

Child Maltreatment and Abuse

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Child Maltreatment: History

- 1874 - New York City court protected a child from parents using the animal protection laws, evoking the doctrine of *parens patriae*
- 1974 - Child Abuse Prevention and Treatment Act
- 1986 - Children's Justice and Assistance Act

Child abuse or neglect, or the newer term "child maltreatment," encompasses abusive as well as neglect issues.

Child Maltreatment

- **Definition:** The physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child.
 - Child under age 18.
 - By a person responsible for child's welfare.
 - Under circumstances in which the child's health or welfare is harmed or threatened.

Child maltreatment is legally defined as the physical or mental injury, sexual abuse or exploitation, negligent treatment or maltreatment of a child under the age of 18, by a person responsible for the child's welfare and under circumstances which indicate that child's health or welfare is harmed or threatened thereby. Child maltreatment is divided into physical abuse, sexual abuse, neglect, which is a big category, and then emotional abuse.

Types of Child Maltreatment

- Physical abuse
- Sexual abuse
- Neglect
- Emotional abuse

Annual Incidence of Child Abuse and Neglect

- Fatalities: 2,000
- Serious disabilities: 18,000
- Serious injury: 141,700
- Substantiated incidents: 992,617
- Child abuse reports: 2.9 million, involving 1.9 million children

Every year there are about 2,000 fatalities from child abuse. There are about 20,000 children who are killed or permanently disabled from child abuse. There are another 141,000 who are seriously injured, many of whom have to be hospitalized. Overall, there are roughly 1 million substantiated instances. It involves about 2.9 million reports on 1.9 million children with about 1 million cases are substantiated as maltreatment. 1.9 million children are reported as victims with 1.6 million investigations.

Child Maltreatment Statistics

- 2.9 million children reported as victims
- 1.6 million investigations

Almost half the time maltreatment is reported by non-professionals, like neighbors, relatives, or people who see a child they think is mistreated. Fifteen percent of the time it's educators and about 11% of the time it is health care professionals. About one-half of the time the report is unsubstantiated, but about 40% of the time when there is a report and an investigation, they really believe they have a child who was at risk or has been injured by violence.

The most common report is neglect. We get a lot of schools calling on children who aren't getting proper nutrition or children being left alone. About 25% of the reports are physical abuse. About 14% are sexual abuse. About 500,000 children are reported for physical abuse and about 400,000 are reported for sexual abuse each year.

Forty percent of the kids are in preschool. We do see a lot of school age and even early adolescence, but a lot of these reports are coming from the school system. In young children, we worry a lot about deaths and permanent injury.

Characteristics of Families of Mal-treated Children

- No risk differences exist for race or ethnicity
- Increased risk in single parent homes
 - 77% higher risk of physical abuse
 - 87% higher risk of neglect
- Major increased risk with poverty. Risk of harm is increased 22 times.

The African-American child is slightly over-represented since they make up about 17 or 18% of the childhood, but the others are about equal to the proportion of children.

Eighty percent of the time the perpetrator is parent, or other relative that puts it up to 90%. Physical abuse, sexual abuse, most abuse is by caregivers -- it is usually a family that is actually hurting the child.

There is an increased risk for a child in a single parent home. They are 77% more likely to be physically abused and have an 87% more likely risk of neglect. The major risk is with poverty. The poorest of the poor children, those who live in families with income below \$15,000 are actually 22 times more likely to be physically harmed in their environment.

Factors Associated with Physical

Abuse

■ Perpetrator Features

- Violent personality traits; use of force to deal with stress
- Low self-esteem, poor impulse control
- Isolation, lack of resources, poverty
- Depression
- Poor bonding with child
- Unreasonable expectations of child
- Use of alcohol or drugs
- History of abuse as child

■ Child Features

- Unwanted child
- Handicapped child, premature
- Annoying: colic, hyperactivity
- Hard to comfort (eg, drug-exposed)

■ Situational Features

- Recent illness
- Financial or marital stress
- Holidays

The characteristics of the physical abuser. The typical perpetrator, and this is more for physical abuse and maybe sexual abuse than true neglect, does tend to be violent. That word is being used a lot, but I think it is a good word because it gives us some insight. These are people that are violent and they use force when they are dealing with stress. They typically have low self-esteem and poor impulse control. They tend to be families in isolation with a lack of resources. They don't have extended families around them. Obviously, you don't abuse people when there's lots of people around helping you. It is fairly linked to poverty. Depression in the caregiver, poor bonding with the child, particularly for physical abuse. Many times it is not the biological parent but the mother's boyfriend.

Unreasonable expectations. There are people who don't know a lot about kids and aren't interested in child rearing, and don't think it's particularly cute when the kid is messing with the poop in his pants. The use of alcohol and drugs lowers the natural inhibitions against hurting children. And they usually have a history of abuse as a child themselves. It occurs in people who have learned that when they are stressed or angry, they lash out and use violence.

The recipe for the child classically is an "unwanted baby" is a bit strong, but often times the children are from a pregnancy that wasn't planned. Clearly, the high maintenance child, the child who is handicapped, who was premature, the child who is annoying, colicky. The baby that doesn't cuddle, the baby that arches its back and has that high-pitched cry, the drug exposed baby, which doesn't know how to bond. It doesn't make eye contact. Perhaps the biggest one I always listen for as a red flag is a recent illness. Kids are hard to take care of when they are sick. They cry more, it's often night time and the parents are tired. Diarrhea is a common problem that leads to maltreatment.

Burns almost always occur because they are cleaning them because they just pooped in their pants one too many times. Stress often pushes them over the edge, whether it is financial or marital. That is why in times of natural disasters and around the holidays we see these kids. It's a time of disappointment with the reality and that sort of expectation of everybody wanting to be surrounded by a loving family.

Physical child abuse. For sexual abuse, we go mainly on

Types of Physical Child Abuse

- Skin injuries: Bruises, burns, bites, lacerations
- Skeletal injuries
- Head trauma
- Chest and abdominal injuries

history. But for physical abuse, kids will come in and say, "My mom slapped me. My mom hit me." but unless they have a physical finding that shows excessive force had been used, we don't define it as child abuse. Significant bruises indicate that enough strength or violence was used to cause the bruises, burns, bites or lacerations. Skeletal fractures, head injuries, shaken baby. And then, big injuries to the chest and abdomen.

Recognition of physical abuse. There is usually a discrepancy between the history and the physical finding. This is particularly true if the parent knows that they did something wrong and so they are trying to lie to you. It's different in the older child where they beat the kid with the belt and they are not about to lie, because to them that is okay. In the young child, they are making up a story, and classically there will be a change in the story, the story will often be incompatible with the child's development, they will tell you the child did something that is incompatible with the child's abilities or there will just be no explanation. A three-month-old with a femur fracture, and they just don't know how it happened. Sometimes, what we look for is kinds of injuries which appear inflicted.

The biggest differential is going to be accidents. When a kid comes in, they are always going to tell you they fell off the couch. Multiple injuries over time, so the child is constantly coming to the health care system, or at a single point in time you see bruises of different ages. Delay in seeking medical attention is a big one, although sometimes they don't really realize their child has a problem and lack of access the care, including financial problems.

Doctors are not investigators. We are not there to investigate or to decide who's guilty. But we are there to take a history and it's very important that what explanation is given to you is recorded. Many times, putting quotes is the best way. You should record the history and not draw conclusions.

Clinical Signs of Physical Abuse

- Discrepancy in history and physical findings
 - Changing caretaker stories
 - Injury history that is incompatible with the development level of the child
 - Lack of explanation for injuries
- Pattern of injuries appears inflicted
- Multiple injuries occur over time
- Supporting observations
 - Delay in seeking medical attention
 - Inappropriate caregivers

Why do we miss the diagnosis of child abuse? There is the desire to believe the caregivers. Many of us still don't think of it as potential abuse. We really just don't think about it. A lot of times, we are focusing on the medical condition and we just don't think, again, about the slightly discrepant explanation.

Many of us do respect "parental rights". All of us want parents to be the caregivers of their children but this gets into that area of discipline. What is appropriate discipline? This is primarily the older child. And there is no question, the reluctance to get involved.

Causes of Failure to Diagnosis of Child Abuse

- Desire to believe caregivers
- Lack of experience by examiner; failure to consider diagnosis of child abuse
- Total focus of care on the medical condition
- Respect for "parental rights"
- Reluctance to get involved with legal system

One of the points that we all know is that it is the very young child who is really most at risk of death in physical abuse. The two big syndromes are the battered child syndrome and then the shaken baby syndrome. The hallmark of a shaken baby is signs of intracranial trauma characterized by subdural blood, cerebral edema. Most of these kids have diffuse intracranial injuries and when they first come in, many times the CTs are not very impressive that they would develop cerebral edema. The triad includes retinal hemorrhages. Then classically, the lack of external signs of trauma. If we just teach people not to shake the baby, we can prevent some of this.

Physical Abuse in the Very Young

Child

- **Very young children** have the highest risk of death from physical abuse
- **Battered child syndrome**
 - Multiple fractures at different stages
 - Typical fractures include metaphyseal fractures and rib fractures.
- **Shaken baby syndrome**
 - Signs of intracranial trauma which may include subdural blood and cerebral edema.
 - Retinal hemorrhages.
 - Lack of external signs of trauma.

Cutaneous signs of accidental injuries include their location on the exploring surfaces; the shins, forehead, the protruding processes of the body and they are typically nonspecific. Where non-accidental bruises typically are on protected surfaces -- the buttocks, particularly when there is punishment. The kids who are stripped and beaten, but also around the neck and ears. Kids that are pinched and pulled, and patterns of objects that are inflicted may be visible on the skin.

Bruises

■ Characteristics of Accidental Burns

- Burns on "Exploring" surfaces: shins, forehead, elbows, over spinous processes over spine.
- Burns with nonspecific patterns.

■ Characteristics of Non-accidental Burns

- Burns on "Protective" surfaces: Buttocks, cheeks, neck, ear pinna, flanks, thighs, genitalia
- Burns with object patterns (eg, irons)

Accidental burns typically are in a splash pattern. Many times there is an area with a drip pattern. The burns are somewhat irregular in depth, non-uniform, and they often involve the face and hands. Or sometimes, when they are shaped like objects, like irons, where they are partial and glancing. The non-accidental burn may be in an immersion pattern. It has a regular edge, uniform depth. Typically the hands and feet or the perineum. The perineum, again, is often involved in the cleansing. Sometimes there is an object that is put to the skin, particularly cigarette burns. With accidental burns, the child's developmental skills must match the story of how the burn occurred.

Burns

■ Characteristics of Accidental Burns

- Splash Burns: Irregular, non-uniform, involve face and chest.
- Object Burns: Partial, glancing burns, often on hands and arms.

■ Characteristics of Non-accidental Burns

- Immersion Patterns: Regular edges, uniform depth, often on hands or feet, or on perineum or buttocks.
- **Object burns** create a pattern, usually on unexposed areas (eg, cigarette burns)
- Child development skills often do not match the history.

Conditions mistaken for physical abuse. Mongolian spots, impetigo are rarely mistaken for abuse. The bone abnormalities type of fractures. I recently saw a child who was removed from a home because he had a toddler's fracture, which is a fairly normal condition. There is no history. Osteogenesis imperfecta. Every lawyer knows that term. I dread it. Easy bruisability. There are some bleeding disorders. Folk medicine includes cupping and "cao gio" in Southeast Asians. So, those are cultural and not considered child abuse. Subconjunctival hemorrhage. The big one for me is what is called benign extra-axial fluid collection, which can cause cystic fibromas or benign subdurals. We will talk about that a little bit later. And then there are some self-inflicted things.

Conditions often Mistaken for Physical Abuse

- **Unusual skin patterns:** Mongolian spots, photodermatitis, impetigo, urticaria pigmentosa.
- **Bone abnormalities:** Toddler's fracture, osteogenesis imperfecta, Ricketts.
- **Increased susceptibility to bruising:** Bleeding disorders, Henoch Schönlein purpura.
- **Folk medicine:** cupping, cao gio
- **Eye findings:** subconjunctival hemorrhages.
- **CNS:** aneurysm, benign extra-axial fluid.
- **Self-inflicted Injuries:** Mental retardation, Riley-day

Bilateral black eyes may occur in accidental when you get a big hematoma that drifts down into the eyes. Pinching around the ear and pulling children by the ears are violent acts that put them at risk.

Bruises in the first year of life - babies do not bruise. You should not be seeing bruises in three and four and five-month-old babies. Now, maybe every once in awhile you'll have a kid who hits his head or something, but if you see bruises in babies, I think that is high risk.

An adult bite mark is clearly abusive. I don't see a whole lot of them. This is a child bite mark.

Immersion burns have a fairly straight edge. Sometimes when burns come in, we can't tell. Sometimes it's good to go back in a couple of days before we make the final assessment.

Rib fractures are very classic for abuse. Almost never accidental with a few exceptions. They are often posterior, with cracks over the vertex and are often multiple. Rib fractures are so hard to see when they first happen, unless you have great radiologists and even then, sometimes we'll miss them until they heal. But we are always looking for fractures. And then of course the buckle handle fracture.

Now, femur fractures are tough. You have to hear the history. I hate to hear a story of a femur fracture in a two and a half year old and try to decide. Radiologists usually use the term "oblique" because every spiral fracture, our CPS workers think is abuse. When you see a fracture within the first two years of life, unless it's clearly a non-inflicted fracture, a skeletal survey should be done.

Child Sexual Abuse

- The physical exam is usually normal in children who have been sexually abused.
- A normal physical exam never rules out abuse.
- Physical findings of sexual abuse include acute or chronic trauma and sexually transmitted diseases
- Perpetrator is known to the child in more than 90% of cases.
- Outcry is the most important factor in diagnosis.
 - Outcry usually is delayed
 - Lack of understanding
 - Ambivalent feelings
 - Threats
 - Bribery
 - Shame, guilt

For child sexual abuse, the physical exam is usually normal in kids and that you can never say that the child hasn't been sexually abused. A physical exam never rules out abuse. But anytime there is an outcry or an allegation, you can never examine a child and say they haven't been abused. Because with physical findings, all we can see is trauma or an STD.

Physical Findings of Sexual Abuse

- Normal examination
- Nonspecific findings
- Suspicious or concerning findings
- Findings specific for sexual abuse
- Findings definitive for sexual abuse

The vast majority of child sexual abuse is by people around the child. There is a grooming process. They go slow and they gradually escalate until the child is more aware of the abuse. The outcry is the most important part of the diagnosis, but that is why it is so hard to prosecute. The outcry is almost always delayed. It's often a gradual process, and all of a sudden they're in deeper than they want to be and they don't know what to do. Many kids do try to talk about their sexual abuse and they are rebuffed by people around them.

Nonspecific Findings of Sexual

Abuse

- Vulvar erythema
- Redness and friability of the vestibule mucosa
- Hymen edema
- Large hymeneal opening
- Condyloma in first year of life
- Nonspecific vaginitis
- Labial adhesions
- Urethral dilation
- Anal tags
- Venous pooling

Physical findings of sexual abuse. Most findings are normal. They are going to be nonspecific. Occasionally, we'll have something we'll call suspicious. There are findings which are specific and then there are findings which are definitive.

Findings Specific for Sexual Abuse

- Hymen transection
- Hymen <1 mm in posterior rim
- Severe Hymen scars: Mounds and avascularity (asymmetric estrogen effect may cause similar findings)
- Condyloma at age less than 2
- Sexually transmitted disease: trichomonas, chlamydia, herpes type II

The definitive ones are rare. Pregnancy, finding a sperm, finding acute torn trauma or HIV, gonorrhea or syphilis.

The nonspecific -- redness, condyloma in the first year of life, non-specific. The specific ones are if you can say the hymen has been transected, and I would say if it's really unequivocal transection, that is actually definitive. The transected hymen that is gone, the new trend is to look at the posterior rim of less than 1 mm. The hymen has to be totally gone for it to be specific. Sometimes you really have mounds or areas of vascularity that you can clearly say are scars. But the problem is that in estrogen you'll get asymmetric effect both as estrogen goes away in the first two or three years of life and then in the preadolescent. Warts after age two, but we almost never find the abuser. This is really tough. And then the STDs; trichomonas, chlamydia and herpes II.

There are conditions mistaken for sexual abuse. There are anatomical foreign bodies, straddle injuries which are common but they usually don't involve the hymen area, there are infections. The big ones are strep. I've seen kids removed for peri-anal and vaginal strep infections. Nonspecific irritations. This is a big one. They don't have to use bubble bath. When kids don't have estrogen between three and eight, the mucosal area of the vestibule is very easily irritated.

Child neglect. The definition is failure to provide for the child's basic needs. There is physical, educational, and emotional neglect. We do have to be sure that the family has access to the things that the child needs. Then, if they don't access it on a regular basis, we sometimes have to intervene. It is the most common form reported.

Findings Definitive for Sexual

Abuse

- Pregnancy
- Sperm presence
- Acute findings of violent assault with tears and bruises to genital or anal structures
- Sexually transmitted disease (non-neonatal transmitted): Gonorrhea, syphilis, HIV

Munchausen by Proxy. It was originally defined as someone who is fabricating an illness, presenting for medical attention, denial of responsibility and it resolves when the child is taken away from the alleged perpetrator. Often it is health care providers that actually are the perpetrators in the Munchausen. Feedback from the health care system fuels this inappropriate attention, and it should be considered a form of child abuse. The people who constantly bring their kids in for medical attention, because mom likes the medical attention - needs the medical attention.

Child abuse reporting. You must report either to CPS or the police. It varies. But usually it's if you are concerned about a family member or this is a stranger or neighbor, reports must be made, not when you are certain, but when there is "reason to suspect". A report in good faith will give you legal protection and failure to report is a crime.

Munchausen by Proxy

- Fabrication or induction of illness by a parent
- Presentation of child for medical attention
- Denial of responsibility for illness
- Resolution of symptoms on separation
- The health care provider often contributes to the morbidity
- Consider a form of child abuse

Child Abuse Reporting

- Reports are made to Child Protective Services or Police.
- Reports must be made when there is a “reason to suspect” child abuse.
- Failure to report child abuse is a crime.