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Child Abuse and Neglect: Recognition, Reporting and Prevention

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Child abuse and neglect are Adverse Childhood Experiences (ACEs). ACEs are potentially toxic stressors that occur during childhood as the result of traumatic events (Centers for Disease Control & Prevention, 2021). The stress from ACEs can change brain development, influence behaviors, and can lead to poor health, as well as poor social and educational outcomes (Iowa ACEs 360, 2021). Healthcare and school employees are uniquely qualified to prevent child abuse in their communities due to their knowledge of child development, awareness of local resource availability, and the inherent trust that many families have in these professionals. In 2020, there were 30,151 assessments for child abuse or neglect in Iowa, from which 10,534 children were identified as having experienced substantiated abuse (Iowa Department of Human Services (DHS), 2020). Professionals who interact with children as part of their employment submit more than two-thirds of the total number of reports of alleged child maltreatment to child protective services annually (U.S. Department of Health & Human Services, 2021). Most commonly, these professionals work in the fields of education, law enforcement, legal, social services, and healthcare.

Categories of Abuse

Iowa code recognizes 11 unique categories of abuse. In Iowa in 2020, 53% of substantiated child abuse and neglect cases were for neglect or denial of critical care, 25% were for exposure to a dangerous substance, 9% were for presence of illegal drugs in a child's body, 7% were for physical abuse, and 5% of cases were due to child sexual abuse. The remaining categories of abuse made up less than 1% of substantiated

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Iowa's Child Abuse and Neglect Categories Iowa Code sections 232.67 through 232.77	
Physical Abuse	
Mental Injury	
Sexual Abuse	
Denial of Critical Care*	Failure to provide adequate food and nutrition
	Failure to provide adequate shelter
	Failure to provide adequate clothing
	Failure to provide adequate health care
	Failure to provide mental health care
	Gross failure to meet emotional needs
	Failure to provide proper supervision, including: • Cruel and undue confinement of a child • Dangerous operation of a motor vehicle with the child in the vehicle. • Illegal drug usage by the caretaker of a child
	Failure to respond to the infant's life-threatening conditions
Prostitution of a Child	
Presence of Illegal Drugs	
Dangerous Substance	
Bestiality in the Presence of a Minor	
Allows Access by a Registered Sex Offender	
Allows Access to Obscene Material	
Child Sex Trafficking	

** This category of abuse is divided into eight subcategories of neglect.*

cases in 2020. Younger children are most vulnerable to abuse. Of "the total number of abused or neglected children in Iowa, 47% were 5 years of age or younger, 26% were 6 to 10 years old, and the remaining (27%) were older than 11 years" (Iowa DHS, 2020).

Sentinel Injuries

Sentinel injuries present as minor injuries, but they have major significance. An estimated 20-25% of injuries diagnosed as child abuse have a prior missed sentinel injury (Hoehn et al., 2018). These frequently missed or minimized injuries provide evidence of ongoing or escalating abuse. In infant victims of maltreatment, bruising is overwhelmingly the most frequently experienced sentinel injury type. Eighty percent of abused infants have experienced previous bruising, while about 11% of abused infants have experienced a sentinel intraoral injury (Sheets et al., 2013). Notably, most sentinel injuries in infants occur well before infants would be expected to be developmentally capable of sustaining such injuries on their own. Two-thirds of sentinel injuries in abused infants occur prior to 3 months of age (Sheets et al., 2013).

Recognition of sentinel injuries provides a crucial opportunity to intervene to prevent further abusive injury to a child. Even brief encounters with the healthcare system may be lifesaving for abused infants and children when healthcare providers consistently consider abuse in their differential. When abuse goes unrecognized, victims remain in the same unsafe environment with a high likelihood of experiencing recurrent abuse.

Medical Assessment

A thorough head-to-toe exam, including skin and genitalia, should be performed at all well-child visits as well as at any time that healthcare providers are concerned for abuse. Bruising in the Ten-4-Faces-P pattern warrants further evaluation (see visual, pg. 5). When appropriate, high-quality photographs of injuries can be useful for documenting injury appearance, size, pattern, and distribution in the medical record. Documentation of known mimics of abuse, such as subconjunctival hemorrhages associated with birth trauma and congenital dermal melanocytosis that may be mistaken for bruising, can prevent suspicion for abuse on subsequent examinations by other practitioners

or by nonmedical staff. The genital exam serves as an opportunity to educate patients and families on body safety.

If a child begins to openly disclose abuse at any time, document verbatim what the child says. Stick to open-ended, follow-up questions. Avoid asking any leading questions as this type of questioning can hinder future forensic interviews, as well as interfere with potential law enforcement proceedings. If the child is both age and developmentally appropriate to participate in a minimal, fact-gathering interview, open-ended questions should be used, e.g., "Tell me about how you got your owies," or "What happened yesterday before you came to the hospital?"

Although there are no injuries which are truly pathognomonic for abuse, there are several injuries that are highly specific. When evaluating injuries and the reported history, carefully consider the following questions: Do they make sense together? Does the history provided by the caretaker match the developmental capabilities of the child and the expected mechanism of injury? For example, a provided history of a neonate jumping off the bed and sustaining rib fractures should raise red flags and warrant further evaluation.

The various diagnostic tests that guide medical assessment within each of the categories of abuse are beyond the scope of this article. However, all clinicians should be familiar with the skeletal survey as an important diagnostic tool. A skeletal survey includes multiple, dedicated views of the axial and appendicular skeleton and should not be done as a babygram. In the evaluation of physical abuse in a child <2 years of age, the child should undergo an initial skeletal survey and a repeat skeletal survey in two weeks, to assess for fractures or dislocations (American Academy of Pediatrics, 2015). Further diagnostic workup can be guided by consultation with a child abuse specialist.

Red Flag Injuries

- History of trauma not consistent with child's development.
- Delay in seeking medical treatment.
- Any bruise in an infant that does not pull to stand.
- Acute or healing intraoral injuries.
- Any fracture in a nonambulatory child.
- Metaphyseal fractures (bucket-handle, corner).
- Rib fractures, especially posterior.
- Unexpected finding of healing fracture.
- Unusual locations of injury.

Mandatory Reporter

Iowa's child protective services are centralized under the DHS. A mandatory reporter is an individual who in the scope of their professional practice examines, attends, counsels, or treats a child. Most healthcare professionals and licensed school officials who interact with children are mandatory reporters. If a mandatory reporter reasonably believes a child may have been abused, the mandatory reporter is obligated by law to make an oral report to DHS within 24 hours, followed by a written report to DHS within 48 hours. The decision to report to DHS relies on the suspicion of suspected abuse. DHS can be contacted at 800-362-2178, 24 hours a day, 7 days a week. If a child is in imminent danger such that immediate protection of the child is advisable, both law enforcement and DHS should be contacted.

In addition to making a report to DHS, medical providers (physicians, nurse practitioners, and physician assistants) may also refer children to a regional child advocacy center for additional physical evaluation and treatment recommendations, if the child is medically stable and suspected to be a victim of abuse and/or neglect. Child advocacy centers are also referred to as child protection centers. These centers are community-based, outpatient, child-focused clinics where multidisciplinary services are offered to children and families affected by abuse. Law enforcement, child protection agencies, and county attorney offices likewise refer children to child advocacy centers for comprehensive assessment, forensic interview, and physical examination. Parents and children are unable to self-refer to child advocacy centers.

Prevention

The good news is that ACEs can be prevented. Communication is the most important tool healthcare and school employees have to make sure children are protected. Listening to children and talking honestly with them is a good way to practice prevention skills. Children are empowered when they understand what to do and who to turn to if they are in danger. Professionals serving as part of parents' support system can reduce the impact of caregiver stress. Early recognition and support of

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caregivers allows for possible intervention to reduce caregiver and environmental risk factors for abuse. Caregivers benefit from having realistic expectations of their child's medical needs and developmental capabilities. Clear anticipatory guidance and discussion of developmental milestones ensures parents adequately comprehend children's needs and capabilities. Education on healthy, age-appropriate discipline methods (e.g. timeout, removal of privileges, positive reinforcement) can help to mitigate use of corporal punishment and the risk of disciplinary escalation into abuse. Parents of newborns should be educated on the dangers of shaking their baby and provided with healthy ways to soothe infants to prevent abusive head trauma.

Positive childhood experiences, including the presence of caring relationships with trusted adults, can reduce the harmful impact of ACEs. We all want children to grow up feeling safe, strong, and free. Early recognition of child abuse and neglect, and active involvement in the prevention of ACEs, allows children to do just that.

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Addressing Vaccine Hesitancy

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Vaccine hesitancy is strong in many families and the COVID-19 vaccine has become a common discussion topic since its development. At times I wonder, "How can I, a licensed, board-certified medical doctor, explain to patients that receiving the COVID-19 vaccine is safe and effective, if I have difficulty convincing my own family members?"

Paul Offit, MD, pediatrician and vaccine expert, describes two types of parents/caretakers commonly encountered in the clinic. One type is **vaccine hesitant**. This is someone who has not yet learned the facts regarding the safety and efficacy of a vaccine, and after learning the facts from their doctor, comes to a reasonable decision to have their child vaccinated. The other type is the **vaccine cynic**. This person does not believe facts or data that prove vaccines like the COVID-19 vaccine are safe and effective, because they do not trust the medical community, pharmaceutical companies, or the U.S. government.[1]

For parents who are vaccine hesitant, here are some main ideas to consider when counseling them:

1. **Listen.** Let the parent/caretaker/patient discuss all of their concerns about the vaccine. A clinic should be a safe place for them to review their concerns. Encourage them to share exactly what worries them about a particular vaccine. It can be helpful to validate a parent's concerns with statements such as, "I understand how you are feeling and I might have thought similarly,

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TEN-4-FACES-P

(Pierce et al., 2010)

TEN

Torso (trunk)

Ear

Neck

4

Bruises in the TEN distribution in a child under 4 years of age, or ANY bruise in an infant less than 4.99 months of age

FACES

Frenulum (mouth)

Angle of the jaw

Cheek

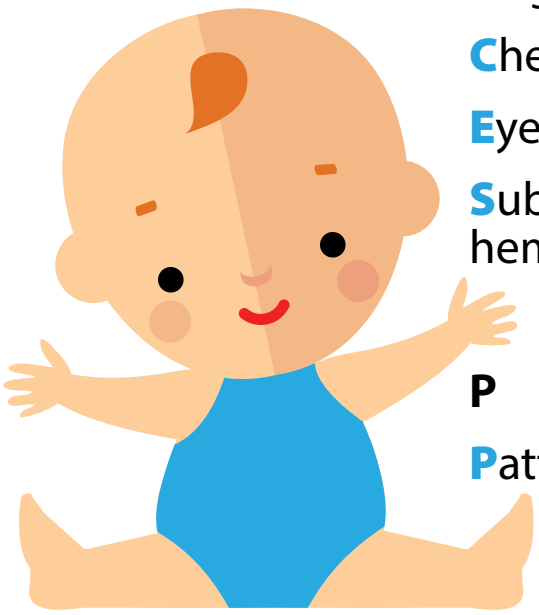
Eyelids (bruising)

Subconjunctival hemorrhage (eye)

P

Patterned skin injuries

"Kids that don't cruise, rarely bruise."



Iowa's Child Advocacy Centers

https://www.iowacacs.org/find-a-center.php

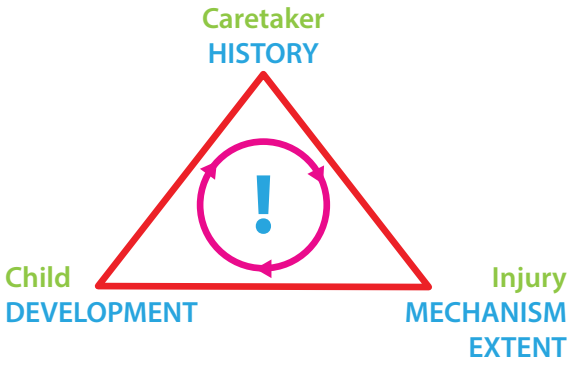
Hiawatha Unity Point Health Child Protection Center	Serving counties in eastern, central and southern portions of Iowa.	(319) 369-7908 or (800) 444-0224, ext. 7908
Davenport Child Protection Response Clinic	Serving counties in eastern Iowa.	(563) 200-1102
Des Moines Blank Children's Hospital Regional Child Protection Center	Serving counties in central and south-central Iowa.	(515) 241-4311
Waterloo Allen Hospital Child Protection Center	Serving counties in northeast Iowa.	(319) 226-2345
Sioux City Mercy Hospital Child Advocacy Center	Serving counties in northwest Iowa.	(712) 279-2548 or (800) 582-0684
Muscatine Mississippi Valley Child Protection Center	Serving counties in southeast Iowa.	(563) 264-0580

To make a referral, call the number provided for the center that is local to the patient. Services offered at child protection centers/child advocacy centers include medical evaluation and treatment, forensic interviews (when referred by DHS and/or law enforcement), counseling and/or referrals, case review and case tracking, prevention and community services, and advocacy services.

Child Protector app: Developed by Children's Mercy and the University of Texas Health Science Center at San Antonio. **https://www.childrensmercy.org/health-care-providers/providers/provider-resources/apps-for-providers/child-protector-app/**.

University of Iowa Stead Family Children's Hospital Child Protection Program. Patient handouts available here: **https://uichildrens.org/medical-services/child-protection-program**.

Do they make sense together?



(R. Oral, personal communication, February 24, 2021).

Contact DHS to report suspected abuse at 800-362-2178, available 24 hours a day, 7 days a week.

however, the research shows the COVID-19 vaccine to be safe and effective. This put my mind at ease when deciding to vaccinate myself and my own child."

Brian Castrucci, DrPH, a health policy researcher who has researched overcoming COVID-19 vaccine hesitancy, recommends responding in a way that has an easy, take-home point. For example, if a parent is worried about a patient developing blood clots after receiving a COVID-19 vaccine, remind the parent that safety measures are in place, which is why the vaccine was placed on hold until it was found to be safe. Also, reviewing the chance of such occurrences in statements such as, you are twice as likely to get hit by lightning than you are to get a blood clot from the COVID-19 vaccine.[2]

2. **Try not to give all the information you know about the vaccine at one time**, but instead share the information you have that answers a specific concern. Sean O'Leary, MD, MPH, vice chair for the American Academy of Pediatrics Committee on Infectious Disease, reports that if we offer up all the information we have, this can be overwhelming and put the parent on the defensive.[3]

3. **Dispel myths and misinformation**. If a parent reports what they have read on social media about a vaccine, and it is not science based, set things straight. Some myths have included false claims, such as the COVID-19 vaccine can alter DNA, cause infertility, or it is the government's way of implanting a tracking device. Our patients and families may not be aware that what they read on social media might be false, even if it is coming from their favorite YouTube influencer. Remind parents there is a lot of misinformation out there and it can be difficult to discern at times. Instead, direct parents to trusted sources such as the CDC, WHO, healthychildren.org, or The Virality Project, a fact-checking website based out of Stanford University.[4] With the help of fact checking, warning labels have been added to more than 167-million pieces of COVID-19 and vaccine content on Facebook. YouTube has removed more than 30,000 videos since October 2020 that were spreading false claims about COVID-19, and has removed more than 800,000 videos found to be related to misleading or dangerous information about coronavirus.[6]

4. **Tell parents that you recommend their child be vaccinated if they are eligible or when it becomes available to their child**. As physicians, we are still the most-trusted source of information concerning their child's health. Your strong recommendation for the COVID-19 vaccine is needed.[5] Consider mentioning it when you are reviewing which vaccines the child is receiving at their well check, i.e., "Your child is due for his four-year vaccines today. I also strongly recommend the COVID-19 vaccine, once it is made available to this age group."

5. **Discuss with parents** your decision to become vaccinated and to vaccinate your own children.

6. **Remind parents that COVID-19 is a real risk to their child**. One in four COVID-19 cases are found in children. There have been nearly 300 pediatric deaths due to COVID-19 along with many more children diagnosed with MIS-C and other long-term sequelae. Although it is true that pediatric patients have done well compared to adults, children should not have the same death rate as adults.[4,7] Vaccinating our pediatric patients against COVID-19 means not only protecting our patients from COVID-19, but also stopping our patients from spreading the virus to their siblings, parents, grandparents, and friends.

Resources:

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What's in this issue

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