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Contact Hours: **3**

# Identifying and Reporting Child Abuse, Neglect, and Maltreatment

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**LEARNING OUTCOME AND OBJECTIVES:** Upon completion of this course, you will have gained the knowledge to identify and report child abuse, child neglect, and child maltreatment. Specific learning objectives include:

- Define child abuse, neglect, and maltreatment.
- Explain the risk factors contributing to child abuse and neglect.
- Recognize physical and behavioral indicators.
- Describe situations in which mandated reporters must report suspected cases of child maltreatment.
- Discuss the legal protections afforded mandated reporters as well as the consequences for failing to report.

## INTRODUCTION

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The government has a responsibility to protect children when parents or other persons legally responsible for a child's care 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.

### History of Child Protection Laws

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 (NYSPCC, 2017). 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 Children's Bureau is the first U. S. government agency to focus exclusively on improving the lives of children and families. It was also the first in the world to do so (Children's Bureau, 2016).

The Child Abuse Prevention and Treatment Act 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 was created to provide national leadership for child abuse and neglect policy and programs (CWIG, 2017b). In the year 2000, the Child Abuse Prevention and Enforcement Act 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 (USDHHS, 2010).

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.

## Impacts of Child Maltreatment

Child maltreatment has significant negative consequences on a child in both the short and long term, including:

- Physical injuries
- Stress that interferes with normal brain development
- Stress that can interfere with the development of the nervous and immune systems
- Increased risk for health problems as adults, including alcoholism, depression, drug abuse, eating disorders, high-risk sexual behaviors, smoking, suicide, and certain chronic diseases

(CDC, 2014)

Data show that:

- 686,000 children were found by Child Protective Services to be victims of maltreatment in 2012.
- The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States is about \$124 billion.



- Nationally, an estimated 1,670 children died from abuse or neglect in 2015. This is an increase of 5.7% compared to 2011. (CDC, 2014; CWIG, 2017a)

## WHAT IS CHILD ABUSE?

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### Definitions

The Centers for Disease Control and Prevention (CDC) has developed uniform definitions pertaining to child abuse. However, since different states and government entities vary in their legal definitions of these terms, it is also important for nurses to know the definitions of *child abuse* and other related terms in the state(s) in which they live and/or practice.

According to the CDC, ***child maltreatment*** can be defined as any act or series of acts of commission or omission by a parent, caregiver, or another person in a custodial role (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child.

- **Acts of commission (child abuse)** are “words or overt action” that are deliberate and intentional. However, harm to a child might not be the intended consequence. Intention only applies to caregiver acts—not the consequences of those acts. For example, a caregiver might intend to hit a child as punishment (i.e., hitting the child is not accidental or unintentional) but not intend to cause the child to have a concussion. Acts of commission include:
  - Physical abuse
  - Sexual abuse
  - Psychological abuse
- **Acts of omission (child neglect)** are the “failure to provide needs or to protect from harm or potential harm. Such acts are the failure to provide for a child’s basic physical, emotional, or educational needs or to protect a child from harm or potential harm. Like acts of commission, harm to a child might not be the intended consequence.” Acts of omission include:
  - Physical neglect
  - Emotional neglect
  - Medical and dental neglect
  - Educational neglect
  - Inadequate supervision
  - Exposure to violent environments

(CDC, 2018a; Leeb et al., 2008)



### FEDERAL GUIDANCE TO STATES

Federal legislation offers guidance to states by identifying a minimum set of acts or behaviors that define child abuse and neglect. The Federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. § 5106g), as amended by the CAPTA Reauthorization Act of 2010, defines *child abuse and neglect* as, at 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”

A *child* is defined as “a person who is younger than 18 years of age or who is not an emancipated minor.”

This legislation sets minimum standards for states that accept CAPTA funding, but each state provides its own definitions of maltreatment within civil and criminal statutes (CWIG, n.d.).

### ABUSED CHILD 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. In the context of child maltreatment laws, 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 residential care setting.

## Types of Abuse

### PHYSICAL ABUSE

Physical abuse of a child includes any nonaccidental physical injury of a child that is inflicted by a parent or caretaker. Physical abuse injuries can range from superficial bruises and marks to fractures, burns, and serious internal injuries. In severe cases, the physical abuse may lead to death. The legal definition of physical abuse also includes actions that pose a substantial risk of physical injury to the child, even if no injury is sustained. In the United States, approximately 28% of adults report having been physically abused as a child (Childhelp.org, 2017).

### SEXUAL ABUSE

Child sexual abuse includes any sexual activity with a minor, who cannot, by law, consent to any form of sexual activity (RAINN, 2018). Federally, it 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), 2010).

Child sexual abuse does not need to include physical contact between a perpetrator and a child. Some forms of child sexual abuse include:

- Exhibitionism (exposing oneself to a minor)
- Fondling
- Intercourse
- Masturbation in the presence of a minor or forcing a minor to masturbate
- Obscene phone calls, text messages, emails, or digital interaction
- Producing, owning, or sharing pornographic images or movies of children
- Sex of any kind with a minor, including vaginal, oral, or anal sex
- Sex trafficking
- Any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare  
(RAINN, 2018)

## **EMOTIONAL ABUSE**

Emotional abuse is maltreatment that leads to impaired psychological growth and development and involves words, actions, and indifference. Perpetrators constantly reject, ignore, belittle, dominate, and criticize the affected children. Emotional abuse may occur with or without physical abuse, but both often occur in conjunction with each other (Prevent Child Abuse, n.d.).

Emotional abuse can be more difficult to identify because there is not “physical” evidence such as bruising. Thus, there are few well-validated measures of childhood emotional abuse (Prevent Child Abuse, n.d.).

Examples of emotional child abuse include:

- Verbal abuse
- Excessive demands on a child's performance (e.g. expectations of high grades in school or becoming “champion” school athletes)
- Penalizing a child for positive, normal behavior (e.g. smiling, vocalization)
- Discouraging caregiver and child attachment
- Penalizing a child for demonstrating signs of positive self-esteem
- Exposing the child to family violence



- Refusal to provide affection  
(Prevent Child Abuse, n.d.)

### **IMPACTS OF EXPOSURE TO VIOLENCE**

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).

Children can also be harmed by exposure to the abuse of others. Children who witness violence in the home experience changes in the anatomic and physiological make up of their central nervous system. A child witness of 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 7 are the most successful, so it is important to recognize the symptoms and intervene as early as possible (Tsavoussis, 2014).

## **Types of Neglect**

Neglect is the failure of a parent or other person with responsibility for the child to provide for the child's needs to the degree that the child's health, safety, and well-being are threatened with harm (CWIG, 2015a, 2015c).

### **PHYSICAL NEGLECT**

Physical neglect is the failure to provide a child with adequate food, shelter, clothing, education, hygiene, medical care, and/or supervision needed for normal growth and development. Leaving a young child or children without supervision by a responsible person is a type of neglect (Childhelp.org, 2017). Infants and toddlers should never be left alone, even briefly. While older preteens may be responsible and independent enough to be left alone, some older teenagers are too irresponsible or have special needs that limit their ability to be safe if left alone.

### **EMOTIONAL NEGLECT**

Emotional neglect includes parent or other caretaker behaviors that cause or have the potential to cause serious cognitive, affective, or other behavioral health problems. 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.



## MEDICAL NEGLECT

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

Educational neglect is the failure to educate a child (e.g., failure to enroll a child in school or preventing a child from attending school) or attend to special education needs (e.g., failure to obtain remedial education services). About 25 states, the District of Columbia, American Samoa, Puerto Rico, and the Virgin Islands include failure to educate a child as required by law in their definition of neglect (CWIG, 2015a, 2015c).

## ABANDONMENT

Abandonment is 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 AND CHILD ABUSE/NEGLECT

Parental substance abuse may be included within the definition of child abuse or neglect in some states. Examples of instances when parental substance abuse is considered to be abuse or neglect include:

- Prenatal exposure of a child to harm due to the mother's use of an illegal drug or other substances such as alcohol.
- Manufacture of controlled substances in the presence of a child or on the premises occupied by a child
- Allowing a child to be present when the chemicals or equipment for the manufacture of controlled substances are used or stored.
- Selling, distributing, or giving drugs or alcohol to a child
- Use of a controlled substance by a caregiver that impairs the caregiver's ability to adequately care for the child

(CWIG, 2016a)



**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.

**SAFE HAVEN LAWS**

"Safe haven" laws designate specific locations as safe places for parents to relinquish their unharmed newborns. The focus of safe haven laws is to protect newborns from endangerment by providing parents with an option to criminal abandonment and to protect law-abiding parents from criminal liability. Thus, these laws are usually limited to very young children (CWIG, 2017b). Provisions of safe haven laws vary from state to state.

- The age of the children who may be left at a safe haven varies among states. For example, in some states and Puerto Rico, only infants who are 72 hours old or younger may be relinquished to a designated safe haven, while other states allow infants up to one month of age.



- In most states, either parent may surrender a baby to a safe haven, but in a few states only the mother may relinquish her infant.
- Each state specifies which locations may function as safe havens. Hospitals, emergency medical services providers, healthcare facilities, and fire stations are common locations.

To date, all 50 states, the District of Columbia, and Puerto Rico have enacted safe haven legislation (CWIG, 2016). Healthcare professionals must be aware of the laws governing safe haven acts in the states in which they practice and live (CWIG 2017b, 2016).

## PREVALENCE AND RISK FACTORS

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Nationally in 2015, an estimated 3.4 million children received either an investigation or alternative response at a rate of 45.1 children per 1,000 in the population. The number of children who received a Child Protective Services response increased by 9% from 2011 to 2015 (USDHHS, 2017).

### Victim Demographics

Nationally, the youngest children are the most vulnerable to maltreatment. In 2015, states reported that:

- 27.7% of victims were younger than three years.
- The victimization rate was highest for children younger than 1 year.
- The percentages of child victims were similar for both boys and girls.
- The majority of victims were of three races or ethnicities: white (43.2%), Hispanic (23.6%), and African American (21.4%).
- African American children had the highest rate of victimization at 14.5 per 1,000 children in the population of the same race or ethnicity. Native American or Alaska Native children had the second highest rate at 13.8 per 1,000 children.
- About 75% of victims were neglected, 17.2% were physically abused, and 8.4% were sexually abused. Additionally, 6.9% of victims experienced other types of maltreatment such as threatened abuse, parent's drug/alcohol abuse, or safe relinquishment of a newborn.  
(USDHHS, 2017)

### Risk Factors

Health professionals must remain 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 Centers for Disease Control and Prevention (CDC) 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 (CDC, 2017)

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 (CDC, 2017)

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, 2017)



Presence of these factors signal 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. A review of recent research on parental substance abuse and its impact on children showed that:

- 1 in 5 American children live in homes with parental substance abuse.
- Children who grow up in homes with prevalent substance abuse are more likely to misuse drugs and alcohol; this leads to multigenerational cycles of addiction.
- Parents who are struggling with substance use disorders are often unable to meet basic physical, psychological, and emotional needs for their children.
- Children whose parents use drugs and misuse alcohol are 3 times more likely to be physically, sexually, or emotionally abused than their peers.
- Children whose parents use drugs and misuse alcohol are 4 times more likely to be neglected than their peers.

(Bergland, 2016)

### **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:

- Risky health behaviors such as substance use and abuse
- Chronic health conditions
- Low life potential
- Early death

(CDC, 2016)



## 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 (CDC, 2017)

The CDC (2017) also reports that evidenced-based programs can abate child maltreatment. 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.

## RECOGNIZING PHYSICAL ABUSE

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### Physical Indicators of Physical Abuse

Healthcare professionals must 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.

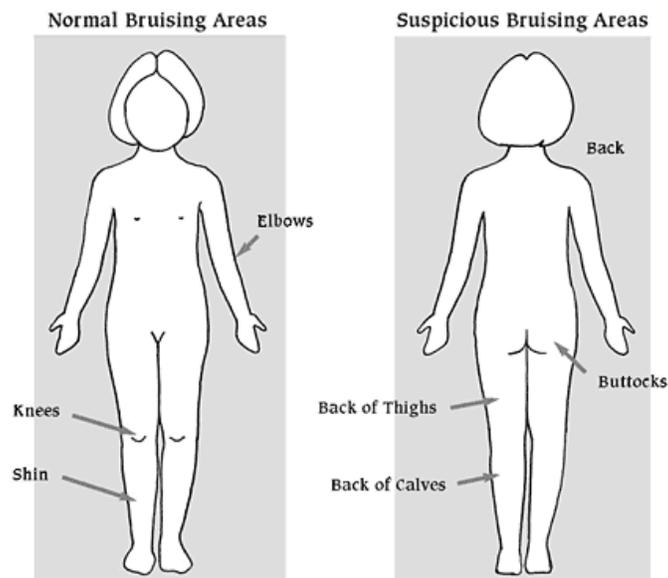
#### BRUISING

It is important to know both normal and suspicious bruising patterns when assessing children's injuries. Some red flags for nonaccidental 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)
- Black eyes
- Bruises around the wrists or ankles (indicating that someone may have tied up the child)
- Bruises that do not fit with the causal mechanism described (Healthy Place, 2016; NSPCC, 2018)



Normal and suspicious bruising areas.  
(Source: Research Foundation of SUNY, 2011.)



This pattern signals the blow of a hand to the face of a child.  
(Source: Research Foundation of SUNY, 2011.)



Regular patterns reveal that a looped cord was used to inflict injury on this child.  
(Source: Research Foundation of SUNY, 2011.)

### LACERATIONS OR ABRASIONS

Typical indications of unexplained lacerations and abrasions that are suspicious 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)  
(Healthy Place, 2016; NSPCC, 2018)

### BURNS

Typical indications of unexplained burns include worrisome:

- 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  
(Healthy Place, 2016; NSPCC, 2018)



A steam iron was used to inflict injury on this child.  
(Source: Research Foundation of SUNY, 2011.)

## FRACTURES

Typical indications of unexplained fractures include:

- Fractures to the skull, nose, or facial structure
- Fractures to the ribs or the leg bones in babies
- Skeletal trauma with other injuries, such as dislocations
- Multiple fractures (especially bilateral)
- Fractures in various stages of healing
- Swollen or tender limbs  
(Flaherty et al., 2014; NSPCC, 2018)

## 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  
(Healthy Place, 2016; NHAC, 2018)



## PEDIATRIC ABUSIVE HEAD TRAUMA

Pediatric abusive head trauma (PAHT) is the third leading cause of head injury in children and the leading cause of serious head injury in the first year of life in the United States (Brown et al., 2016). 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 et al., 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 (AAP, 2009).

The clinical presentation of infants or children with AHT can vary. PAHT diagnosis generally includes subdural hematomas, retinal bleeding, fractures, cerebral edema, and rib or long bone fractures (Brown et al., 2016). 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
- (Brown et al., 2016; Kidshealth.org, 2018)

Long-term effects of PAHT may include:

- Partial or total blindness



- Hearing loss
  - Seizures
  - Developmental delays
  - Impaired intellect
  - Speech and learning difficulties
  - Problems with memory and attention
  - Severe mental retardation
  - Cerebral palsy
- (KidsHealth.org, 2018)

### **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
- (Mayo Clinic, 2015)

Presence of the following **parent or other persons legally responsible 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 or lack of emotional control
- Lacks support network; is isolated from family and friends
- Has poor self-esteem
- Uses the child to meet his/her own physical and/or emotional needs
- Lacks parenting knowledge
- Lacks interpersonal skills
- Has unrealistically high standards and expectations for the child  
(Clermont County CPS, 2018)

### **FACTITIOUS DISORDER IMPOSED ON ANOTHER**

Factitious disorder imposed on another (FDIA), formerly known as Munchausen syndrome by proxy (MSP), is a mental illness as well as a form of child abuse. In FDIA, an adult perpetrator (most often the child's mother) falsifies an illness in the child to gain attention from healthcare professionals, family, friends, and, in some cases, general members of the community. There are not other obvious external rewards such as monetary gain (APA, 2013; Cleveland Clinic, 2014).

According to the *Diagnostic and Statistical Manual of Mental Disorders 5* (APA, 2013), **diagnostic criteria** for FDIA are:

- Falsification of physical or psychological signs or symptoms or induction of injury or disease in another, associated with identified deception.
- The individual presents another individual to others as ill, impaired, or injured.
- The deceptive behavior is evident even in the absence of obvious external rewards.
- The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.



It is important to note that the perpetrator, not the child, receives this diagnosis.

**Possible warning signs** of FDIA in children include:

- The child has a history of many hospitalizations often accompanied by an unusual set of symptoms.
- Worsening of the child's symptoms is usually reported by the perpetrator and is not witnessed by healthcare professionals.
- The child's reported condition and symptoms do not agree with results of diagnostic tests.
- There might be a history of more than one unusual illness or death of children in the family.
- The child's condition improves when hospitalized but worsens when the child returns home.
- Blood in lab samples might not match the child's blood (e.g., parent "switches" the child's blood for someone else's blood).
- There might be signs of chemicals in the child's blood, stool, or urine.  
(Cleveland Clinic, 2014)

## RECOGNIZING PHYSICAL AND EMOTIONAL NEGLECT

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### Physical Neglect

Indicators of physical neglect include:

- Consistent hunger
- 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
- Abandonment  
 (Clermont County CPS, 2018)

## Emotional Neglect

A **child** may demonstrate behavioral indicators of neglect such as:

- Begging or stealing food
- Extended stays at school (early arrival or late departure)
- Constant fatigue, listlessness, or falling asleep in class
- Alcohol or other substance abuse
- Delinquency, such as thefts
- Reports there is no caretaker at home
- Runaway behavior
- Habit disorders (sucking, nail biting, rocking, etc.)
- Conduct disorders (antisocial or destructive behaviors)
- Neurotic traits (sleep disorders, inhibition of play)
- 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  
 (Clermont County CPS, 2018)

A **parent or guardian (other person legally responsible)** exhibiting the following behavioral indicators may be emotionally maltreating/neglecting a child:

- 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  
(Clermont County CPS, 2018)

## RECOGNIZING SEXUAL ABUSE

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Child sexual abuse involves the coercion of a dependent, developmentally immature person to commit a sexual act with someone older. For example, an adult may sexually abuse a child or adolescent, or an older child or adolescent may abuse a younger child. A perpetrator does not have to be an adult in order to sexually abuse a child (RAINN, 2018).

Most perpetrators of child sexual abuse are people who are known to the victim. As many as 93% of children who are sexually abused under the age of 18 know the abuser (RAINN, 2018). 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 (Clermont County CPS, 2018; RAINN, 2018).

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.

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 (Clermont County CPS, 2018; RAINN, 2018).

### Physical Indicators of Sexual Abuse

Physical evidence of sexual abuse may 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 ensure 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
- Painful bowel movements  
 (Clermont County CPS, 2018; RAINN, 2018)

## **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  
 (Clermont County CPS, 2018; RAINN, 2018)

Sexually abusive **parents/guardians** or other persons legally responsible 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  
(Clermont County CPS, 2018; RAINN, 2018)

## **SEX TRAFFICKING**

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” (Cornell Law School, n.d.; U.S. Code, n.d.).

Commercial sexual exploitation of children (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.

The United Nations Office on Drugs and Crime reported a rise in the percentage of child victims from 20% to 27% over a 3-year time period. Of every three child victims, two are girls and one is a boy (UNODC, 2012).

Additional data show that:

- Gender and age profile of victims detected globally are 59% women, 14% men, 17% girls, and 10% boys.
- 600,000 to 800,000 women, children, and men are bought and sold across international borders every year and exploited for forced labor or commercial sex.
- When internal trafficking victims are added to the estimates, the number of victims annually is in the range of 2 to 4 million.
- 50% of those victims are estimated to be children.
- It is estimated that 76% of transactions for sex with underage girls start on the Internet.
- 2 million children are subjected to prostitution in the global commercial sex trade.
- There are 20.9 million victims of trafficking throughout the world as of 2012.
- There are 1.5 million victims in the United States.
- The average age of victims is 11 to 14 years.  
(Ark of Hope for Children, 2017)



## 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  
(Ark of Hope for Children, 2017)



### 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 were not allowed?
- Has anyone ever threatened your family?
- Has anyone taken your driver’s license/passport/papers?

Sources: Ark of Hope for Children, 2017; Becker & Bechtel, 2015.

## RECOGNIZING AND RESPONDING TO VICTIMS’ DISCLOSURES

It is difficult for young children to describe 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; 2014b)

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 do not 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. Coordination of services with a child forensic interviewer is essential (USDOJ, 2015).

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 (USDOJ, 2015).



**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.

## GATHERING FORENSIC EVIDENCE

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Whenever there are allegations of suspected child abuse or neglect, any records of physical findings may be used as evidence at a trial. Therefore, photos, diagrams, and accurate reporting of medical examination findings are invaluable. Such documentation should use language that is not open to misinterpretation (Pulido, 2012).

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 be 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, 2015)

## REPORTING CHILD ABUSE, MALTREATMENT, AND NEGLECT

The government has a responsibility to protect children when parents fail to provide proper care and to intervene in cases of child maltreatment. Thus, each state has laws and a system in place to receive and respond to reports of child maltreatment.

### **Who Must Report Abuse?**

Anyone may report suspected child abuse at any time and is encouraged to do so. Such reports are typically confidential and may be made anonymously by members of the public.

Nearly all states designate certain 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.

In more than one third of states, **any person** who suspects child abuse or neglect is required to report it.

It is important that all professionals be informed of the laws that pertain to the jurisdiction of their own practice (CWIG, 2015b).

## 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 (CWIG, 2015b).

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

### 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, who is also okay. While she is not mandated to report a suspicion of child abuse since she is not currently acting in her professional capacity, 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 makes a point to call Janie the next day and frequently thereafter. One month later, Janie tells Sharon that the school social worker has helped her find a program 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.



### REASONABLE CAUSE

There can be “reasonable cause” to suspect that a child is abused or maltreated if, considering the physical evidence observed or told about, and based on the reporter’s own training and experience, it is possible that the injury or condition was caused by neglect or by nonaccidental means.

**Certainty is not required.** The reporter need not be certain that the injury or condition was caused by neglect or by nonaccidental means. The reporter need only be able to entertain the possibility that it could have been neglect or nonaccidental in order to possess the necessary “reasonable cause.” It is enough for the mandated reporter to distrust or doubt what is personally observed or told about the injury or condition.

In child abuse cases, many factors can and should be considered in the formation of that doubt or distrust. Physical and behavioral indicators may also help form a reasonable basis of suspicion. Although these indicators are not diagnostic criteria of child abuse, neglect, or maltreatment, they illustrate important patterns that may be recorded in the written report when relevant.

## How Is a Report Made?

In most jurisdictions, 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.

Most healthcare facilities also have policies and procedures in place regarding the reporting of suspected child abuse. Nurses and other healthcare professionals must know what guidelines are in place at their place of employment as well as state mandates.

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.

### **Consequences for Failing to Report**

Nearly every state enacts penalties, in the form of a fine or imprisonment, for 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 (CWIG, 2015b).

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.

### **Legal Issues for Reporters**

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 (CWIG, 2016c). Likewise, in most states, the identity of the reporter is specifically protected from disclosure to the alleged perpetrator (CWIG, 2015b).

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.

Among the requirements for receiving federal funding under the Child Abuse Prevention and Treatment Act (CAPTA) is that states must preserve the confidentiality of all child abuse and neglect reports and records to protect the privacy rights of the child and of the child's parents or guardians, except in certain limited circumstances. All jurisdictions have provisions that protect abuse and neglect records from public scrutiny; many jurisdictions include specific provisions that protect the records from public view (CWIG, 2017d).



## CONCLUSION

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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 (Peterson 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 all children. Mandated reporters are obligated to report suspected child abuse, neglect, and maltreatment. Reporting suspected child abuse is their duty as professionals, but it is also an opportunity to help improve the health and well-being of 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 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  
<https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=46&articleid=715>

National Runaway Switchboard  
800-786-2929

Safe Horizon  
<http://www.safehorizon.org>



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## TEST

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1. According to the CDC, which one of the following is an act of omission?
  - a. Sexual abuse
  - b. Inadequate supervision
  - c. Psychological abuse
  - d. An overt action that causes harm
  
2. The Federal Child Abuse Prevention and Treatment Act defines a child as a person who is:
  - a. Younger than 18 years of age.
  - b. Still living with his or her parents.
  - c. An emancipated minor.
  - d. Still in school.
  
3. Emotional abuse can be more difficult to identify than other forms of abuse because:
  - a. Children are less likely to talk about it.
  - b. Perpetrators deny doing it.
  - c. There is not physical evidence.
  - d. It is more accepted by society.
  
4. A child witness of domestic violence may develop posttraumatic stress disorder and demonstrate:
  - a. Highly organized behavior.
  - b. Sleep disorders.
  - c. A very outgoing personality.
  - d. A cheerful disposition.
  
5. A father decides to relinquish his 1-month-old infant to a safe haven. In order to do so, the father should know that:
  - a. All 50 states allow fathers to relinquish infants.
  - b. In some states, his infant is considered too old to be left at a safe haven.
  - c. Both parents of an infant must be present to relinquish an infant to a safe haven.
  - d. Federal laws dictate which locations may be used as safe havens.



6. A mother brings her 2-month-old female baby to the infant's pediatric medical practice. She tells the triage nurse that the baby has been crying since yesterday afternoon after having fallen and "bumped her tummy and legs on some furniture." The nurse notes a bruise on the baby's abdomen that is in the shape of a small belt buckle. The area around the bruise is slightly swollen. Which statement validates the nurse's suspicions that the baby has been abused?
- The abdominal bruising indicates an object may have been used to make the bruise.
  - This type of bruising is normal for a 2-month-old baby.
  - Abdominal bruising is usually accidental.
  - The bruising is probably not abuse because the mother seems to be concerned about her child.
7. The mother of a baby boy reports that the baby was subdued when she picked him up from the babysitter the previous evening and that his lethargy has worsened over the past eight hours. The triage nurse suspects possible abusive head trauma when observing which other sign?
- Equal pupil sizes
  - Wheezing
  - Vomiting
  - Sunken fontanel
8. Which is a **true** statement about child sexual abuse?
- Most children readily report sexual abuse.
  - Victims may develop eating disorders that persist into adulthood.
  - Boys are more likely than girls to report being sexually abused.
  - The negative effects of child sexual abuse are nearly identical for each person.
9. Which is considered a physical indicator of child sexual abuse?
- Fear of physical examination
  - Forcing sexual acts on other children
  - Painful discharge of urine
  - Inappropriate sexual knowledge for age
10. When child sexual abuse is suspected, the **best** way to question a child is to:
- Establish trust by assuring the child you will not share his or her disclosure with others.
  - Extensively interview the child yourself to gather all the details that might be needed by the legal system.
  - Use only proper anatomic terms for genitalia instead of the child's own terms.
  - Avoid further detailed questioning after a child has disclosed abuse and report the abuse to authorities.



- 11.** A recommended practice for taking good forensic photographs of suspected abuse is to:
- First photograph the child's face, body, identification number, and date.
  - Avoid photographing clothing.
  - Take at least four photographs each of full body, mid-range, and close-up.
  - Do not explain the process to the child in order to avoid causing embarrassment.
- 12.** Which is a **true** statement about the reporting of child abuse?
- Coroners are typically not required to report suspected child abuse or neglect.
  - In more than one third of states, any person who suspects child abuse or neglect must report it.
  - Healthcare professionals are the only group typically mandated to report child abuse or neglect.
  - Reports of suspected child abuse or neglect may not be made anonymously.
- 13.** "Reasonable cause" to suspect child abuse or maltreatment requires:
- Certainty that an injury was nonaccidental.
  - Doubting what is personally observed or stated about an injury.
  - Believing what a parent says happened to an injured child.
  - Believing it possible that an injury occurred because of abuse or neglect.
- 14.** Which is a **true** statement regarding reporting suspected child abuse?
- Lack of complete information prohibits a person from reporting suspected child abuse.
  - Information necessary to locate a child is crucial.
  - Few healthcare facilities have policies and procedures in place to guide employees when they encounter suspected child abuse.
  - It is not acceptable to initiate a telephone report when child abuse is suspected.
- 15.** When a mandated reporter fails to report suspected child abuse or maltreatment, it is important to know that:
- There are moral but no legal consequences for failing to report.
  - CPS can act even though the suspected abuse has not been identified and reported.
  - Mandated reporters can be held legally liable by civil systems.
  - Penalties for failing to report cannot include imprisonment.

