NCPD 2.0 contact hours

By Julia Overton

Child Abuse: Recognition, Reporting, and Response

ABSTRACT: *Because child abuse occurs across all genders, ethnicities, and socioeconomic groups, nurses working with pediatric patients and their families need keen observation and assessment skills. The purpose of this article is to discuss the recognition, reporting, and appropriate response to child abuse. Caring for children who have been abused and their families is challenging yet presents the opportunity to demonstrate Christ's compassion. Awareness of one's own emotional responses requires meaningful self-care strategies that are also discussed.*

KEY WORDS: *child abuse, child maltreatment, neglect, nursing, pediatrics, Period of PURPLE Crying, spiritual care*

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Although the world has been preoccupied with the SARS-CoV-2 pandemic, an insidious increase in child abuse also has occurred (Kang & Jain, 2020; Sidpra et al., 2021). This rise in family violence has been observed during past difficult times, such as the 2008 economic recession in the United States (Bryant et al., 2020). Considering increasing rates of child abuse, nurses must remain vigilant in recognizing signs of child abuse, understand their responsibilities in reporting suspected abuse, and care appropriately for the patient and family. As child abuse is emotionally traumatizing for healthcare professionals, applying principles of self-care is essential.

PREVALENCE

In the United States in 2017, 674,000 children were abused or neglected, and 1,720 died as a result (Children's Bureau, 2019). The death rate equals roughly five children per day; 72% of fatalities were children under age three. The highest incidence of maltreatment is in children less than 1 year of age (Children's Bureau, 2019).

Child abuse occurs across all genders, ethnicities, and socioeconomic groups (Christian, 2015). The negative effects of abuse impact the child across the age spectrum, producing possible reduced cognitive functioning, altered brain development, and chronic diseases in adulthood (Dye, 2018). The emotional, physical, and mental sequelae can result in substance abuse and mental health diagnoses, among others (Dye, 2018).

WHAT IS CHILD ABUSE?

The U.S. Federal Child Abuse Prevention and Treatment Act (CAPTA, 2010) considers a child to be anyone under 18 years of age, unless a state law, for cases of sexual abuse, specifies a younger age. Child abuse and neglect is defined as

> 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. (CAPTA, 2010, § 5101, Note (§ 3)

Federal law offers guidance to states about the minimum acts and behaviors that define child abuse and neglect while specific definitions are made by each state (Child Welfare Information Gateway, 2019).

The World Health Organization (2017) states, "Four types of child maltreatment are generally recognized: physical abuse, sexual abuse, psychological (or emotional or mental) abuse, and neglect" (para. 1). A child may experience maltreatment of one type or any combination of types. In almost 75% of cases, neglect is the most prevalent form of abuse (Children's Bureau, 2019).

The second most common type of abuse is physical at 18.3% (Children's Bureau, 2019) and can be indicated by unexplained injuries or inconsistent explanations of injuries, multiple bruises in odd places on the body not consistent with normal child activity and/or in various stages of healing, and certain types of bone fractures. A thorough physical exam is essential for identifying physical abuse. Most inflicted head injuries occur at around 2 to 4 months of age when an infant's crying peaks (Hernandez, 2021), often referred to as the Period of PURPLE Crying (Barr, n.d.).

Injuries at varying stages of healing are indicative of abuse. Children younger than 2 years who may have been abused should have a complete skeletal survey to check for the presence of fractures, both new and healed (Hernandez, 2021). Concurrently, it is important to look for underlying causes. For example, a bleeding disorder or genetic condition could lead to weak bones, resulting in the child's sustaining broken bones in the absence of abuse. As children get older, defensive injuries may also be present on physical exam (Christian, 2015).

Sexual abuse occurs in 8.6% of child abuse cases (Children's Bureau, 2019). Hailes et al. (2019) reported that lasting impacts include psychosocial (sexual misbehavior, substance misuse, nonsuicidal self-injury, sexual offences against others), psychiatric (posttraumatic stress disorder, eating disorders, depression, schizophrenia), and physical (obesity, human immunodeficiency virus, pain, fibromyalgia). Some indications that sexual abuse has occurred include trauma or complaints of pain or dysfunction in the genital or anal area, unexplained sexually transmitted infection, age-inappropriate sexual


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Sidebar 1. Period of PURPLE Crying

The Period of PURPLE Crying, developed by pediatrician Ronald Barr and the National Center on Shaken Baby Syndrome, is a different way to understand colic (Barr, n.d.). Being told one's child has colic can often sound as though the child is unwell, as opposed to the child experiencing a normal developmental period which starts around week two and lasts until around month four of life (Barr, n.d.). The "period" refers to the fact that this is a stage of life that will end. PURPLE is an acronym:

Peak of crying: Baby may cry more each week, peaking around month two.
Unexpected: Crying can come and go without reason.
Resist soothing: Baby may keep crying, no matter what parents do.
Pain-like face: Baby may look in pain—even when not.
Long lasting: Crying can last as long as 5 hours a day.
Evening: Baby may cry more in the afternoon and evening.

This explanation can encourage parents that their experiences with a crying baby are normal, and they are not bad parents (Barr, n.d.). The Period of PURPLE Crying program is used internationally to teach parents about crying, soothing, and dealing with frustration. These tips include informing parents that they can leave their baby in a safe situation, such as the crib, for 10 to 15 minutes with quick check-ins, and still be good parents (Marcin, 2020). Audio or video monitoring is another option. The Period of PURPLE Crying website is geared for parents and contains useful information (http://purplecrying.info/).

behavior or knowledge, and pregnancy (Vrolijk-Bosschaart et al., 2018). There are many risk factors for sexual abuse: female gender, disability, young age of the victim, caregiver substance abuse, financial problems, and concurrent physical abuse; reoccurring sexual abuse is usually perpetrated by a parent or close caregiver (Palusci & Ilardi, 2020).

Emotional or psychological abuse comprises 5.7% of abuse cases (Children's Bureau, 2019). Emotional abuse may entail belittling, ignoring, and blaming children and harming their emotional development. Emotional abuse is linked to alexithymia in abused individuals, the difficulty or inability to identify emotions in oneself or others (Brown et al., 2018). Emotionally abused persons also are more likely to develop eating disorders. According to Kids Helpline (2021), other signs in a child of possible emotional abuse include poor self-image, developmental delays, disruptive behavior, frequent anxiety or fear, excessive attempts to please parents, substance abuse, self-harming behaviors, lying, and stealing.

Emotional abuse through parent–child interactions can be subtle and difficult to detect (Kimber et al., 2019). There is a concern among professionals that the agencies that are supposed to protect children do not take reports of emotional abuse as seriously as other types of abuse (Naughton et al., 2017). Thus, it is imperative that nurses recognize and report to the appropriate authorities any signs of possible emotional abuse.

FACTORS INFLUENCING ABUSE

Several parental factors increase the risk of child abuse, whereas other parental factors are protective. Factors that increase the chance of abuse can be summed up in a single word: stress. Merrick and Latzman (2014) report that single parenthood, low income, large number of dependents, young parental age, and general parenting stress increase the risk of child abuse. Other risk factors are substance abuse, parents lacking an understanding of child development, and parents who have experienced abuse, whether as a child or later in life from an intimate partner.

Protective parental factors are employment, education, adequate housing, met needs, and access to healthcare and services (Centers for Disease Control and Prevention [CDC], 2021). Education, such as the Period of PURPLE Crying that informs families about ways to soothe children and offers coping strategies for parents—including making sure the child is safe and then walking away if becoming frustrated—along with home visitation after birth can help decrease the incidence of child abuse (Merrick & Latzman, 2014). (Sidebar1)

The presence of specific factors involving the child can increase the chance of abuse. This is not to say that victims are at fault for the abuse. These factors include age under 4 years, a child with special needs, disabled children, and children with increased health needs such as a chronic illness (CDC, 2021). These factors are likely to increase parental stress, a known contributor to child abuse. A protective factor is having a good relationship between the child and at least one parent (Merrick & Latzman, 2014).

Recent research has demonstrated that the community in which a family lives impacts the possibility of child abuse (CDC, 2021). Communities with violence and negative social determinants of health—high unemployment, widespread poverty, and poor social connection—have higher incidences of child abuse. Conversely, communities with positive social connections with adults outside the family who can serve as role models and communities that support parents have lower incidences of child abuse (CDC, 2021; Merrick & Latzman, 2014).

During the COVID-19 pandemic, adverse childhood experiences (ACEs), including child abuse, have increased. It is thought this is due to social isolation resulting in the loss of support systems, and economic hardship leading to increased stress for parents and families (Bryant et al., 2020). A similar trend was seen during the 2008 economic recession in the United States. Bryant et al. (2020) argue that due to the pandemic, universal screening for ACEs is necessary in pediatrics so children are able to receive the help and support needed after experiencing trauma. The Pediatric ACEs and Related Life Events Screener (PEARLS) tool can be helpful in screening children ages 0 to

11 (PEARLS Child, n.d.) or adolescents ages 12 to 19 (PEARLS Adolescent, n.d.; Aces Aware, 2021).

NURSES' ROLE IN IDENTIFICATION AND REPORTING

A nurse's initial role in child abuse is identifying when a child's injuries could be due to abuse. A rule of thumb commonly used for identifying possible abuse is "Those who don't cruise rarely bruise" (Hernandez, 2021, para 2), reminding providers that a bruise in a preambulatory child carries high suspicion for abuse. Another key in identifying abuse is injury where the explanation given does not match the severity or appearance of the bruise or injury (Christian, 2015).

For example, an infant is brought into the emergency room for fussiness and decreased eating. Upon examination, the patient is found to have bilateral retinal hemorrhages. When asked about possible causes, the parents report that the infant fell out of a swing a few days ago but was caught before hitting the ground and did not develop any bruises. In this case, retinal hemorrhages are suspicious for child abuse as the infant is under 3 years of age and the explanation does not fit the injury. Without an underlying reason, such as a genetic disorder, retinal hemorrhages require significant force to occur (Whyte DeMarco et al., 2018). The case study in sidebar 2 explores how child abuse can be assessed and identified (Sidebar 2).

Nurses should be vigilant to look for signs of emotional abuse and ask questions that may bring it to light.

Nurses are mandatory reporters in the United States and Canada. All nurses should be familiar with their state or provincial rules for reporting suspected abuse to the proper authorities. In these cases, the duty to report outweighs client confidentiality. According to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule of 2003,

> Covered entities may disclose protected health information to report known or suspected child abuse or neglect, if the report is made to a public health authority or other appropriate government authority that is authorized by law to receive such reports. (Office for Civil Rights, 2003, p. 2)

Nurses must report when they "reasonably suspect" or "have reason to believe" that abuse has occurred; proof is not necessary (Child Welfare Information Gateway, 2019). Merrick and Latzman (2014) found reasons why professionals may hesitate when reporting suspected abuse: lack of familiarity with the process of reporting, fear of misinterpreting cultural

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Sidebar 2. Case Study

A 10-month-old girl, Jane*, is brought into the emergency room. The parents report lethargy and a poor appetite, shown by reduced energy and decreased interaction for several days. Jane's parents do not remember anything unusual happening before they noticed the changes. Jane is admitted to the pediatric unit for dehydration and investigation. The ER physician has flagged Jane as potentially suffering from abuse.

Sara*, the RN, admits Jane to the pediatric unit. Jane's vital signs while asleep are temperature 36.8 (Celsius), respiratory rate of 30, blood pressure is 80/38, with a heart rate of 150 apically. While performing the head-to-toe physical exam, Sara notes full fontanels and bruises on Jane's arms and torso. Some bruises appear new, whereas others are at later stages of healing. Capillary refill is noted to be slightly delayed, averaging 4 seconds. Urine is concentrated and output is low. Sara starts a peripheral intravenous catheter for bloodwork and fluid administration. The physician writes orders for a minimum oral intake with orders to insert a nasogastric tube if Jane is not able to meet the minimum intake for more than two feeds.

Sara asks Jane's parents about what led up to the changes in Jane's eating and energy. The parents reply that "nothing happened" and that "the changes happened overnight." Sara continues to ask the parents about what happened the night before the changes. The parents shared that they had some friends over, "but nothing happened." Jane's parents are becoming frustrated, so Sara stops asking questions.

The next day the social worker interviews the parents and discovers that alcohol and drugs were used the night before Jane's status change, and that Jane's parents do not remember anything from that night. After an interdisciplinary team discussion, a report of suspected child abuse is made to the appropriate government agency.

*Names changed to protect privacy.

practices, and fear of making the situation worse. The fear of disrupting the therapeutic relationship also impacts the decision to report. However, professionals must remember that the mortality rate from abuse increases by 25% with each reoccurring event (Hernandez, 2021).

A report of suspected child abuse is made to local child protective services (CPS) or law enforcement; if the danger is immediate, local law enforcement should be notified (Child Welfare Information Gateway, 2019). Anyone can make a report and in some states all persons are mandatory reporters. When making a report to CPS, it is necessary to provide a "complete, honest account" (Child Welfare Information Gateway, n.d., "What Do I Report" section) about why abuse is suspected. It is not the responsibility of the reporter to provide proof of abuse (Child Welfare Information Gateway, n.d.). The appropriate local agency will evaluate the report and determine if an investigation is needed. Nurses in both Canada and the United States can access the Childhelp National Child Abuse Hotline (https://www.childhelp.org/hotline/) which is staffed by crisis counselors and provides information and referrals.

NURSING CARE

Providing nursing care to patients who have been abused and their families can be challenging and emotionally stressful. The physiological nursing concerns are unchanged (e.g., treatment of refeeding syndrome, increased intracranial pressure, or care of fractures). One aspect of care that does not change in child abuse situations is the need for family-centered care; however, that care can look different from case to case.

Family-centered care is a central principle of pediatric nursing and recognizes that the family is a constant in a child's life and that parents are the experts about their children (Hockenberry & Wilson, 2019). When caring for an abused child, the main goal is to keep the child safe. Thus, at times, parents who are suspected perpetrators of abuse may not be allowed to visit or be involved with the child's care. Regarding who may visit a child suffering from suspected or confirmed abuse, nurses should follow instructions or guidance given by other professionals, such as Child Protective Services (CPS) in the United States or the Ministry of Child and Family Development (MCFD) in Canada. However, if and when parents are able to be involved with the patient's care, the nurse can model healthy interactions with the child and demonstrate to parents how to care for their child, as many parents of abused children were themselves abused as children or lack an understanding of appropriate parenting techniques (Hockenberry & Wilson, 2019).

Discharge planning and teaching becomes an intricate process in cases of child abuse. Often, questions will arise about the patient's caregiver after discharge, as the caregiver may not be the parents (Gibbs, 2018). Sometimes it is challenging to know who to teach. Other times, discharge teaching may not be possible for most of the admission, but instead be relegated to the last day or two. Discharge teaching for a child who has suffered abuse may include medication administration, management of any healing injuries, and a safety plan.

Nurses may be unfamiliar with the specifics of care for patients who have been abused (Gibbs, 2018). Government and health organizations often implement safety plans for these patients. In British Columbia, Canada, for example, MCFD will implement a safety plan for the child. The plan details who is allowed to be with the child and the level of supervision required. The plan details who is allowed to receive the child's health information. It is important to review this plan at the beginning of each shift as the plan can change based on the investigation of abuse.

Social workers may be a resource regarding the case investigation and changes in the plan. It is also important for nurses to make sure that vital information is passed from shift to shift, according to their workplace procedures. For example, in a recent case in the author's practice, one parent was not allowed to visit the patient or receive information of the patient's care. If that parent attempted to visit the patient, staff were instructed to call the police nonemergency number. This type of communication is vital among all frontline staff, not just the primary nurse; it is also essential to have contact information readily available.

Nurses based in the community or in ambulatory settings can be involved in a child's health for a longer time than acute care nurses. Interestingly, the U.S. Preventive Services Task Force (2018) found that there is not sufficient evidence to "recommend for or against preventive interventions in primary care settings" (p. 2125) for children who do not show signs of maltreatment. However, nurses in primary care and community settings may perform screenings. A November 2019 report from the CDC stated that prevention of adverse childhood experiences (ACEs), such as abuse, can significantly reduce the later incidences of chronic conditions, coronary heart disease, risky health behaviors, depression, and negative impacts of socioeconomic outcomes (Merrick et al., 2019). By administering ACEs screening tools (ACES Aware, 2021), primary care and community-based nurses can identify children and youth at risk due to a history of ACEs and intervene to mitigate future health outcomes.

Coping mechanisms are crucial for healthcare professionals when working with emotionally challenging patients.

As difficult as it can be, the nurse's role is not to assign blame (Gibbs, 2018). Other agencies have responsibility to investigate and proceed to the judicial system if necessary. The healthcare professional's role is to record objective documentation that can provide an accurate picture of the situation, which might be needed during legal proceedings. Documentation should include the patient's clinical status and any parental interactions. Examples of parental interaction documentation would be that "mom attempted to soothe patient by holding, singing, and offering soother" or "the nurse entered the room to observe patient's feed. Mom on phone call, reminded of patient's feed. Mom responded, 'Not now, I'm busy.' Mom required multiple reminders and did not feed patient. Nurse completed feed."

For the nurses in nonacute care, recognizing and reporting child abuse remains vital and mandatory. Although a clinic or community-based nurse may not care for patients in the acute phase after an injury, such nurses have opportunity to help prevent child abuse.

ROLE OF FAITH

In most nursing literature, spirituality denotes personal experience and finding meaning, whereas religion refers more to the institutions of faith and spirituality (Bryant-Davis & Wong, 2013). Working with patients who have experienced child abuse can lead nurses to question the moral underpinnings: "Why do things like this happen?" or "Why would God allow this?" For Christians, one response to evil is to "lament and protest" (G. Bellerby, personal communication, February 17, 2020) while holding securely to God's sovereignty and goodness. The psalmist asks, "Why, O LORD, do you stand far off? Why do you hide yourself in times of trouble?" (Psalm 10:1, NIV), lamenting the seeming lack of God's presence amidst trials. However, the psalm ends by describing the comfort found in God's character as defender and encourager.

While lamenting the tragedy of child maltreatment, Christian nurses can demonstrate the care of God to patients and their families through "love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness and self-control" (Galatians 5:22-23, NIV). Patients and their families may not have experienced such pleasantness. Being cared for by someone who demonstrates God's character may lead them to "taste and see that the LORD is good; blessed is the one who takes refuge in him" (Psalm 34:8, NIV).

Yet for victims of abuse, faith is a complicated realm. On one hand, belief in a sovereign God or a higher power can bring relief and healing through their faith. On the other hand, negative religious beliefs, for example, that the trauma happened to punish the victim for a moral failing, can lead to increased risk of depression (Bryant-Davis & Wong, 2013).

In general, religiosity has a protective factor against adult mental health issues. However, Feinson and Meir (2015) found that for survivors of child abuse, this protective factor is not as great. This may be related to a feeling of being betrayed by God. The researchers discovered that abuse either alienates children from their religion or, conversely, can lead to more stringent religious adherence.

Gilligan (2009) noted that most healthcare professionals' understanding of the value of religion in healthcare

Web Resources

- **American Academy of Child & Adolescent Psychiatry**
  https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Child_Abuse_Resource_Center/Home.aspx
- **ACES Aware**
  https://www.acesaware.org
- **Child Help**
  https://www.childhelp.org/story-resource-center/child-abuse-education-prevention-resources/
- **Child Maltreatment (Canada)**
  https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/prevention-resource-centre/children/child-maltreatment-what-guide-professionals-who-work-children.html
- **National Center on Shaken Baby Syndrome**
  http://purplecrying.info/sub-pages/protecting/commonly-asked-questions.php
- **National Children's Advocacy Center**
  https://www.nationalcac.org/child-abuse-and-prevention-resources/
- **The Period of PURPLE Crying**
  http://purplecrying.info/

was based on personal views, not on research. Nurses with a clear understanding of how child abuse and religion interact can be a resource for patients whose religious beliefs are an integral part of who they are and how they interpret the events of their lives (Gilligan, 2009). Nurses may try to ascertain whether patients who are old enough to process feelings and families are aware of the spiritual support available and help connect them, if desired by the patient and family.

Although faith communities have been a place of child abuse, those in churches and religious institutions can offer a protective presence, helping families meet needs and thus decreasing parental stress (McLeigh & Taylor, 2020). Church congregants also act as moral beacons in the community:

> Religious institutions are often an integral part of the fabric of communities across the globe. In addition to their aims of providing spiritual and moral guidance, faith communities … [provide] formal resources that can help families better care for themselves and their children, thus potentially mitigating factors known to influence child maltreatment. (McLeigh & Taylor, 2020, p. 2)

SELF-CARE FOR THE NURSE

Coping mechanisms are crucial for healthcare professionals. Caring for abused children can evoke many emotions, so healthcare professionals must find constructive ways to process their emotions to help prevent burnout (Wei et al., 2020). Nurses are familiar with the need to advocate for their patients; they also must advocate for themselves. Assistance might include asking for a different assignment or seeking more support while facing emotional challenges at work. Alternatively, ask a colleague to help so the primary nurse can step away to process his or her emotions. Taking a mental health day if the moral distress is overwhelming may help.

In some settings, interprofessional team debriefing is practiced. Self-care possibilities while on shift might include

- Taking a moment to become aware of your body and inhale slow breaths.
- If allowable, step away and get outside for a few minutes.
- Silently recite Scripture that is calming or strengthening or read a short passage on your phone.
- Pray and receive the compassion of God directed toward you.

Once off shift, options include journaling, creating art, or enjoying nature to constructively process emotionally challenging work experiences. Interacting with a mentor, spiritual director, or friend is beneficial; participating in a support group or nurse group is also valuable (Kleis & Kellogg, 2020), as is regular participation in a faith community. Wei et al. (2020) advocate for healthcare professionals to practice regular emotional hygiene, such as self-reflecting, establishing boundaries, getting adequate sleep, exercising, and recognizing the healthcare provider's own uniqueness and contributions.

CONCLUSION

Within the pediatric population, child abuse requires that nurses are competent to recognize, report, and respond to child abuse. Comprehensive physical exams paired with observing parental–child interactions are important in identifying child abuse. While treating patients and families, nurses have a role in helping patients and families access religious and spiritual supports. Equally important, nurses must recognize the need for and undertake self-care to manage the moral distress and emotions arising from caring for children who have been abused. Recognizing and addressing the need for self-care can help nurses avoid burnout and have the resources to continue nursing as ministry to children experiencing abuse.

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