Aspects of Abuse: Recognizing and Responding to Child Maltreatment

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Child maltreatment is a public health problem and toxic stress impacting at least 1 in 8 children by the age of 18 years. Maltreatment can take the form of physical and sexual abuse, neglect, and emotional maltreatment. While some children may experience only one form of maltreatment, others may survive multiple forms, and in some cases particularly complex forms of maltreatment such as torture and medical child abuse. When considering maltreatment, providers should be adept at obtaining a thorough history not only from the parent but when appropriate also from the patient. The most common form of child maltreatment is neglect, which encompasses nutritional and medical neglect, as well as other forms such as physical and emotional neglect. Talking with caregivers about stressors and barriers to care may give insight into the etiology for neglect and is an opportunity for the provider to offer or refer for needed assistance. Familiarity with injury patterns and distribution in the context of developmental milestones and injury mechanisms is critical to the recognition of physical abuse. While most anogenital exam results of child victims of sexual abuse are normal, knowing the normal variations for the female genitalia, and thereby recognizing abnormal findings, is important not only forensically but also more importantly for patient care. Pattern recognition does not only apply to specific injuries or constellation of injuries but also applies to patterns of behavior. Harmful patterns of behavior include psychological maltreatment and medical child abuse, both of which cause significant harm to patients. As health professionals serving children and families, pediatric providers are in a unique position to identify suspected maltreatment and intervene through the health care system in order to manage the physical and psychological consequences of maltreatment and to promote the safety and well-being of children and youth by making referrals to child protective services.

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Introduction

Child maltreatment is a public health problem that encompasses both the abuse and neglect of children by a parent or caregiver, which respectively include acts of commission and omission. Although the pediatric population includes young adults in their late teens and early 20s, child abuse and neglect refers to children and youth below the age of 18 years in keeping with the legal definition of a child. Maltreatment, however, can and does occur across the lifespan. According to federal definition as delineated in the Child Abuse Prevention and Treatment Act (CAPTA) as Amended by P.L. 111-320, the CAPTA Reauthorization Act of 2010[1]

> the term "child abuse and neglect" means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm;

Child abuse includes physical, sexual, and emotional acts toward children and youth, while child neglect includes physical, emotional, medical, educational, and supervisional acts of omission. More specifically, neglect occurs when the basic needs of a child are not being met. These needs include the emotional, educational, nutritional, physical, supervisional, and medical needs for children and youth. Neglect can result from the willful omission or disregard for the child or from a lack of ability or resources. In either case, the impact of the neglect on child well-being can be the same. Child physical abuse includes physical acts that harm or have the potential to harm or injure children. Such acts can include hitting, kicking, punching, beating, stabbing, biting, pushing, shoving, throwing, pulling, dragging, dropping, shaking,

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strangling/choking, smothering, burning, scalding, and poisoning. According to CAPTA,[1] sexual abuse is defined as

> the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Sexual assault is different in that the perpetrator can be an acquaintance, stranger, or other individual who is not in a caregiving role. Medical Child Abuse is more complex form of maltreatment in which a caregiver fabricates, exaggerates, and/or induces signs and symptoms of illness resulting in excessive utilization of medical care and interventions.[2–4] It is not only physically abusive but also has elements of emotional maltreatment and neglect. Emotional maltreatment can entail both acts of commission and acts of omission that negatively impact the well-being of a child. It is defined best in the American Academy of Pediatrics' 2012 Clinical Report, which states

> Caregiver behaviors include acts of omission (ignoring need for social interactions) or commission (spurning, terrorizing); may be verbal or nonverbal, active or passive, and with or without intent to harm; and negatively affect the child's cognitive, social, emotional, and/or physical development.[5]

In addition to the uniquely complex forms of maltreatment such as child torture and Medical Child Abuse, which incorporate physical abuse, emotional abuse, and neglect, many children experience more than one form of maltreatment.[6] The impact of child maltreatment on child well-being is great. Consequently, recognizing signs and symptoms of abuse and neglect, and making appropriate referrals for assessment and treatment are critical skills for health care providers.[7] By recognizing and appropriately responding to child maltreatment, ongoing and potentially escalating abuse can be interrupted and interventions can be implemented to improve outcomes for children and families.

Epidemiology

Child abuse is not rare, it is however, not always recognized, reported, or disclosed. The cumulative prevalence of substantiated cases of maltreatment based on the 2011 national rate of child maltreatment is 1 in 8 children by the age of 18 years.[8] This rate is based on the number of substantiated cases of child maltreatment reported annually to child welfare agencies in the US. All reported abuse and neglect may not be substantiated in the child welfare system. Therefore, these rates provide an estimate of the true prevalence of child maltreatment and more realistically represent the tip of the iceberg. The 2011 National Survey of Children's Exposure to Violence (NatSCEV II) used telephone surveys of youth and/or a caregiver for younger children to assess exposure to violence and abuse. The results indicated that in their lifetime, 9.5% of the over 4500 children and youth surveyed (ages 1 month–17 years) had a history of sexual victimization, over 25% experienced maltreatment by a caregiver, and over 20% had witnessed a family assault.[9] In the mid-1990s, over 17,000 adults receiving care through Kaiser Permanente Health Appraisal Clinic in San Diego in conjunction with the Centers for Disease Control participated in The Adverse Childhood Experiences study.[10] Over 28% reported experiencing physical abuse, over 20% reported childhood sexual abuse, over 10% reported emotional abuse, and over 12% reported that their mother was treated violently. A smaller sample (8667) was later assessed for childhood neglect, of which over 14% reported emotional neglect and almost 10% reported physical neglect. While the data is not perfect, because biases can inflate or underestimate the true prevalence, it is clear that child maltreatment is not uncommon.

There are factors that can be protective against or can increase the risk for maltreatment. From an ecological perspective, these risk and protective factors can be based within the child, the family, community, and society at large. Protective factors include safe, stable, and nurturing relationships between a child and caregiver[11]; social supports; connectedness to family; clear and developmentally appropriate rules and expectations for children; conflict resolution and problem-solving skills; shared activities with parents; and community and cultural beliefs that support families and the parent.[12] Risk factors include but are not limited to maternal depression, being less than 4 years old (except for sexual abuse),[13] having special needs, a parental history of child maltreatment, having a non-biological male caregiver in the home, domestic violence, having a caregiver with poor understanding of child development, parental substance abuse, income inequality, and community violence.[14–19] While risk and protective factors are important to identify, child maltreatment can occur in any family regardless of race, ethnicity, education, or socioeconomic status.

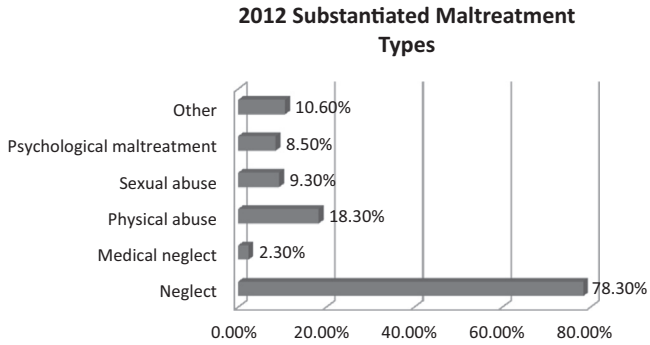

FIG 1. Distribution of substantiated child maltreatment. (Adapted from U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.[13])

Recognition and Evaluation of Neglect

Child neglect is the most prevalent form of child maltreatment substantiated in the US child welfare system. Of the 678,810 victims of child abuse and neglect in FFY 2012, 78.3% were neglected (Fig 1); moreover, of the 1640 estimated fatalities from child abuse and neglect, 69.9% suffered neglect and 8.9% suffered medical neglect.[13] The subtypes of neglect include educational neglect, emotional neglect, nutritional neglect, physical neglect, supervisional neglect, and medical neglect. Neglect is a toxic stress that can result in developmental delay, physical harm, and psychological harm.[5,20]

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While health care professionals may not be in a position to recognize all subtypes, we may care for children who lack adequate food, clothing, shelter, medical care, or supervision or have been abandoned or harmed as a result of inadequate protection from hazards (Table).[21]

TABLE. Presentations of neglect in a medical setting. (Adapted from Dubowitz et al.[21])

Forms of neglect observed in pediatric medical settings
Noncompliance with medical recommendations
Delay or failure to seek medical care
Inadequate nutrition, non-illness related failure to thrive, and unmanaged morbid obesity
Illicit drug-exposed newborns or childhood ingestions
Injuries and ingestions resulting from inadequate protection from environmental hazards (e.g., guns and car restraints
Inadequate nurturance or affection
Inadequate clothing
Unmet educational needs
Abandonment
Homelessness

Nutritional Neglect

Nutritional neglect can include not only non-illness-related failure to thrive but also morbid obesity. The physical appearance of a child can be the first indication of nutritional neglect. It is, however, critical to obtain and track growth measurements, specifically weight, height, and head circumference for children 0–2 years and body mass index for children older than 2 years. Failure to thrive occurs when the weight for age falls below the 3rd to 5th percentiles or drops by 2 major percentiles. On the other hand, obesity is defined by a body mass index (BMI) at or above the 95th percentile. The diagnosis of nutritional neglect, however, is not based solely on the growth chart. Obtaining a thorough history in a culturally sensitive, nonjudgmental way is paramount to the assessment and interventions for malnutrition and obesity in addition to a physical examination, and observation of feeding when failure to thrive is suspected.[22,23] Elements of the history to elicit when assessing for nutritional neglect include the following:

- Review of systems for illness-related failure to thrive
- Obtaining a thorough dietary history
  - Quantity and frequency of bottle/nursing
  - Formula preparation
  - Amount of juice consumption
- Physical activity level
- Maternal depression
- Screening for intimate partner violence in the home

- Inquiring about abuse of the patient
- Inquiring about the parental history of childhood abuse
- Inquiring about economic stressors that may contribute to food insecurity
- Asking about parental intellectual disability ("Did you have an IEP or take specialized classes when in school?")

Physical signs of malnutrition can include bradycardia, hypothermia, listlessness, fat and muscle wasting, prominent ribs and facial bones, abdominal distension, edema, and sparse hair. When the history and physical findings suggest nutritional neglect, the response of the provider should include obtaining the appropriate labs and studies to safely manage the patient's condition. While any reasonable suspicion of neglect should be reported to child protective services, consideration should also include the severity and chronicity of the malnutrition or obesity, and the likelihood that health care interventions will or will not work.[24,25]

Medical Neglect

Recognizing medical neglect, which includes the failure to or delay in seeking needed health care as well as noncompliance with medical recommendations, is not difficult for health care providers. Responding to it is, however, more challenging. Sensitively exploring with the parent what might be contributing to their noncompliance is important and should include assessment for stressors that may be barriers to compliance. Examples include joblessness or employment with limited ability to take leave, homelessness, difficulty with transportation to medical/dental visits, parental illiteracy or intellectual disability, and language barriers. Before reporting to child protective services, there should be reasonable attempts to assist the family with compliance and to educate them about the medical condition, treatments, and the risks of noncompliance. If collaborating with the family in this way is unsuccessful or if the child has suffered harm or is at great risk of harm, then a report to child protective services should be made.[26]

Other Forms of Neglect

Illicit drug-exposure including prenatal exposure as well as childhood ingestions of illicit drugs or alcohol constitute neglect. Similarly, ingestions and injuries that result from environmental hazards from which children should be protected are also considered neglect.[21] Some examples of environmental hazards include accessible guns, unrestrained children in cars, lack of safety gates for young children, inappropriate access to chemicals and medications, exposure of children with pulmonary conditions to cigarette smoke, and exposure to domestic violence. Health care providers can intervene early by identifying risks such as maternal depression, mismatch between the child and caregiver's temperament as well as those previously mentioned, and referring to other professionals for assistance.

Recognition and Evaluation of Physical Abuse

Physical abuse can result in a variety of injuries of varying degrees of severity. The AAP committee on Child Abuse and Neglect has posited that "minor forms of abuse may lead to severe abuse unless abusive skin injuries are identified and labeled as such and interventions are made."[27] This statement highlights the fact that skin injuries are the most common presentation of physical abuse and that early identification is the best way to prevent future harm. Researchers have found that just over 27% of abused infants had a previous sentinel (relatively minor but suspicious) injury prior to being diagnosed with more serious child abuse.[28] Yet, there are no standardized screening tools available. A systematic review of the accuracy of screening instruments for identifying child abuse showed that most instruments identify abuse after it has occurred and therefore is not an appropriate screening tool.[29] As such, physical abuse should be on the differential diagnosis when making assessments about any injuries.

When assessing an injury, a clear and thorough history is necessary. There should be concern for abuse if there is no history of trauma, the history is inconsistent with the injury(ies), the history is changing, the history is inconsistent with the child's age and development, and/or there was an unexpected or unexplained delay in seeking medical care. The history should include as many details about how and when the injury occurred as possible. The pediatrician should document reported and observed developmental abilities of the child. After obtaining a history, a complete physical exam is performed. This includes a thorough

skin exam including under the diaper, behind and inside of the ears, as well as inside the mouth as injuries in these areas are easily missed.

Sheets et al.[28] found that 80% of sentinel injuries were bruises, therefore it is important to recognize when bruises are concerning for physical abuse. The greater the mobility of a child, the more likely he/she is to have accidental bruising. Conversely, it is uncommon for infants and pre-cruisers to bruise. Thus, bruising in any child younger than 9 months old who is not yet cruising/walking should raise concern for physical abuse or a medical problem.[30] In a population of children who presented for non-trauma-related care, Labbe and Caouette[31] showed that children 8 months of age or younger have fewer bruises than in older age groups and more specifically they had fewer than 3 bruises. Their study also showed that despite age and range of mobility, there are certain parts of the body that are less likely to be bruised accidentally. Less than 2% of children had injuries on anterior and posterior thorax, abdomen, pelvis, buttocks, chin, ears, and neck. Other researchers have found similar trends and created a TEN-4 Bruising Clinical Decision Rule which states that any bruising without a history to the torso, ears, or neck of a child 4 years old or younger should be highly suspicious for abuse and requires further evaluation.[32] If there is any pattern to the injury, it should be noted as this is suggestive of an object. The pediatrician does not have to determine what object was used but only recognize that patterned bruises are uncommon with accidental injuries. The same can be said of patterns as related to burn injuries. Burns can be thermal, (scald from liquid or contact with an object), chemical, or electrical. The pattern of the burn can help you determine the position of the child when the injury occurred and therefore allow you to determine the plausibility of the history provided. One study looking at the distribution of accidental versus abusive burns found that abusive burns are more likely to be on bilateral upper/lower extremities and buttocks/perineum.[33] The pattern of a burn can also be suggestive of contact with an object.

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Included in screening for physical abuse is assessment of child and parental risk factors before an injury occurs. Having a complete psychosocial assessment that is updated regularly to reflect changes in a child's home and/or family is key when assessing child and parental risk factors. For example, there are certain psychosocial factors that if present increase the concerns for abuse. These include parental alcohol or substance abuse, domestic violence, parental mental illness, and prior child protective services involvement or parental incarceration.[34] The presence of these factors by themselves do not make a diagnosis of child abuse; however, if a child presents with a concerning injury, then these factors increase the suspicion for child abuse.

The next steps in the evaluation is working to exclude medical etiologies for the injuries and to determine if there are any additional injuries. The need for and type of further testing is determined by the age, history, type of injury, and exam findings. For example, if there are concerning bruises and a history that raises concern for a coagulopathy, then further lab tests are done to rule out the possibility. These tests include a complete blood count with platelet, PT/PTT, INR, Von Willebrand antigen and activity, factor VIII, factor IX, D-dimer, and fibrinogen.[35] It is important to remember that a child can have both a coagulopathy and have been abused. The AAP recommends that all children less than 2 years old with a concern for abuse have a complete skeletal survey. If there are facial injuries or if abusive head trauma is suspected, a head CT and/or brain MRI should be obtained. If there is acute intracranial hemorrhage, then an ophthalmologist should be consulted to perform an indirect ophthalmoscopic exam to evaluate for the presence and distribution of retinal hemorrhages. Abnormal labs may be indicative of injury, such as transaminitis secondary to a traumatic liver injury or anemia secondary to intracranial or intraabdominal bleeding. Other lab tests for medical etiologies are determined on a case-by-case basis. A child abuse pediatrician is helpful in determining further steps and should be consulted where available to help direct further management.

Recognition and Evaluation of Sexual Abuse

The AAP recommends that pediatricians provide longitudinal sexual education to parents, children, and/or adolescents, counseling parents on what is normal sexuality and how to discuss sexuality with their children.[36] Thus, screening for sexual abuse should occur at all well visits and if the child presents with genitourinary complaints or concerning behavioral/emotional problems that raise concern for sexual abuse.[37] This includes age-appropriate discussions with children about privacy and safe/unsafe touches. Additionally, all adolescents should be asked about unwanted sexual contact during routine visits when overall sexual health is discussed. Most children present for evaluation after they have made a disclosure of sexual abuse to a non-professional. In rare instances, children may present with anogenital findings, pregnancy, sexually transmitted infection (STI), or witnessed sexual abuse.[38]

When concern for sexual abuse is raised, the history is obtained from parents/caregivers without the child present. The history is used to determine safety, whether a report should be made to CPS, the need for mental health care, the need for a physical exam, and the need for gathering forensic evidence. If a child presents after a disclosure, it is important to know how the disclosure was made (spontaneous statements versus statements elicited by questioning) as young children can be influenced by suggestive or leading questions. A detailed medical and social history is taken as well, making sure to include when the last contact was with the alleged perpetrator. A complete review of systems should focus on urogenital complaints and any new/worsening behavioral problems. If the child is verbal and developmentally capable, a medical interview is conducted which help make determinations about testing, treatment, and safety. If the child is interviewed, take care to use age-appropriate language and open-ended questions. At a minimum, the medical interview is used to elicit the type of sexual contact e.g. genital-genital and fondling, time of last contact, and a physical and behavioral review of systems. A medical interview is different from a forensic interview, which is necessary to gather more details about the abuse to establish a safety plan and/or initiate a criminal investigation.[34]

The physical exam in sexual abuse should be a complete head to toe evaluation, as many children who are sexually abused are also subjected to other forms of abuse.[38] The exam is completed by a provider who can recognize and interpret abnormalities. Primary pediatricians should familiarize themselves with normal anatomy by making a genital exam a part of all routine physical exams. In addition to making the pediatrician comfortable with the anatomy, routine genital exams convey to children/families that genital health is as important as that of the rest of the body. Emergent genital exam is needed if there is complaint of anogenital pain/bleeding, the last sexual contact was within 72 hours of presentation, and there was a possible transfer of biological materials that can be collected as forensic evidence. Emergent medical intervention is needed to assure health and safety of the child, and psychological evaluation is needed for possible suicidal ideation.[39] The genital exam is performed supine with knees bent and hips abducted (frog-leg position) for pre-pubertal children, and in lithotomy position for adolescents. Gentle labial separation and traction is applied in order to visualize the external structures of the vaginal introitus. Labial traction is done by using the thumb and index finger to pull the labia majora outward and downward. A speculum is only used in adolescents if there is a concern for intravaginal trauma. A pre-pubertal child would require an exam under anesthesia if an intravaginal injury is suspected. Anal exam is done in supine position with knees pulled up to the chest with gentle traction of the buttocks. Most anogenital exams are normal in cases of sexual abuse.[40–43] There are several reasons for this finding. First, not all sexual abuse will leave physical evidence that it has occurred e.g. fondling or oral-genital contact. Secondly, the properties of genital tissue are such that there may not be any injury even though there was penetration due to the tissue's ability to stretch and accommodate. Thirdly, because there can be a delay of years in reporting

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sexual abuse, any injury may heal without any evidence of trauma by the time the child is examined.[44,45] Therefore, the absence of physical findings does not exclude the possibility of sexual abuse and/or penetration. Despite the prevalence of normal exams, it is still important to do a thorough physical exam as it helps to reassure the child that they are healthy despite having been sexually abused, and if evidence of injury is present, it is used to determine if further medical evaluation and testing is necessary. Concerning physical findings include any abrasions or bruising, acute or healed tear of the posterior hymen, decreased amount or absence of posterior hymen, injury to or scarring of the posterior fourchette, fossa navicularis or hymen, and anal bruising or laceration.

The prevalence of STIs is low in pre-pubertal children thus screening and prophylactic treatment is not recommended if the child is asymptomatic.[38] Positive tests for chlamydia, gonorrhea, and syphilis outside the neonatal period are indicative of sexual contact. Adolescents are at higher risk for STIs and should have routine screening for all STIs.[38] In cases of acute sexual assault, adolescents should also be prophylactically treated for STIs. Anyone who is at risk for STIs due to unprotected vaginal intercourse is also at risk for pregnancy. Pregnancy prophylaxis should be given to all pubertal children within 72–96 hours or according to the hospital's protocol. Many communities have resources in place such that an emergent exam, treatment, and collection of forensic evidence can be completed in a timely manner.

Recognition and Evaluation of Medical Child Abuse

In 1785, Raspe[46] wrote about the Adventures of Baron Munchausen, a fabulist. As a tongue-in-cheek tribute to the Baron, Asher[47] in 1951 wrote about adults who told "a matrix of fantasy and falsehood" to doctors and over-utilized medical care, coining the term "Munchausen's syndrome," intrinsically linking adult actions to motive, noting a "psychological kink."[47] Meadow's[48]1977 article on Munchausen syndrome by proxy discussed 2 cases in which a caregiver non-accidentally injured their child. The use of the words "by proxy" began a torrid fascination with the intent of the abuser, focusing on adult mental health rather than harm or potential harm to the child. In 2002, the American Professional Society on the Abuse of Children (APSAC) taskforce introduced split mental health terminology: *factitious disorder by proxy* for the caregiver and *pediatric condition falsification* for the child.[49] Roesler and Jenny[50] in 2009 introduced the following Medical Child Abuse definition:

> Acts by a caregiver resulting in unnecessary and harmful or potentially harmful medical care to a child. The unnecessary medical care may be the result of either a pattern of persistent misinformation provided by the caregiver to medical provider(s) or by falsification of symptoms, or by actual induction of illness in the child by the caregiver.

The American Medical Association Code of Ethics requires the medical community to consider the historian as trustworthy in order to make sound medical judgments.[51] Perpetrators of Medical Child Abuse take advantage of this ethical standard, and the inaccurate historian uses this trust to exaggerate, fabricate, or induce symptoms resulting in diagnoses, medications, procedures, and attention. As a result, children can linger for years unnecessarily in a sick role. While unintentional participation in Medical Child Abuse by the practitioner does not equate to malpractice, continued participation and failure to report once suspicions arise is a liability. The medical community cannot control the impact of Medical Child Abuse nor can it ensure the safety of a child since the caregiver may seek care from different providers and medical institutions. In addition, the medical community is not privy to other abuse/neglect as the knowledge of the victim child is fragmented by the perpetrator. Therefore, any reasonable suspicion for Medical Child Abuse should be reported to the appropriate child welfare agency.

Medical Child Abuse is a form of physical abuse in which the medical evaluations and interventions are the tools of abuse that contribute to physical and mental harm. As with all other forms of child maltreatment, the threshold to report Medical Child Abuse is suspicion, not diagnosis. Reporting abuse begins the multidisciplinary teaming (MDT) of child protective services (CPS), a child abuse pediatrician, police, and attorneys, which establishes institutional critical thinking crucial to recognition, intervention, and evaluation of Medical Child Abuse.

Medical Child Abuse can be generational, instigated by a traumatic event, a caregiver actualizing his or her sickly behavior on the child, or an unknown etiology. Thus, a comprehensive medical and psychosocial history should be taken on all caretakers and children, including a comprehensive review of medical records. The caregiver's anxiety or perception of self, the child,

providers, and level of care is vital to recognition.[50] Typically, perpetrators are primary but may also be secondary caretakers. There is an over-representation of women as perpetrators in the literature in part due to historical socially prescribed caretaker roles.

Providers should recognize that there are unintentional and intentional participants even among caregivers. Intent does not dictate harm, actions do. It is critical for providers to recognize the historian's consistency in information: evolution in an explanation of injury, chronic discrepancies of child presentation versus history, ever-expanding familial ailments, multiple unspecified diagnoses, and medications prescribed based solely on history. Medical Child Abuse is often coupled with medical neglect. Providers should document the historian as well as implausible/questionable histories, escalating behaviors, actual diagnosis with exaggerated non-related symptoms, unexplained tests with no medical findings, suspicious multi-bacterial infections/sepsis, or observation of questionable behaviors, which can be indicators of Medical Child Abuse.[50] It is also important to obtain consultation reports from subspecialists as diagnoses and recommendations may be misrepresented by the historian.

Caregivers who request and subsequently refuse appropriate interventions; ignore recommendations; focus on undiagnosed ailments; and insist on controversial diagnoses, dangerous interventions, and/or improper administration of medication should heighten the awareness of the provider. In addition, providers must be mindful of caregivers who split providers by avoiding specialty or consistent primary care, favoring walk-in visits, urgent care, ER, or facility hopping. It is believed that perpetrators are well-educated and empathetic and use these characteristics while engaging the medical community in the abuse, yet this is a blind spot for providers as splitting providers requires no system savvy or empathy on the part of the perpetrator.

Children can be unintentional and/or intentional active participants in the Medical Child Abuse if they identify with the sick role. The provider should scrutinize children's use of adult terminology that is not age appropriate (e.g., child's definition of a seizure is a shiver) and explore self-injurious behavior (e.g., biting inner cheek for blood justify a bleeding tendency). Children may respond inaccurately to pain scales as their definitions may be inaccurate (e.g., taking of blood pressure renders a higher score than migraines). It is important to capture peculiarities in history via quotes and record direct observations—i.e., provider seeing the child do cartwheels despite the caregiver requesting a wheelchair, insistence on unnecessary medical equipment, and request for excessive excused days via doctor's notes despite no medical findings. In addition, a preliminary screening instrument may help to identify early indicators of Medical Child Abuse.[52]

The first step in medical evaluation is identification of safety versus risk. Concerns for escalating life-threatening events require an interdisciplinary intervention plan before the caregiver is alerted of the investigation. An immediate medical safety concern, such as caregiver threats of leaving the hospital with the child against medical advice, however, triggers CPS to assume custody of the child. If an acute medical need is present, CPS and attorneys representing the child welfare agency can obtain a court order to support an acute inpatient stay that safely and strategically addresses the veracity of each diagnosis and/or to wean off unnecessary medications to determine the true medical need in the absence of the obstructive caregiver. If the child is medically stable and the immediate safety concern is the parent, CPS can remove, complete a removal medical screening, and place the child in foster care with an accurate historian. If the child is medically stable and the Medical Child Abuse represents long-term risk in combination with a caregiver with protective capacities, an in-home safety plan may be viable. This intervention requires extensive MDT communication, coordination, and oversight with structured obtainable steps.

In all scenarios, the MDT will consult with the primary physician to ensure safety moving forward. A comprehensive medical record review by a Child Abuse Pediatrician can help determine real medical need versus historical exaggerated, fabricated, or induced ailments.[50] Often, most real diagnoses are found to be secondary to Medical Child Abuse. Although similarities may exist, each family requires a new approach. Intervention and evaluation can be adjusted, yet long-term MDT and community dedication to the health and well-being of the child is imperative.

Recognition and Evaluation of Psychological Maltreatment

Pediatric providers are in a unique position to observe healthy and dysfunctional parent–child

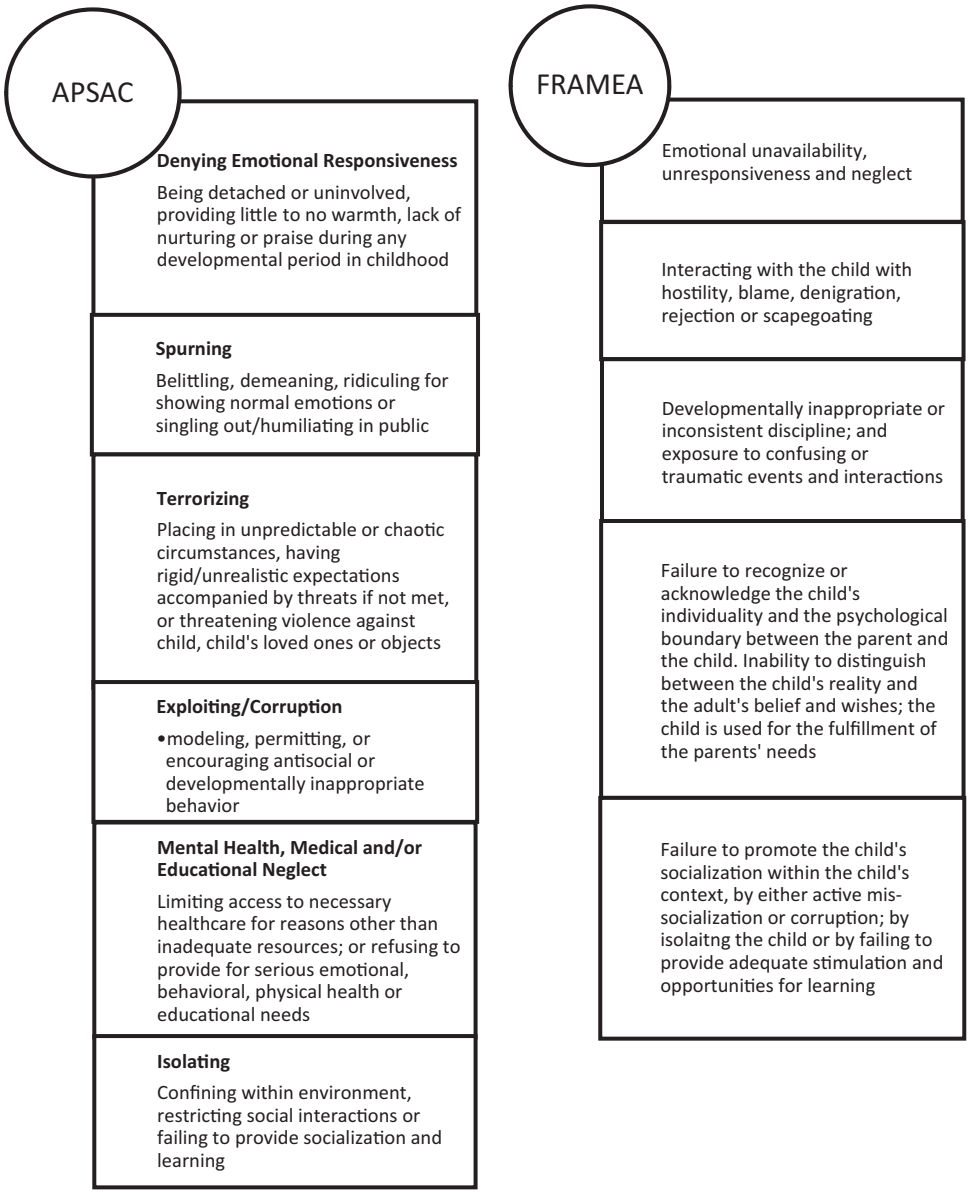

FIG 2. Categories of emotional maltreatment. (Adapted from Hart et al.[55] and Glaser.[54])

interactions and to intervene when those interactions are or can be harmful to the child. It is important to note that all poor parenting is not emotionally abusive or neglectful. There is a continuum of parenting that ranges from positive and healthy to psychological maltreatment.[53] The risk of harm to the child is primarily what distinguishes dysfunctional parenting from psychological maltreatment. Psychological maltreatment encompasses both emotional neglect and emotional abuse and often co-occurs with other forms of maltreatment. The American Professional Society on the Abuse of Children defines psychological maltreatment as a repeated "pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs."[54] Both Glaser and the American Professional Society on the Abuse of Children provide classifications of behaviors that constitute emotional maltreatment (Fig 2).[54,55] Both classifications include a range of behaviors from emotional unresponsiveness and unavailability, representing emotional neglect, to cruel or inappropriate behaviors toward a child, representing emotional abuse.

While pediatric providers may directly observe emotional maltreatment by a parent or caregiver, getting

history directly from the pediatric patient is best tool for identification. The AAP recommends assessing for household and family stresses such as parental mental illness, substance abuse, and family violence helps to identify high-risk patients and asking the verbal patient (not in the presence of a parent/caregiver) about interactions with their parents and caregivers. These interactions including consequences (physical and verbal) for misbehavior and the patient's sense of safety at home, which may reveal a pattern of emotional abuse.[5]

Responding to Suspected Maltreatment

The response to suspected child maltreatment should always include reporting a reasonable suspicion to the appropriate child welfare agency. This should be done simultaneously with the initiation of additional studies for evaluation. Delaying a report until abuse can be medically proven is fraught with risk. Typically, mandated reporters are professionals who have frequent contact with children; therefore, all health care professionals are mandated reporters for child abuse and neglect.[56] Standards for reporting vary by State, but most use the following terminology as the threshold: "on suspicion or known child abuse/neglect."[57] Most States require mandated reporters to identify themselves upon report but also allow their identities to remain confidential.[57] In addition, when a suspicion is reported in good faith, the reporter has immunity from liability. Conversely, there are consequences for mandated reporters who "willfully fail to make such a report."[1] Mandated Reporters are the link between the community and the State to ensure we protect our children from harm. "The basis for government's intervention in child maltreatment is grounded in the concept of *parens patriae*—a legal term that asserts that government has a role in protecting the interest of children and in intervening when parents fail to provide proper care."[1]

Medical and Mental Health Treatment

The child welfare system does not bear the sole responsibility of intervening on behalf of maltreated children. Child maltreatment is a toxic stress that can result in death as well as physical, developmental, and psychological impairment in those who survive. Therefore, pediatric providers are not only obligated to report suspicions, but they are also critical to the recovery and restoration of child victims. Early recognition of child maltreatment, assessing the extent and degree of injury, treating physical injuries and/or

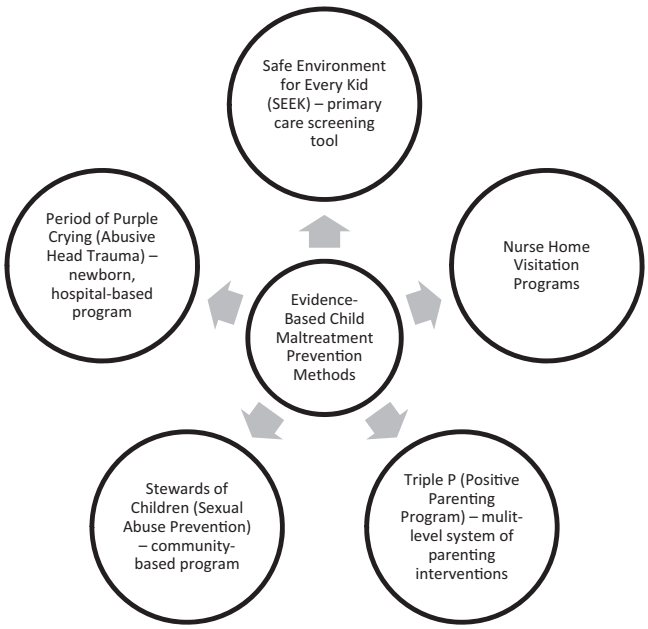

FIG 3. Evidence-Based Child Maltreatment Prevention Programs. (Adapted from Centers for Disease Control and Prevention.[64])

sequelae, and directing patients to trauma-specific mental health service providers help improve outcomes for child victims.

Brain-injured children and those victimized in early childhood are at great risk for impaired brain development.[58] This subgroup benefits most not only from early recognition of maltreatment but also from comprehensive developmental assessments and prompt developmental intervention services.[59] Treatment for parents of young children, like Parent–Child Interaction Therapy (PCIT), and for children and youth such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT) are examples of evidence-based mental health treatment modalities for child maltreatment.[60–62] The recovery of children is not completely bound, however, to the medical and mental health services received. The mental health of the caregiver, the response of the non-offending caregivers to the allegation, the response of child welfare, the engagement of the non-offending caregiver in their mental health treatment, and additional experiences of victimization can all impact the outcome of survivors.

Early recognition of child maltreatment, assessing the extent and degree of injury, treating physical injuries and/or sequelae, and directing patients to trauma-specific mental health service providers help improve outcomes for child victims

Prevention and Anticipatory Guidance

Providers of pediatric health care have a unique opportunity to partner with parents to promote the health and well-being of children. While providers must be able to recognize and appropriately report suspicions for abuse and neglect, both the American Academy of Pediatrics and the Centers for Disease Control recognize the importance of promoting safe, stable, and nurturing relationships in order to prevent maltreatment.[11] This partnership allows for providers to not only encourage healthy parenting by equipping and preparing parents for anticipated and unanticipated challenges but also to discuss age-appropriate disciplinary techniques; identify potential risks for maltreatment; provide advice, support, and referrals for services that may mitigate such risks; and encourage parental behaviors that promote safety and resilience. Caregiver concerns and the provider's observations may trigger specific history taking and anticipatory guidance pertinent to child maltreatment. Since child maltreatment is not always clinically apparent, each well child care visit is an opportunity to assess for and prevent child maltreatment. The AAP's *Clinical Report on The Pediatrician's Role in Child Maltreatment Prevention* includes information about specific risk and protective factors and guidance on when and how to incorporate maltreatment prevention into every well child care visit.[63] The AAP's Section on Child Abuse and Neglect has additional resources for providers including policies, publications, and links to medical diagnostic child abuse programs by state, accessible at http://www2.aap.org/sections/childabuseneglect/. Child abuse is a public health problem, so its prevention is not limited to individual pediatric health care providers. Other means of effective prevention include nurse home visitation programs, hospital-based educational outreach for newborns, and community-based educational outreach and interventions (Fig 3).[64] Child abuse can be prevented, but doing so requires efforts targeting not only the individual patient and family but also the community and society at large.

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