Angelo P. Giardino · Michelle A. Lyn
Eileen R. Giardino *Editors*

A Practical Guide to the Evaluation of Child Physical Abuse and Neglect

Third Edition

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Springer

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This book is dedicated to SuEllen Fried, MA, and Maura Somers Dughi, JD, who are the two Lifetime Members of the Prevent Child Abuse America Board of Directors. These two outstanding child advocates have effectively worked over decades to raise awareness about the need of children and families to live and grow in safe and nurturing environments. Both SuEllen and Maura have been instrumental in catalyzing local, regional, and national efforts to prevent child abuse and neglect before it ever happens. They are inspirational figures who give voice to the vulnerable and to the resilient among us and countless children and families have benefited over the years from their tireless efforts.

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Foreword

Eight years have passed since the previous edition of this book, and as I reflect on this time, I am reminded of how much we have accomplished in the care of children and families dealing with abuse and how much is still left to be done. In 2017, I had the honor of serving as the President of the American Academy of Pediatrics, representing the voices of 70,000 pediatricians and other health care providers committed to the health and well-being of children and families in the USA. This role allowed me to see the good and bad news we have regarding children and their safety. On the good news side, we continue to take heart that a great deal of professional attention is focused upon the problem of child abuse and neglect. In every state of our country, there are mandatory reporting laws that require nurses, physicians, and social workers to report suspicions of maltreatment to the appropriate authorities for investigation. The act of reporting provides legal immunity to the reporter except when performed in bad faith. Progress in understanding the factors that place children at risk for harm from physical abuse and neglect now permits effective prevention and intervention initiatives. The peer-reviewed literature dealing with child abuse and neglect has proliferated with high-quality work being done and reported on the many dimensions related to the epidemiology, mechanism, treatment, and prognosis of child maltreatment. Efforts are being directed toward developing an evidence-based approach to the prevention of child abuse and neglect. Home visiting programs stand out as a shining example of the progress we can make supporting young parents to become excellent caregivers to their children, thus ensuring the health and well-being of the next generation. These are some of the positives. However, there is bad news as well, and negatives exist and remain as reasons for concern. Despite a tremendous amount of attention to the problem of maltreatment, there are still too many cases. While the incidence in the USA has been declining recently, it still remains at an unacceptable level. A single case is one too many. There is increased awareness among both the professional and lay members of our society. Underreporting continues to be a problem. There is a different standard for health professionals reporting suspected child abuse and a layperson reporting the same. The work of Jenny and colleagues documented that victims of abuse are at times missed on initial evaluations by physicians. This group of patients

presents on subsequent visits with more serious signs of abuse. This book represents a valuable and current resource for health professionals who can use it to guide the evaluation of children suspected of abuse or neglect.

In 1996, the World Health Organization declared violence against children a public health priority, mentioning specifically gun violence. Children and families remain vulnerable both in the USA and internationally as well. The words of the Secretary General of the United Nations spoken in the 2006 "World Report on Violence against Children" still ring true: "The central message of the study is that no violence against children can be justified; all violence against children can and must be prevented. Every society, no matter its cultural, economic, or social background, can and must stop every form of violence. A multidimensional approach, grounded in human rights principles and guided by evidence-based research, is urgently needed to prevent and respond to violence in all circumstances." Quantifying the actual number of child maltreatment victims globally is difficult because of variations in definitions from nation to nation, limited data collection efforts, and the tragic realization that some forms of violence against children are socially acceptable in some parts of the world and indeed may be legal and occasionally state-sponsored. Add to this risk and misery the waves of child victims seen almost nightly on our video screens fleeing worn-torn conflicts after being exposed to unspeakable acts of violence, now including chemical attacks once thought eliminated in modern civilized times. The conscious institutional indifference to the plight of fleeing children and families is a form of neglect.

In critical care, my own specialty, we often provide care to child abuse victims and families who suffer from the more extreme effects of inflicted injuries. Rigorous work in the field of outcome measures determines that victims of child abuse have longer hospital lengths of stay, more complications, and more difficulties in discharge planning on average when compared to children with noninflicted injuries. They are also more likely to be readmitted to hospitals. Each year, at least 1700 children are known to die as a result of child abuse and neglect. More than twice as many die as a result of intentional penetrating wounds. Recent estimates show that 90% of the fatal cases of child abuse and neglect are in children under 3 years of age and more than 60% are in children under 1 year of age. At Texas Children's Hospital, the former Chair of Pediatrics in 2004, Dr. Ralph D. Feigin, addressed the fact that more children died as a result of abuse than malignancy. Texas Children's responded by building a well-organized and strong child protection team to assist our community in evaluating suspected cases, training large numbers of health care professionals and child advocates in how best to recognize child maltreatment and then to comply with the mandated reporting responsibility. Additionally, the team has an academic component to engage in further work in our understanding of the multiplicity of aspects of this social problem. Now, in addition to this traditional clinical and academic work, this child abuse team addresses prevention efforts, initiatives to promote resilience in our communities, and academic work around a host of other adversities such as food insecurity, postpartum depression, and the vulnerabilities faced by children whose parents are incarcerated. While we have done much, a great deal of work remains to be done in order to ensure that all children have the greatest

opportunity to be raised in a safe and nurturing family who are supported by a concerned and interested community.

We are traveling on a long journey toward dealing with child abuse and neglect. This book represents a practical contribution to the understanding and evaluation of child maltreatment and ultimately toward its prevention and elimination.

Houston, TX, USA
June 2018

Fernando Stein

Preface

… something I learned in 1968 when I walked into the University of Colorado School of Medicine as a pediatric intern. I learned then, from [C.] Henry Kemp, that child abuse and neglect is not just a medical problem, a social problem, or a legal problem. It is ultimately a child's and a family's problem, and solving it requires each of us in medicine, social work, law enforcement, the judiciary, mental health, and all related fields to work together for that child and family.

(Krugman 1991, p. 101)

Child abuse and neglect is a major threat to the health and well-being of children throughout the world. Maltreatment has long been known to occur primarily in the family setting and is a problem firmly rooted in the pattern of caregiving provided to the child (Ludwig and Rostain 1992). Historical review and cultural studies indicate that caregivers have maltreated children in all cultures and nations of origin (Hobbs et al. 1993; Korbin 1987; Lazoritz 1992; Levinson 1989; Radbill 1987; Solomon 1973). Over the past decade, we have seen growth of the child protection movement, a steady increase in the professional literature dealing with child abuse and neglect, increased public awareness of the issues surrounding child maltreatment, and the promulgation and enactment of model legislation. Despite a greater focus on the issues of abuse, child abuse and neglect remain a major problem facing children and families today (CM 2008).

The revised manual, *A Practical Guide to the Evaluation of Child Physical Abuse and Neglect (2nd edition)*, is intended as an updated resource for health care professionals. Many of the new photographs that have been included in this revision came from the teaching archive at Texas Children's Hospital and we recognize the dedication and commitment of medical photographer, Jim deLeon, who tirelessly sought to serve children and families during his quarter century of service at the hospital. It is the purpose of the text to help increase knowledge of abuse and provide easy access to basic information concerning the health care evaluation of a child suspected of having been physically abused or neglected. The manual provides a framework from which to comprehensively evaluate the child and draws upon the most up-to-date literature for the available evidence to support best practices. The intended audience for the manual includes health care providers and

related professionals who work with abused children, including physicians, nurses, nurse practitioners, clinical social workers, mental health professionals, and child protection workers. Law enforcement personnel and attorneys may use the manual as a resource when working with children and families. The text provides practical information with a balance between the areas of content and the comprehensiveness of material included. The authors include clinically relevant information to guide the initial interview, examination, and the accurate documentation of the evaluation of a child who may have been physically maltreated. Toward that end, the ultimate goal of this manual is to assist the professional in performing and documenting a complete and accurate evaluation.

The text uses the terms *health care professional* and *health care provider* interchangeably in recognition that many disciplines provide care to abused and neglected children and their families. The term *parenting* is often subsumed in the term *caregiving* to indicate the practices and actions to which the child is subject.

A Short Historical Reflection on Professional Attention to Child Abuse and Neglect

In undertaking the revision process to produce the second edition, we had the opportunity to reflect upon the professional journey that our field has been traveling upon. This is most clearly illustrated by the trajectory of our peer-reviewed literature regarding child abuse and neglect.

Although child abuse is as old as recorded history, it has become an issue for pediatricians only in the mid-twentieth century. John Caffey first described the association between subdural hemorrhage and long bone fractures in 1946 (Caffey 1946). He recognized that both were traumatic in origin but did not recognize the causal mechanism. Caffey thought that trauma leading to these injuries was either unobserved or denied because of negligence. In one reported case, Caffey (1946) raised the possibility of inflicted trauma but stated that the “evidence was inadequate to prove or disprove [intentional mistreatment]” (p. 172). In the early 1950s, Frederic Silverman (1953) emphasized the repeated, inflicted nature of the trauma, despite denial by caregivers. Subsequent medical literature contained reports of abuse, but little attention was given to the issue. It was not until C. Henry Kempe and his colleagues coined the term “battered child” in 1962 that the medical and legal communities took action (Kempe et al. 1962).

Within a few years, most states in the USA had adopted abuse-reporting statutes (Heins 1984). By 1967, all 50 states had some form of legislation regarding child maltreatment (Fontana and Besharov 1979; Heins 1984). Legislative efforts culminated in a 1974 federal statute called the Child Abuse Prevention and Treatment Act (PL 93–247). This law focused national concern on the prevention, diagnosis, and treatment of child abuse. Model legislation was part of this effort, and states were encouraged to evaluate their statutes and adequately address the issues of child abuse and neglect.

Of historical interest, Kempe first used the term battered child in a 1961 address to the American Academy of Pediatrics to describe young children who were vic-

tims of serious physical abuse. Subsequently, he and his colleagues published a study by the same name in 1962 (Heins 1984; Kempe et al. 1962). The first description was of children generally younger than 3 years old, often with evidence of malnutrition and multiple soft tissue injuries. Subdural hemorrhages and multiple fractures were commonly found. Kempe et al. (1962) also included children with less severe or isolated injuries in their description of the battered child. Although any child with an inflicted injury has been battered, the term battered child is typically used to describe a child with repeated injuries to multiple organ systems. Health care providers who treat children should be able to identify those who are severely abused and injured and should know how to respond accordingly as well.

Fontana et al. (1963) extended the early conceptualization of child abuse to include forms beyond physical injury by introducing the term maltreatment syndrome. Maltreatment included both battered children and children who were poorly fed and inadequately supervised. Fontana et al. (1963) added neglect to the evolving description of child abuse.

The original articles by Caffey (1946), Silverman (1953), Kempe et al. (1962), and Fontana et al. (1963) provide the modern medical history of child abuse. Their insight and persistence set the stage for the recognition of child abuse as a pediatric problem and resulted in an outpouring of medical, social, and psychological literature dealing with abuse and neglect.

Thirty years after the Kempe et al. (1962) article, Dr. Richard Krugman (1992), then the director of the C. Henry Kempe National Center for Prevention of Child Abuse and Neglect, observed how far the child protection movement had come in a short time. He compared the 1962 figure of 447 reported victims of battering to the 1991 estimate of 2.7 million reports of abuse (Krugman 1992). Krugman stressed the staggering disparity between 447 cases and 2.7 million reports, even if not all reports of abuse result in a determination of maltreatment. In addition, Krugman (1992) observed that the 1991 estimate of 2.7 million reports of abuse did not account for the number of unreported cases that were not suspected, misdiagnosed, or simply not reported. Figure 1 shows the exponential growth of the professional literature moving from occasional articles to an evidence base of hundreds and now thousands of peer-reviewed articles currently available.

Child abuse and neglect is now regarded as a public health problem throughout the globe. It is recognized as part of the continuum of violence and victimization against the vulnerable that includes other forms of family violence as well. Paolo Sergio Pinheiro in his August 2006 report to the UN General Secretary made clear that there can be no compromise in challenging violence against children: “Children’s uniqueness—their potential and vulnerability, their dependence on adults—makes it imperative that they have more, not less, protection from violence” (The United Nations Secretary General’s Study on Violence Against Children 2006, p. 5).

It is the responsibility of the health care professional to conduct the health care evaluation of the child suspected of having been abused or neglected, to consider a broad differential diagnosis, and to accurately identify the child’s condition based on the information available. Working in the context of a multidisciplinary team, the health care provider then participates in the investigation and works to ensure proper medical and community action that involves treating the child’s existing injuries and ensuring protection from future injury.

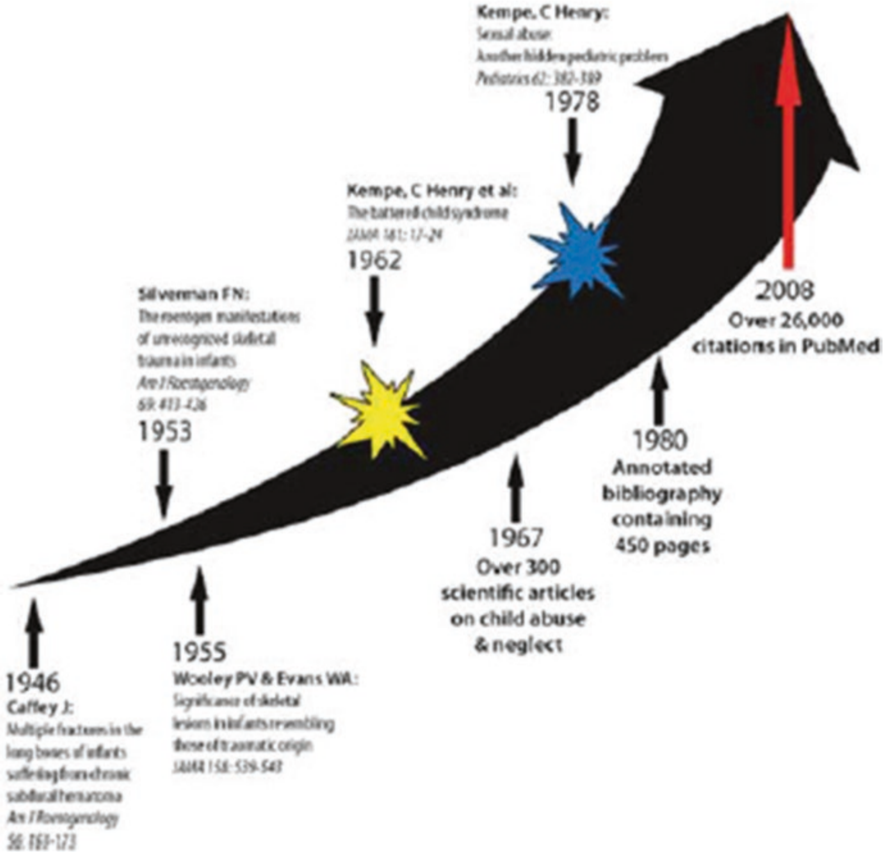

Fig. 1

How the Book Is Organized

The manual is organized into four main parts, as follows. Part I contains Chaps. 1 and 2, which provide an overview on the phenomenon of child abuse and neglect and offer a general approach to the evaluation of the maltreated child. The need for a systematic and comprehensive approach in the evaluation of suspected child maltreatment cases is highlighted. In addition, the authors support an interdisciplinary evaluation to enhance attention to both physical and psychosocial aspects and to facilitate the development of comprehensive treatment plans that build upon each discipline's different skills and perspectives.

Part II, composed of Chaps. 3, 4, 5, 6, 7, 8, and 9, addresses specific forms of maltreatment such as skin injury, abusive head trauma, and neglect. Each of these chapters addresses mechanisms of the specific type of injury, characteristic findings, clinical approach, differential diagnosis, and proposed treatments where applicable.

Some information is repeated in several chapters to allow for those providers who may need to use a specific chapter as a reference when working with a child with a given symptom or finding. When more detailed information is available in a related chapter, the reader is referred there as well. In addition, Chap. 9 concludes with current information on the evaluation of child fatalities including information on the postmortem examination.

Part III includes Chaps. 10, 11, and 12 and addresses the relationship of child maltreatment to children with special needs, the overlap of intimate partner violence with child maltreatment and on approaches to the prevention of child abuse and neglect. Finally, Part IV comprised of Chaps. 13, 14, 15, and 16 covers a number of the issues related to the teamwork so essential to the evaluation and investigation of child abuse and neglect. Overarching team issues as well as specifics related to psychosocial assessment and interaction with the child protection system are addressed, as well as legal issues, and the important interface with mental health professionals that may occur in cases of suspected and substantiated abuse and neglect. These chapters are intended to give more detail regarding these critically important issues.

In conclusion, this manual is written to assist the health care provider in performing a systematic evaluation of the child suspected of abuse or neglect. It is our hope that as the clinician develops greater expertise in the evaluation of the maltreated child, he or she will recognize patterns suggestive of physical abuse and neglect more easily, be better able to complete the appropriate medical and psychosocial evaluations of the child, and become more cognizant of the ultimate responsibility to work with other professionals and agencies to ensure the safety and recovery of the victimized child. We believe that the needs of the child and family are best served by knowledgeable health care professionals who clearly understand their role as health care provider and child advocate. We agree with Dr. Krugman that in the final analysis, child abuse and neglect is a "child's and a family's" problem and we hope that this book helps health care professionals assist children and families as they confront this challenge.

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Authors' Note

Every effort has been made to ensure that information concerning the recommended ordering of laboratory and diagnostic tests, the interpretation of laboratory values, and suggested drug dosages and usages stated in this manual are accurate and conform to the accepted standards at the time of publication. However, the reader is advised to consult printed information on each test or drug prior to ordering a study or administering any medication, especially when ordering unfamiliar tests or using infrequently used drugs.

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Kelli Connell-Carrick has devoted her career to the children and families affected by child maltreatment. She was an assistant professor at the University of Houston Graduate College of Social Work, a research associate of both the Center for Public Policy at the University of Houston and the Center for Child Welfare at the University of Texas at Arlington, and was involved in a statewide evaluation of retention and job training of CPS and adult protection workers. Dr. Connell-Carrick has over 60 competitively selected publications and presentations in the areas of child maltreatment, neglect of infants and toddlers, parenting education, foster care and aging out, and professional development of child welfare staff. She has also coauthored two books, *Understanding Child Maltreatment: An Ecological and Developmental Perspective*, published by Oxford University Press (with M. Scannapieco), and *Methamphetamine: What You Need to Know* (with Sallee, Liebe, Myers and Sallee), published by Eddie Bowers. She is published in such journals as *Child Welfare*, *Child and Adolescent Social Work*, and *The Journal of Interpersonal*

Violence. Dr. Connell-Carrick was the PI on a large federal grant from 2005 to 2008 that involved developing, delivering, evaluating and disseminating a training curriculum to CPS supervisors throughout the state of Texas on the needs of youth aging out of foster care. In 2004, Dr. Connell-Carrick won the Humanitate Award for Outstanding Literary Achievement from the North American Resource Center for Child Welfare.

Paige Culotta is a board-certified pediatrician currently in her third year of her child abuse pediatrics fellowship with Baylor College of Medicine at Texas Children's Hospital in Houston, where she also completed her pediatrics residency. Dr. Culotta received an undergraduate degree in biology from Louisiana State University in Baton Rouge and went on to complete medical training at the Louisiana State University Health Sciences Center in New Orleans. At Texas Children's Hospital she assists the Child Protection Team medical consultation service in identifying, evaluating, and diagnosing suspected child maltreatment cases and also participates in medical examinations of sexual abuse victims at the Children's Assessment Center. Dr. Culotta has a special interest in teaching and is currently pursuing a master's degree in education at the University of Houston. She has given numerous lectures in the community as well as to medical students, residents, and staff physicians to promote knowledge and prevention of child abuse. She has an interest in research on medical child abuse with a focus on improved screening and prevention.

Allan DeJong has been involved in the management of suspected physical and sexual abuse of children for over 35 years. Dr. De Jong began studying and managing child sexual abuse cases at Thomas Jefferson University Hospital upon joining the faculty at Jefferson Medical College of Thomas Jefferson University in 1978. Dr. De Jong currently holds the rank of Clinical Professor of Pediatrics at the Sidney Kimmel Medical College of Thomas Jefferson University. Dr. De Jong has been the Medical Director for the Children's Advocacy Center of Delaware (CACD) since it opened in 1996 and helped establish CACD sites in each of Delaware's three counties by 2003. He became Director of the Children at Risk Evaluation (CARE) Program at Nemours—Alfred I. duPont Hospital for Children in 1997 and has practiced full time as a child abuse pediatrician since that time. He is board-certified in General Pediatrics and in Child Abuse Pediatrics. Dr. De Jong has lectured regionally and nationally on physical and sexual abuse of children, and has 36 publications in the field of child abuse. He is a member of the Ray Helfer Society, the International Society for the Prevention of Child Abuse, the Pennsylvania Attorney General's Medical/Legal Advisory Board for Child Abuse, and the Delaware Child Protection Accountability Commission, and is the Chair of the Suspected Child Abuse and Neglect (SCAN) Education Program Advisory Board for the Pennsylvania Chapter of the American Academy of Pediatrics.

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Angelo P. Giardino is Senior Vice President/Chief Quality Office at Texas Children's Hospital. Prior, Dr. Giardino served as the Chief Medical Officer for Texas Children's Health Plan, a provider-sponsored HMO that serves over 430,000 Medicaid and CHIP enrollees in Texas. He is a Certified Physician Executive (CPE) within the American Association for Physician Leadership. He completed the Patient Safety Certificate Program from the Quality Colloquium, is certified in medical quality (CMQ) as designated by the American Board of Medical Quality, and is a Distinguished Fellow of the American College of Medical Quality. He is Professor of Pediatrics and Section Head of Academic General Pediatrics at Baylor College of Medicine. Dr. Giardino is a member of the American Academy of Pediatrics' Committee on Child Health Finance, and he recently completed a 3-year term on the quality improvement committee for the Children's Hospital Association and worked on quality measurement and the role of value-based alternative payment models in the pediatric setting. Dr. Giardino received his medical degree and doctorate in education from the University of Pennsylvania and completed his residency and fellowship training at The Children's Hospital of Philadelphia. He received his Master's in Public Health from the University of Massachusetts. He holds subspecialty certifications in Pediatrics and Child Abuse Pediatrics by the American Board of Pediatrics. He is a recipient of the Fulbright & Jaworski L. L. P. Faculty Excellence Award at Baylor College of Medicine. His academic accomplishments include publishing several textbooks on child abuse and neglect and presenting on a variety of pediatric topics at national and regional conferences.

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and states that her most prized accomplishment is supporting students to achieve their professional goals.

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Dr. Lyn is an administrator, educator, and clinician. She previously served as the Chief of Child Protection in the Section of Emergency Medicine. Her academic accomplishments include published chapters, development of curricula on the evaluation of child maltreatment, and presentations on a variety of pediatric topics related to evaluation and management of children in health care crisis. She has participated in numerous radio and television broadcasts to discuss topics of injury prevention, child maltreatment, and emergency medicine. Dr. Lyn is the recipient of the Baylor College of Medicine Department of Pediatrics Award of General Excellence in Teaching and the Baylor College of Medicine Fulbright and Jaworski Excellence in Teaching Award. She is also the recipient of several Houston community awards including the Breakthrough Women Award from Texas Executive Women and The Houston Chronicle and the Unstoppable Leader Award from the Greater Houston Women Chamber of Commerce.

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Dr. Maria Scannapieco has worked in the public child welfare arena for 30 years as an educator and researcher, with direct child protection and foster care administration experience. Maria Scannapieco has received over a million dollars a year since 1996 from state and federal grants for workforce development, training programs, curriculum development, technical assistance, and research. She has extensive experience in grant development, implementation, management, and dissemination. Dr. Scannapieco has over 150 publications and presentations competitively selected many in the areas of the impact of child maltreatment, out-of-home placement, youth aging out of foster care, Indian Child Welfare, and training and retention of child welfare workers. Dr. Maria Scannapieco has three books with Oxford University Press (with Rebecca L. Hegar) *Kinship Foster Care: Practice, Policy, and Research* (1999), *Understanding Child Maltreatment: An Ecological and Developmental Perspective* (2005) (with Kelli Connell-Carrick), and *Understanding Mental Health Problems of Children and Adolescents: A Guide for Social Workers* (with Kirstin Painter).

Carl J. Schmidt is a forensic pathologist with extensive experience in child abuse. He is Associate Professor in the Department of Pathology at the University of Michigan and the Chief Medical Examiner for Wayne and Monroe Counties, also in Michigan. He trained in pathology at the Medical College of Ohio in Toledo and trained in forensic pathology in Detroit. Dr. Schmidt has published on child abuse and sudden infant death. He also has participated in forensic training in Latin America, especially Colombia. He has also been part of Michigan's Child Death Review Team since 1996, and has contributed to training for CDR since 2000.

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Part I
Child Abuse as a Health Problem

Chapter 1
Introduction: Child Abuse and Neglect

Angelo P. Giardino, Michelle A. Lyn, and Eileen R. Giardino

Definition

Child Abuse

Child abuse and neglect, *child maltreatment*, and *child victimization* are interchangeable terms that refer to a major public health problem confronting children and families. Abuse manifests when the child's or adolescent's caregiver fails to provide for the youth's health and well-being either by causing an injury or, as in neglect, by not meeting a basic need. Because of the multifaceted nature of abuse, a comprehensive definition of child abuse and neglect draws upon information from a number of disciplines and a variety of professionals. The phenomenon of child maltreatment has diverse medical, developmental, psychosocial, and legal consequences. Child abuse and neglect, along with its synonyms, describes a wide range of situations. It involves caregiver acts of commission or omission that had or are likely to have injurious effects on the child's physical, developmental, and psychosocial well-being. Child maltreatment is broadly categorized into (a) physical abuse, (b) sexual abuse, (c) emotional/psychological abuse, and (d) neglect. Neglect is

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further subcategorized into specific areas, such as physical, supervisional, educational, and emotional/psychological (see Chap. 7).

Physicians and nurses commonly focus on definitions that highlight the medical aspects of injury, while clinical social workers tend to focus on family and caregiving systems that give rise to abuse. Law enforcement officers and attorneys may concentrate on the evidence that determines guilt or innocence of the suspected perpetrator of the abuse. Definitions are purposely broad to encompass the many different etiologies, presentations, and clinical manifestations of abuse or neglect cases (Azar 1991; Bourne 1979; Helfer and Kempe 1987; Hobbs et al. 1993; Ludwig 1992; Wissow 1999). Clinical situations may vary widely, ranging from the relatively rare case of a child who is tortured to death by a psychotic caregiver to the more commonly seen case of a toddler who sustains a bruise to his or her buttocks during the application of corporal punishment. The unifying theme in all definitions of child maltreatment is that abuse and neglect occurs in the context of either active or passive caregiving behavior that is destructive to the normal growth, development, and well-being of the child (Ludwig 1993).

At the federal level, the Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as:

> Any recent act or failure to act on the part of a parent or caregiver, 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. (CAPTA 2010, p. 6)

The wording in the federal legislation sets the minimum standard for states that accept federal funding, and then each state defines child abuse and neglect in its own state statutes and regulations (Child Welfare Information Gateway 2008). *Physical abuse* occurs when a child has suffered injury due to the actions of his or her caregiver. Specifically for physical abuse definitions, laws tend to speak to acts of commission during which a child is injured by the actions of a caregiver. *Neglect* describes inadequate parenting or caregiving where there is potential for injury resulting from omissions on the part of the caregivers in meeting the child's basic needs. Neglect is present when a child experiences poor hygiene, exposure to the elements, lack of compliance with medical therapy, inadequate supervision, and forms of malnutrition related to parental control over feeding (see Chap. 7). Neglect definitions then tend to speak to acts of omission that fail to provide for the child's basic needs, which put the child at risk for physical, emotional, or educational harm (Leeb et al. 2008). Acts of commission and omission are considered deliberate and intentional even if the harm to the child is not the intended consequence since "intention only applies to the caregiver acts – not the consequence of those acts." For example, a caregiver may intend to hit a child, applying corporal punishment for discipline, so the act of hitting is not accidental or unintentional, but if the child has a concussion, albeit not the desired result, the intentional act resulted in physical abuse (Leeb et al. 2008).

The Fourth National Incidence Study (NIS-4) (Sedlak et al. 2010) defines physical abuse according to the harm standard as:

- **Physical abuse.** Physical abuse includes shaking, throwing, purposefully dropping a child, hitting, pushing, grabbing, dragging or pulling, punching or kicking, and other physical abuse. The NIS classifies children as physically abused under the harm standard if they suffered at least a moderate injury from physical abuse. Moderate injuries are defined as physical, mental, or emotional injuries or conditions (or behavior problems) resulting from physical abuse which are serious enough to persist in observable form for at least 48 h. Examples include bruises, nightmares, depression, and fearfulness (Sedlak et al. 2010, pp. 3–6).

The NIS-4 defined neglect according to the harm standard as falling into three distinct categories:

- **Physical Neglect**: This type of neglect includes abandonment; refusal of custody; illegal transfer of custody; unstable custody arrangements; medical neglect; inadequate supervision; inadequate attention to needs for food, clothing, shelter, or personal hygiene; and other disregard for the child's physical needs or physical safety. From inadequate supervision to the end of this list, the NIS includes the child in the harm standard estimates only if the maltreatment results in demonstrable injury or impairment that is serious or fatal.
- **Emotional neglect**: Maltreatment of this type includes inadequate nurturance or affection, chronic or extreme domestic violence in the child's presence, knowingly permitting drug or alcohol abuse or other maladaptive behaviors, failure or refusal to seek the needed treatment for an emotional or behavioral problem, overprotective treatment, inadequate structure, inappropriately advanced expectations, exposure to maladaptive behaviors and environments, and other inattention to the child's developmental or emotional needs.
- **Educational neglect**: Children are included in this category when their parent (or parent-substitute) knowingly permits their chronic truancy an average of at least 5 days per month, exhibits a pattern of keeping the child home without legitimate reason, fails to register or enroll a school-age child in school in violation of the state law, or refuses to allow or provide the needed attention for a diagnosed educational problem, learning disorder, or other special education needs (Sedlak et al. 2010, pp. 3–8 to 3–10).

Regardless of personal or professional preference for a specific definition, it is important that healthcare providers both (1) understand the definition of child abuse and neglect and (2) comply with the required actions contained in the state laws governing the geographical area in which they practice. In all 50 of the United States, healthcare professionals such as nurses, physicians, and social workers are considered mandated reporters and are required to report suspected cases of child abuse and neglect to the appropriate authorities. Finally, federal

and state laws on child abuse and neglect refer to cases of harm caused by caregivers, either parents, or those in caregiving roles (US Department of Health and Human Services 2008). Cases of harm to children and adolescents caused or perpetrated by noncaregivers are also seen as crimes (e.g., assault) but are not viewed as child maltreatment owing to the lack of a caregiving relationship between the perpetrator and victim.

Reporting

Healthcare professionals use clinical skills and judgment to decide if a child's injuries are due to abuse and/or neglect. They are mandated reporters of suspected child abuse and neglect and are obligated in all jurisdictions to comply with the law (see Chap. 17). Clinical social workers are an excellent resource for helping healthcare professionals understand specific child abuse reporting laws and guidelines.

Scope of the Problem

Epidemiology

The incidence of child maltreatment (the number of new cases identified in a 1-year period) is often determined through research using data sources from reports of abuse and neglect. The data sources represent those cases known to social service or law enforcement agencies. The flaw in determining incidence by this method is that not all abuse is reported and not all reports are considered to be actual abuse or neglect after investigation. Aggregation and comparisons among studies are problematic because reports often originate from reporting standards that vary. For example, a legal standard that holds up to rules of evidence governing an adversarial courtroom situation would likely yield different results than a social service's standard for abuse, which is less strict and allows the investigator's judgment as well as physical evidence to be used.

In the federal fiscal year (FFY) 2016, child protective services (CPS) agencies received an estimated 4.1 million reports of suspected maltreatment. This number involved approximately 7.4 million children. A child abuse report is considered to be substantiated if investigation yields a determination that the child has been abused or is at significant risk of being abused or neglected. Substantiation implies a degree of certainty on the part of the CPS agency that the abuse occurred or that the child is at significant risk of such. Of the 4.1 million referrals, after processing and investigation, approximately 676,000 children were substantiated to be child

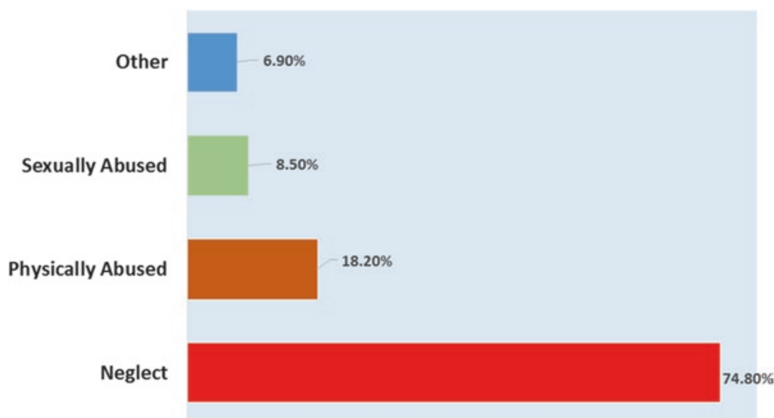


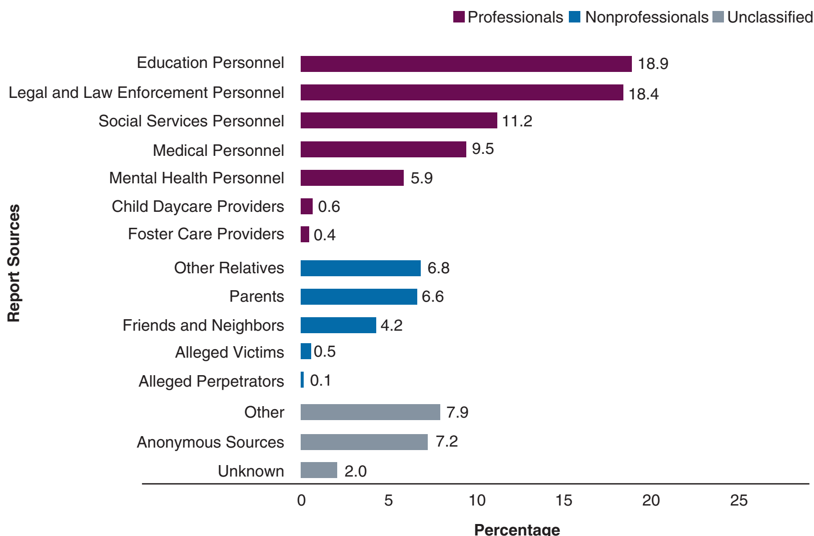
Fig. 1.1 Types of maltreatment by percentage (unique count of child victims and duplicate count of maltreatment types). (US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child maltreatment 2016*. Available from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment)

maltreatment victims. The most common form of substantiated abuse in 2016 was child neglect, which accounted for 74.8% of cases, followed by physical abuse at 18.2%, then child sexual abuse at 8.5% of cases, and, finally, other maltreatments which accounted for 6.9% of cases (US Department of Health and Human Services et al. 2018). See Fig. 1.1.

For FFY 2016, professionals submitted 64.9% of the reports. The highest reporting professionals were education personnel (18.9%) followed closely by legal and law enforcement personnel at 18.4%, with medical personnel including professionals and nonprofessionals at 9.5% (US Department of Health and Human Services et al. 2018). See Fig. 1.2.

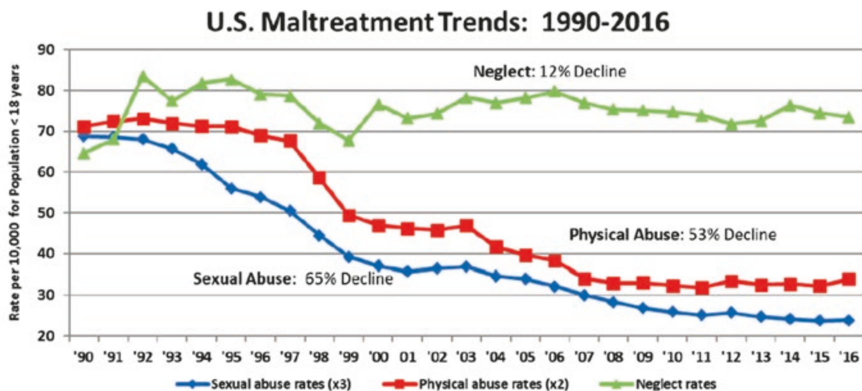
Finkelhor, Saito, and Jones (2018) analyzed trends in reporting and substantiation rates for child abuse and neglect from the 1990s through 2016. They identified a decline in the number of substantiated cases of physical abuse. According to their most recent analysis, the incidence of substantiated physical abuse cases declined 553% from 1992 to 2016 (Fig. 1.3). Cases of child sexual abuse have also declined substantially, with a 65% decrease in the number of substantiated cases observed from 1992 to 2016. However, child neglect, which is the most common form of child maltreatment, declined at the lowest rate, 12% (Fig. 1.3).

The NIS-4 was mandated by the US Congress in the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) to provide up-to-date epidemiologic incidence data that uses a different method than the counting of reports to and investigated by CPS agencies (US Department of Health and Human Services



Data are from the Child File. Based on data from 49 states. States were excluded from this analysis if more than 25.0 percent had an unknown report source. Numbers total to more than 100.0 percent due to rounding. Supporting data not shown.

Fig. 1.2 Report sources, 2016 (US Health and Human Services et al. 2018, p. 8)



Note: Trend estimates represent total change from 1992 to 2016. Annual rates for physical abuse and sexual abuse have been multiplied by 2 and 3 respectively in this figure so that trend comparisons can be highlighted.

[1] The statistics in this table and this figure concern substantiated cases of sexual abuse, physical abuse and neglect. A substantiated case means case that has been reported to a child protection agency, investigated and deemed to have occurred according to a "preponderance of evidence." The child maltreatment cases referred and investigated by state child protection agencies primarily involve abuse by caregivers. The cases do not include many involving stranger abusers, unless some element of caregiver neglect was involved.

Fig. 1.3 Child maltreatment trends. (From Finkelhor, Saito, and Jones 2018 used with permission)

2009). The NIS methodology views maltreated children investigated by CPS agencies as representing only the "tip of the iceberg" (Fig. 1.4). Children investigated by CPS are included along with maltreated children who are identified by professionals in a wide range of agencies in representative communities