Abuse and Neglect

Child Abuse

What is child abuse?

The Federal Child Abuse and Treatment Act (2003) defines child abuse as “any mistreatment or neglect of a child resulting in non-accidental harm or injury.” Child abuse can be further categorized into four classifications: neglect, physical abuse, sexual abuse and emotional abuse.

The majority of cases of child abuse fall into the category of neglect.

**Neglect** occurs when a child is not receiving proper care, supervision, or discipline. This also includes children who have been abandoned and the encouragement or approval of the child’s commission of delinquent acts.

**Physical abuse** is defined as an injury inflicted upon the child by a caregiver via a variety of non-accidental means including (but not limited to) hitting with a hand, strap, stick or other objects; punching, kicking, shaking, throwing, burning, stabbing, or choking to the extent that demonstrable harm results.

**Sexual abuse** is the committing or allowing of sexual activity with or by the child.

**Emotional abuse** is any activity that creates or allows serious emotional damage and then refuses treatment.

Who are the children?

Children of all ages can experience some form of child abuse. The age groups most frequently afflicted are the less than 6-year age group and the 12-14 year age group. All ethnicities (although ~50% are Caucasian) and socioeconomic groups are affected. Risk factors do however include low socioeconomic status, family violence, unemployment, substance abuse, inexperienced parents, and social isolation.

Reports of Child Abuse

Every year in this country, there are over 3 million reports of child maltreatment. Over 1 million of these cases are confirmed. Professionals such as medical personnel, educators and daycare providers make more than half of all reports that allege child abuse. Currently there are 5-6 deaths each day related to child abuse in the United States.

In North Carolina, the reported number of abuse or neglected children has increased by 10 % for over the last 5 years. About 30% of reports to Child Protective Services are substantiated. The number of deaths related to child abuse is 25-40 per year (data from www.preventchildabusenc.org).
**Indicators of Child Maltreatment**

The maltreated or abused child can manifest a variety of behaviors. Potential behavioral indicators of child maltreatment may be:

- Acute traumatic response: newly manifested clinging behavior and irritability
- Regression: loss of bowel or bladder control, thumb sucking, renewed need for security blanket, withdrawal
- Sleep disturbance: nightmares, sleepwalking, bedwetting, inability to sleep alone
- Eating disorders: feeding difficulties in a young child, anorexia nervosa, overeating
- School problems: change in performance, loss of concentration, easily distracted
- Social problems: anger/acting out, altered levels of activity (hyperactivity or inactivity), sexualized behavior inappropriate for age, poor peer relationships
- Behavioral sequelae: poor self-esteem, depression, guilt, suicidal gestures, delinquency, running away, substance abuse, prostitution, psychosomatic gastrointestinal or urinary complaints

The maltreated or abused child can also manifest a variety of physical indicators. Medical indicators for sexual abuse may be:

- Bruising, scratches, bites, grasp marks
- Sexually transmitted diseases
- Bloodstains on underwear
- Pain in anal, genital, gastrointestinal and urinary areas
- Unexplained genital injuries
- Enuresis (bedwetting) and encopresis (fecal incontinence)

Males may also experience pain on urination, penile swelling and discharge. Females may have a vaginal discharge, urethral inflammation or pregnancy.

Indicators for physical abuse may include:

- Bruises (multiple, various stages of healing over non-bony prominences)
- Suspicious lesions (marks from belts, cords, cigarette burns)
- Burns
- Fractures (rib, scapula, metaphysical)
- Head injury
- Abdominal injury

For the child with indicators for physical abuse, differentiating accidental from non-accidental trauma is critical. When obtaining the patient’s history, variables indicating a questionable injury include:
• Discrepant history: injury does not fit the history, details inconsistent or change over time
• Delay in seeking treatment
• Injury blamed on younger sibling or playmate or as “self-inflicted”
• Injury “not witnessed”
• Injury inconsistent with child’s developmental level
• Multiple injuries or injuries at various stages of healing
• Poor hygiene

Reporting
Anyone who has reasonable cause to suspect a child is abused or neglected must report that information to the Department of Social Services (828-439-2003). Under state statute, medical personnel making the report in good faith are able to claim immunity from criminal and civil liability should an angry caregiver file a lawsuit against whoever initiated the report even if it is determined no maltreatment occurred. At BRHC, hospital staff should contact the department manager or social worker for assistance in reporting.

Since these cases have tremendous legal implications for the child and the caregivers, it is important to create a clear, accurate medical record, which preserves the detail of the case. The medical record may be admitted as evidence in any subsequent court actions and thus documentation is imperative.

Intimate Partner Violence (IPV)
Intimate Partner Violence (Domestic Violence) is a repeated cycle of tension-building behaviors on the part of an abusive partner, followed by an explosive pattern of coercive behaviors that may include some combination of physical violence, psychological abuse, sexual abuse, progressive isolation, deprivation, and intimidation. These behaviors are sometimes followed by a calm or “honeymoon” period or may move directly back into the tension-building phase where the cycle repeats. This pattern is perpetrated for the purpose of obtaining and maintaining power and control over an intimate partner. IPV is potentially lethal and very damaging to the victim’s health, autonomy, personal safety, and access to resources.

Nearly one in three women will experience IPV in their lifetime. It is the leading cause of injury to females age 15-44. A small percentage of males are also victims of IPV; the majority of male victims are abused by a male intimate partner. IPV occurs in all types of intimate relationships including heterosexual, gay/lesbian, and transgender relationships.

Victims of IPV often experience:
• Isolation from friends and family
• Fear of their partner
• Limited personal freedom
• Limited access to resources
• Health problems/injury
1. Chronic pain
2. Gastrointestinal symptoms
3. Eating Disorders
4. Depression/Anxiety/PTSD
5. Suicide
6. Permanent injury or death

Patient Advocacy

There are no mandatory reporting laws for domestic violence. However, you may refer a person to **Options of Burke County (828-438-9444)**. Never ask the victim what they did to cause the abuse. There is no excuse for domestic violence.

- Do not minimize the abuse or make light of the victim’s concerns.
- Tell the victim that you are concerned for her/his safety.
- Do not ask the victim about the abuse in front of the partner. Ask about suspected abuse in private.
- Do not gossip with other healthcare staff about what the victim shares with you. Always maintain confidentiality. This is extremely important for patient safety.
- Do not try to make decisions for the victim or tell the victim what to do.
- Listen compassionately.
- Never confront the abusive partner with what the victim shares with you. This will put the victim in greater danger.

Indicators of IPV/ Domestic Violence

You should observe and consider the following:

- Patient seems anxious around partner.
- Patient denies physical abuse, but presents with unexplained bruises/injuries, burn, fractures, or injuries in multiple stages of healing.
- Patient has injuries on face and head and/or areas hidden by clothing.
- Patient presents with signs of sexual abuse to genital area, breasts, or buttocks.
- Extent or type of injury is inconsistent with explanation by patient.
- A delay exists between time of injury and presentation for treatment.
- Patient explains injury in hesitant, embarrassed or evasive manner.
- Review of medical records shows repeated use of ED or other medical and/or social services.
- Suspected abuser insists on accompanying patient and answers questions directed at the patient.
- Pregnant woman with injuries to the breast and/or abdomen.
- Evidence of untreated or old injuries (i.e., scars, healed fractures)
- Psychiatric, alcohol or drug abuse history in patient or partner.
- History of suicide attempts or suicidal ideation.
- Fear of returning home and/or fear for safety of children.

Considerations
At a minimum, the following procedures shall be followed for evaluating suspected intimate partner/ domestic violence:

1. Examine the patient in private in a non-threatening way if injuries are a result of battering.
2. Treat medical injuries as indicated. Caution should be taken when medications are prescribed that may make the patient unable to protect herself/himself from assault.
3. Document suspected or confirmed abuse by collecting and retaining evidence, including photographing injuries with patient’s consent, and/or use of body diagrams.
5. As part of your routine health assessment, ask female patients about IPV in a non-threatening manner in private only. Males with indicators of IPV should also be asked about IPV. Examples of non-threatening questions include “Do you feel safe in your relationship?” “Is there anyone from a previous relationship that makes you feel unsafe?” “Does your partner ever hurt or threaten to hurt you in a physical way?”

Elder Abuse
Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult. Elder abuse also can take the form of financial exploitation or intentional or unintentional neglect of an elder adult by the caregiver.

Statistics
In the United States, the number of people age 60 and older is growing rapidly. An estimated 2.1 million of these older Americans are victims of physical, psychological, and other forms of abuse every year. Experts suggest as many as 10% of older adults may be victims of abuse. Reliable statistics are difficult to confirm because many violations go unreported.

Approximately 70% of reported cases through Adult Protective Service Agencies are for neglect. About 1/3 of the reported cases involve emotional or psychological abuse. Financial exploitation occurs in approximately 1/3 of elder abuse cases. In addition, abuse is two or three times more prevalent in people over age 80 than in those 60-80.

Cultural Issues
Societal attitudes make it easier for abuse to continue without report or intervention. Factors include devaluation and lack of responsibility for older adults and society’s belief that what goes on in the home is a private “family matter”. Defining what is considered “abuse” varies across diverse cultural and ethnic communities. When society fails to recognize the importance of assuring dignified, supportive, and non-abusive life circumstances for every old person, it shows a lack of respect which contributes to the violence against older people.

Religious or ethical belief systems sometimes allow for mistreatment of family members, especially women. Those who participate in these behaviors do not consider them abusive. In some cultures, women’s basic rights are not honored, and older women in these cultures may not realize they are being abused. They may not be able to call for
help outside the family and may not even know that help is available. Healthcare providers have a responsibility to recognize and report disabled adults at risk for abuse, neglect, and exploitation in accordance with North Carolina laws. A disabled individual is identified as an elderly patient who is mentally or physically incapacitated due to advanced age.

Types of Abuse
Abuse takes various forms and a victim may be subjected to more than one type. The most common types include:

- **Caregiver Neglect** - typically involves a caregiver’s refusal or failure to provide an older person with necessities, such as adequate food, clothing, shelter, medicine, and assistance with activities of daily living. If the caregiver has responsibility for paying bills, neglect also can include failure to pay the bills or to manage the elder person’s money responsibly.

- **Emotional or psychological abuse** - can range from name calling or giving the “silent treatment” to intimidating and threatening the individual. It is the deliberate inflicting of anguish, emotional pain, and distress through verbal assaults, threats, intimidation, humiliation, harassment, and isolation from friends and regular activities.

- **Financial abuse or material exploitation** - occurs when someone takes an individual’s money or belongings without permission. Can range from misuse of an elder’s funds to embezzlement.

- **Physical abuse** - is the use of force, such as punching, slapping, restraining, biting, burning, pinching, pushing, and pulling, which results in pain, impairment, or bodily injury. It can range from slapping or shoving to severe beatings and restraining with ropes or chains.

- **Sexual abuse** - is nonconsensual sexual contact of any kind. It can range from sexual exhibition to rape. Sexual abuse is not often reported as a type of elder abuse.

- **Self-neglect** - is any behavior that threatens a person’s own health and safety. It is most often characterized by a person’s refusal or failure to provide food, water, clothing, shelter, medicine, and personal hygiene for herself/himself.

- **Abandonment** - is the desertion of a dependent person by the person or persons responsible for providing care.

Risk Factors
Experts suggest that 10% of all older adults are victims of abuse. Authorities believe that the reported cases are just the tip of the iceberg and for every one that is reported there are five that are unreported. Common risk factors that may lead to abuse include:

- Stressful care giving circumstances, especially if the older person has a physical or emotional impairment
- Caregiver resentment of the older person’s dependency
- Ongoing problems and dysfunctional dynamics of the family, such as a history of violence
• Isolation
• Poverty
• History of dysfunctional personality in the victim or the abuser, such as alcoholism, drug addiction and emotional or mental disorders

**Indicators of Abuse**
Many of the symptoms listed below can occur because of debilitating conditions or medications. The appearance of these symptoms should prompt further investigation to determine the cause.

• **Physical Abuse**
  - Bruises or grip marks around the arms or neck
  - Rope marks or welts on the wrists and/or ankles
  - Repeated unexplained injuries
  - Dismissive attitude or statements about injuries
  - Refusal to go to same ED for repeated injuries

• **Emotional/Psychological Abuse**
  - Uncommunicative and unresponsive
  - Unreasonably fearful or suspicious
  - Lack of interest in social contacts
  - Chronic physical or psychiatric health problems
  - Evasiveness

• **Sexual Abuse**
  - Unexplained vaginal or anal bleeding
  - Torn or bloody underwear
  - Bruised breasts
  - Venereal disease or vaginal infections

• **Financial Abuse or Exploitation**
  - Life circumstances do not match with the size of the estate
  - Large withdrawals from bank accounts, switching accounts, unusual ATM activity
  - Signatures on check do not match elder’s signature

• **Neglect**
  - Sunken eyes or loss of weight
  - Extreme thirst
  - Bedsores
  - Poor hygiene
  - Dirty clothes
  - Matted hair

**Assessment of Suspected Abuse**
If you suspect an older adult is being abused, provide a setting where the individual will feel safe talking about the situation. The physical examination and interview should be done apart from the caregiver. Many victims may be reluctant to report abuse because they are ashamed and afraid of abandonment or retaliation. They may react angrily and
vehemently deny any suggestions that there is anything wrong. Remember the goal of reporting abuse of an older person is to ensure the safety of the victim. If a patient has dementia or is unable to answer your questions appropriately, you should base your determination on your physical assessment, interview with caregiver, and assessment of their interactions.

Possible screening questions might include:
• Has anyone ever hurt you?
• Has anyone ever touched you without your consent?
• Has anyone ever made you do things you did not want to do?
• Who cares for you at home?
• Are you afraid of your caregiver?

To identify potential neglect and financial exploitation, you might ask these questions:
• Are you satisfied with your living situation?
• What is a typical day like for you?
• Who gives you your medications?
• Who helps you with dressing, bathing, and preparing meals?
• Has anyone ever failed to help you take care of yourself when you need help?
• Has anyone ever withheld food or medications from you?
• What happens when you and your caregiver disagree?
• Are you afraid of anyone at home?
• Are you left alone a lot?
• Who manages your finances?
• Have you ever signed anything that you did not understand?
• Has anyone taken anything of yours without asking your permission?

To assess an injury, you might ask these questions of the patient and the caregiver separately:
• When did it happen?
• How did it happen?
• How long ago did it happen?
• How often does this happen?

**Preventing Abuse**
Patient education plays a key role in preventing abuse to an older patient. You can offer these tips to avoid becoming a victim:
• Stay sociable and active—keep in touch with neighbors and friends, and keep up with routine health care.
• Keep your possessions in order—open your own mail, arrange for direct deposit of checks, do not leave valuables lying around.
• Consult a lawyer—consider designating a power of attorney should you become disabled and do not sign anything until someone reviews it.
• Know whom to ask for help—you can contact Adult Protective Services.
Reporting
Most states require healthcare workers to report suspected abuse. Contact your leader, supervisor or social worker if you encounter an elderly person in any of the following situations:

- You detect evidence of mistreatment without a reasonable clinical explanation
- The patient complains of abuse
- You believe that the risk of abuse and neglect is high

Joint Commission Standard

To address this pervasive health care issue, the Joint Commission has developed standard PC. 01.02.09 :

The hospital assesses the patient who may be a victim of possible abuse and neglect.

The intent of the above standard is that each hospital have objective criteria for identifying and assessing possible victims of abuse and neglect, they are used throughout the organization and staff is trained in their use. This standard recognizes that victims of abuse or neglect may come to a hospital through a variety of channels. The patient may be unable or reluctant to speak of the abuse, and it may not be obvious to the casual observer. Nevertheless, to give the patient appropriate care, hospital staff members need to know if a patient has been abused, as well as the extent and circumstances of the abuse.

Carolinas HealthCare System Blue Ridge Policy and Procedure

To meet this goal, Carolinas HealthCare System Blue Ridge has developed Policies and Procedures and screening tools for identifying and assessing possible victims of abuse. Key policy/procedure points that are relevant to both juvenile and adult suspected abuse include:

- Be familiar with the abuse, neglect, and exploitation (Reporting Abuse and Neglect Policies)
- Examine and interview the patient in private.
- Document the chain of custody of patient's belongings and or evidence.