800-345-KIDS (5437)

Child Welfare Information Gateway
http://www.childwelfare.gov

National Center for Missing and Exploited Children
http://www.missingkids.com
800-THE-LOST (843-5678)

National Clearinghouse on Child Abuse and Neglect Information
http://www.calib.com/nccanch

National Domestic Violence Hotline
http://www.thehotline.org
800-799-7233
800-787-3224 (TTY)

National Runaway Switchboard
800-786-2929

Safe Horizon
http://www.safehorizon.org

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1. The CDC defines child maltreatment as any act or series of acts of commission or omission by a parent or caregiver that results in:

a. The child receiving inadequate food, clothing, or medical care.

b. Neighbors or bystanders believing that the child is in danger.

c. Harm, potential for harm, or threat of harm to the child.

d. The child receiving inadequate or inappropriate education.

2. A single mother of three school-aged children is self-employed as a housekeeper. The oldest child, a 10-year-old, frequently misses school so that she can go to work with her mother or stay at home with the younger children when they are sick. According to the CDC definition of child maltreatment, the mother's treatment of her 10-year-old would be considered:

a. An act of omission for neglecting to provide for the girl's educational needs.

b. An act of commission for intentionally keeping the girl from attending school.

c. An infraction of child labor laws.

d. An individual decision to provide for her children.

3. In some states, a maltreated child may include a person up to the age of 21 under what circumstances?

a. The child has a disabling condition and resides in a private residential school.

b. The child's parents or close family members continue to provide for his or her care.

c. None; by definition, an abused child is always under the age of 18.

d. The child resides in a residential care facility or public institute for the deaf.

4. A child witness of domestic violence may develop posttraumatic stress disorder and demonstrate:

a. Speech problems.

b. Irritability.

c. Hyper-organization.

d. Creative play patterns.

5. A female high-school student who lives in a "safe-haven" state is 8-1/2 months pregnant. She confides to the school nurse that she doesn't want the baby. The nurse explains that the state's "safe-haven" law would allow the girl to:

a. Deliver the baby in the hospital at no charge if she lets someone adopt the baby.

b. Leave her newborn infant in a suitable location such as a police station or fire department if she notifies authorities immediately.

c. Leave the baby at the hospital at any point in time if she becomes overwhelmed, and no one will ask any questions.

d. Be charged with a misdemeanor instead of a felony if she decides to abandon her newborn infant.

6. Which parental characteristic places a child at risk for abuse?

a. Both attending school and working

b. Abusing drugs and alcohol

c. Suffering from chronic pain

d. Becoming a parent later in life

7. A mother brings her 2-month-old female baby into the emergency department at 10 p.m. She tells the triage nurse that the baby has been vomiting ever since dinnertime. The nurse notes a bruise on the baby's right temple, and the mother explains that the baby hit her head on the doorframe while being carried earlier that day. Which statement describes an accurate nursing assessment by the triage nurse?

a. An injury to the head of any baby is suspicious for abuse.

b. This type of bruising is normal for a 2-month-old baby.

c. The history of how the injury occurred is not consistent with a bruise to the temple.

d. The baby's bruise could be a result of vomiting.

8. The mother of a male baby reports that the baby was subdued when she picked him up from the babysitter the previous evening, and his lethargy has worsened over the past eight hours. The triage nurse suspects possible abusive head trauma when observing which other sign or symptom?

a. Equal pupil sizes

b. Wheezing

c. Vomiting

d. Sunken fontanel

9. Which is a **true** statement about child sexual abuse?

a. Detecting child sexual abuse is a relatively simple matter.
b. Victims may develop eating disorders that persist into adulthood.
c. Boys are more likely than girls to report being sexually abused.
d. The negative effects of child sexual abuse are nearly identical for each person.

10. What is an indicator that a female adolescent may be a victim of sex trafficking?

a. Being accompanied by a concerned father to a healthcare appointment
b. Getting pulled over by the police for suspected drunk driving
c. Reporting back pain related to a new exercise regimen
d. Appearing consistently dehydrated and malnourished

11. A single mother who lives in poverty with her three school-age children frequently needs to send the children to school in soiled clothing and without showering. The school nurse alerts the district social worker that the children all smell bad and have worn the same clothes to school every day for the past week. The social worker's investigation finds that the children are **not** neglected because:

a. The mother is financially unable to provide the children with showers and clean clothing.
b. The children are enrolled in school and have good school attendance records and performance.
c. The body odor of school-age children is often foul smelling.
d. The mother is a single parent.

12. When child sexual abuse is suspected, the best way to question a child is to:

a. Use anatomical dolls.
b. Extensively interview the child to ensure all details are correctly documented.
c. Substitute the child's own terms for genitalia with the proper anatomic terms.
d. Coordinate services with a child forensic interview specialist.

13. Potentially, the most serious consequence of a mandated reporter's willful failure to report a case of suspected child abuse is:

a. Being charged with a misdemeanor.
b. Facing criminal penalties.
c. Leaving oneself open to a civil suit for monetary damages.
d. Leaving the child unprotected.

14. A social worker or police officer may place a child into protective custody without a court order or parental consent:

a. When it is common knowledge that the court is reluctant to grant such orders.

b. Only when done in cooperation with the examining physician.

c. When immediate action is needed to protect the child from abuse or neglect.

d. Only after obtaining approval from Child Protective Services.