Medical & Psychological Aspects of Child Abuse & Neglect

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Today’s Objectives

• Statistics
• Intimate Partner Violence and the Child
• Under-Reporting by Primary Care Pediatricians
• Neglect
  – Failure-to-Thrive
  – The Substance-Exposed Newborn
• Abuse
  – Suspicious Injuries
• Children/Youth in Foster Care
  – Physical & Psychological Health Needs
  – Accessing Healthcare Services
  – Outcomes
Child Abuse Statistics

• ~900,000 children are victims of child maltreatment every year
• >1500 deaths/year reported in US
• Under-reported and unrecognized cases
  – Only 50% reported to CPS
• Sensitive measure of demographic, social and economic conditions
• Statistics outside US not reported

Arizona Statistics

• Child Abuse Hotline reports - 17,586
• Reports responded to – 17,378
• Substantiated reports - 1366
• Substantiation rate – 7.9%
• Number of new removals – 3978
• Number of children in Out-of-Home care – 10,707

Arizona Child Fatality Team - 18th Annual Report Nov 2011
Intimate Partner Violence (IPV) and the Child

• The Child as a Victim of Abuse
  – Pregnancy increases the risk of IPV (3-19%)
    • Poorer health outcomes
    • Association between CAB & IPV
      – Co-occurrence in 30-60% of families

• The Child Exposed to Abuse
  – Profound behavioral & emotional effects as adults
    • Internalizing behaviors
    • Social dysfunction
    • Emotional abuse (↑ risk 6X)
    • Physical abuse (↑ risk 4.8X)
    • Sexual abuse (↑ risk 2.6X)

*Pediatrics. 2010;125;1094-1100*

The Adverse Childhood Experiences (ACE) Study
Child Abuse Under-Reporting

- PCPs did not report any injury to a child that may have been caused by abuse
  - Even though reporting is mandated by law in all states
- Providers did not report three quarters of the injuries they thought were possibly a result of abuse
- Providers did not report more than one quarter of those they thought were likely to have been caused by abuse
- PCPs cited 4 key aspects of the decision-making process
  - PCP’s familiarity with the family,
  - Elements of the case history,
  - Use of available resources, and
  - Clinician’s experience-based expectations of the CPS response.
- Child abuse underestimated by death certificates

McCarthy C. Doing the Right Thing: A Primary Care Pediatrician’s Perspective on Child Abuse Reporting. *Pediatrics* 2008;122:S21–S24
Diagnosis of Medical Neglect

- A child is harmed or is at risk of harm because of lack of health care;
- The recommended health care offers significant net benefit to the child;
- The anticipated benefit of the treatment is significantly greater than its morbidity, so that reasonable caregivers would choose treatment over non-treatment;
- It can be demonstrated that access to health care is available and not used; and
- The caregiver understands the medical advice given.

*Pediatrics.* Dec 2007;120(6): 1385-1389
Reasons that Families Fail to Seek Appropriate Medical Care

- **Patient & Parent Factors**
  - Poverty or economic hardship
  - Lack of access to care
  - Family chaos & disorganization
  - Lack of awareness, knowledge, or skills
  - Lack of trust in healthcare professionals
  - Impairment of caregivers

- **Physician Factors**
  - Pediatricians’ misunderstanding of different cultures
  - Lack of parent health literacy
  - Lack of communication in the medical setting
Failure To Thrive

- FTT describes a sign, not a diagnosis
- Diagnosis of infants & young children
  - < 2 years of age
- Failure to gain weight
  - Disproportionate
  - No obvious etiology
- Inadequate caloric intake
- FTT can be secondary to abuse or neglect
  - Family dysfunction, stress, substance abuse
Substance-Exposed Newborns

- Fetal exposure to drugs/alcohol 20%
  - At least 10% exposed throughout pregnancy
- Alcohol use – 10.0% of pregnant women
  - Binge drinking 4.4%
  - Heavy alcohol use 0.8%
- Illicit drugs – 4.5% within past month
- Problem is under-reported

2009 National Survey on Drug Use & Health: National Results
• In determining if a child is neglected, consideration shall be given to:
  – The drug or alcohol abuse of the child's parent, guardian or custodian.
  – The use by the mother of a dangerous drug, a narcotic drug or alcohol during pregnancy if the child, at birth or within a year after birth, is demonstrably adversely affected by this use. For the purposes of this paragraph, "dangerous drug" and "narcotic drug" have the same meaning prescribed in section 13-3401.

Added in the Second Special Session of 2003 as part of HB 2024 which substantially amended child protective services laws
Risk Factors for Physical Abuse

- Young maternal age
- Unwanted pregnancy
- Parental history of childhood family disturbance
- Foster care
- Poverty
- Substance use/abuse by caretakers
Infantile Homicides

- Age < 5 years
- Perpetrator usually
  - parent or caretaker, male
- Fatal circumstance
  - beating, arson, burns, neglect
- Precipitation
  - “discipline”, neglect
Physical Abuse

- Child abuse is a symptom of family dysfunction which results in injury to a child.
- Suspicious histories
- Delay in seeking medical care
- Suspicious injuries
Suspicious Histories

- Inconsistent
- Injury not age appropriate
- Injury out of proportion to history
- Unexplained or inadequately explained injury
- Delay in seeking medical care
Suspicious Injuries

- Bruises
- Burns
- Fractures
- Head injuries
- Abdominal injuries
- Genital and anal injuries
- Others
Suspicious Bruises

• **Location** in areas spared during normal play activities
  - buttocks, lower back, upper thigh, face

• **Shape** may reveal object of abuse

• **Color** may date the trauma

• Injury that is not developmentally appropriate
## Age of Bruises

<table>
<thead>
<tr>
<th>Color</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red - blue</td>
<td>fresh</td>
</tr>
<tr>
<td>Dark blue - purple</td>
<td>1 - 3 days</td>
</tr>
<tr>
<td>Green - blue</td>
<td>7 - 10 days</td>
</tr>
<tr>
<td>Yellow - brown</td>
<td>8 days</td>
</tr>
<tr>
<td>Resolution</td>
<td>2 - 4 weeks</td>
</tr>
</tbody>
</table>
Suspicious Burns

• **Shape**
  – cigarette, dry contact burn

• **Type** of thermal injury
  – flame, immersion, dry contact

• **Distribution**
  – well demarcated, shape of object
  – sparing in flexural areas
Suspicious Fractures

- Multiple fractures
- Multiple sites
  - 84% of accidental fractures are isolated
- Type
  - spiral, metaphyseal
- Location
  - skull, posterior rib, first rib
- Various stages of healing
Head Injuries

- Most common cause of death by child abuse
- Child < 1 year is at highest risk of death
- 80% of deaths from head trauma in children < 2 years are result of abuse
- Skull fractures
- Retinal hemorrhages
- Abusive Head Trauma
  - (Shaken Baby Syndrome)
Abusive Head Trauma (AHT)

• Advances in the understanding of mechanisms of abuse
  – Shaking
  – Blunt impact
  – Combination

• Clinical spectrum of injury
  – Cerebral, spinal cord injury, cranial
  – Secondary hypoxic, ischemic injury

Abusive Head Trauma

- Constellation of clinical findings
  - retinal hemorrhages in 75-90% of cases
  - subdural/subarachnoid hemorrhages
  - little or no evidence of external trauma
- Most likely shake-plus-impact injury
- Often delay in seeking medical care
- Infant “went to sleep, didn’t wake-up”
Confessions in AHT

- Confessions are uncommon
- Retrospective review 112 cases
  - Perpetrator confession to violence (29)
  - No confession (83)
- No statistically significant difference in injuries between groups
- Confessions of shaking
  - Extremely violent (100%)
  - Repeated (55%) (2-30 times, mean 10)
  - Stopped infant’s crying (62.5%)
  - Impact (24%)
  - No correlation between repeated shaking & SDH

Adamsbaum, C. *Pediatrics* 2010:126:546-555
Abdominal Injuries

• Hidden trauma
• Second most likely cause of death
• Crushing injuries
• Puncture wounds
• Lacerations
Genital and Anal Injuries

• Any and all genital / anal injuries are considered suspicious and should be fully investigated!

• Diaper-age child with genital or groin injuries very concerning!
  – This area is padded and protected
Other Non-Accidental Injuries

- Sudden Infant Death Syndrome (SIDS)
- Apnea (Acute Life-Threatening Events)
- Poisoning
- Pediatric Condition Falsification
  - Illness/condition falsification → victimization
  - Munchausen by Proxy
  - Medical abuse
  - Suspected excessive and unnecessary health care utilization
Reasons for Placement

- Neglect: 61%
- Physical Abuse: 34%
- Sexual Abuse: 4%
- Emotional Abuse: 1%

Child Welfare Reporting Requirements Semi-Annual Report
October 2010 through March 2011
Mental Health Disorders

Adaptation to Foster Placement

• Honeymoon period
  – Initial period - child appears to adapt well

• Within 3 months
  • Limit-testing/acting-out
  • Withdrawn, depressed, angry, aggressive

• Severe attachment disorders
  • Hiding/hoarding food
  • Polyphagia (over-eating) / polydipsia (over-drinking)
  • Rumination (voluntary reflux of foods into mouth)
  • Self-stimulatory behaviors
  • Repetitive behaviors

Behavioral Health Services

• The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with CPS
  – Delineates the Urgent Response procedures

• The Child and Family Team (CFT) Practice
  – CFT practice for children/adolescents with complex needs

• The Psychiatric Best Practice Guidelines for Children: Birth to Five Years of Age
  – Defines best practice guidelines for birth to five

• The Transition of Youth into Adulthood protocol
  – Transition of children to the adult BH system at age 18 or 21
Permanency

- Recognition of importance of permanency
  - Long-term foster care and separation
  - Removed for protection, never returned home
- Shift of foster care from caretaking to focus on permanency
- Oregon Project - demonstrated that intensive services and aggressive planning could result in the reunification or adoption of children
- Adoption Assistance and Child Welfare Act of 1980, (P.L. 96-272), re-conceptualized foster care as a temporary service
- Core elements of child welfare practice
  - Family involvement, prevention of foster care placement, assessment, planning, and permanency
Accessing Services

• Establish a PCP and Medical Home
  – 10 EPSDTs in 1st 2 years of life
    • Developmental & Behavioral Health Assessments
  – Annual EPSDT after age 2

• Establish a Dental Home
  – No referrals needed for dental care
  – Dental care begins at age one (1)!!
  – Routine preventative visits twice/year

• Ensure RBHA services ASAP
  – Auto-enrollment after 1 Oct 10
  – Ensure communication - PCP & BH Provider
Keys to Successful Placement & Permanency

• Establish a PCP and Medical Home
• Ensure thorough & timely EPSDT evaluations
• Ensure RBHA services **early** on
  – Do NOT take “wait and see” attitude
• Ensure ongoing & comprehensive BH services
  – Child & Family Team (CFT) Process
Outcomes for Children in Foster Care

• With the correct support and services, long-term stable placements demonstrate improvements in:
  – Health status
  – Physical growth
  – Educational achievement

Fanshel D, Shinn EB. *Children in Foster Care: A Longitudinal Investigation.* New York, NY: Columbia University Press; 1978
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