Recognizing and Responding to Child Abuse in the Medical Setting

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As medical professionals it is imperative that we keep child abuse and neglect on our differential diagnosis when assessing children, no matter where we provide care. We must follow our clinical instincts and gather additional history to better understand the mechanism of injury, ask for photo/video documentation to determine plausibility of an injury, and separate the child from the caregiver to obtain a potentially unbiased history when needed. Proficiency in doing a complete anogenital examination, noting normal variants as well as recognizing possible infections or injuries, and referring for additional medical treatment is essential. When young children present with unusual or concerning findings, from marks on the skin to lesions or injuries in the anogenital area, we need to differentiate accidental from inflicted causes as well as rule out medical conditions that mimic abuse as indicated by Dr. Andrea Z. Ali-Panzarella in the article, “A Diagnostic Approach to Conditions that Mimic Sexual Abuse” and by Dr. Vi Ngo in the article “A Closer Look: Medical Conditions that Mimic Physical Abuse.”

In the article, “Understanding Abusive Head Trauma: A Primer for the General Pediatrician,” Dr. Stephanie A. Deutsch describes how babies and young children who present with lethargy, vomiting, or mental status changes must be considered to be victims of abusive head trauma (or shaken baby syndrome) especially when other medical conditions are ruled out. In the article, “Pulling the Wool Off Our Eyes: Medical Child Abuse,” Dr. Amber Hoffman underscores the need to keep a keen eye out for concerns of medical child abuse, especially when the clinical presentation and medical data do not add up. Most importantly, if we, as pediatric clinicians, ever have a “reasonable cause” to suspect abuse, we must adhere to our mandate to make a report to child protective services (CPS) and law enforcement.

Child maltreatment is a devastating public health issue, particularly for child victims. Abuse negatively affects nonoffending caregivers, siblings, communities, and, at times, health care providers. As medical professionals, we can detect, report, and thus stop the abuse from occurring. However, recognizing abuse or neglect can be difficult as we may have to surmount our own biases or belief systems whether they be that “people don’t intentionally hurt their children” or “people don’t fabricate symptoms to obtain unnecessary medical procedures.” Abuse happens in all communities; it is not confined to certain social, racial, or economic groups. We must weigh all of the medical information that we have at our disposal to determine if a report or further evaluation is warranted as we do not want to cause trauma or family disruption. However, if we have any cause to suspect abuse or neglect is occurring it behooves us to make a report to CPS and law enforcement, because stopping abuse outweighs any potential inconvenience to the family. Whereas a medical provider will not be prosecuted for reporting a concern for abuse, a provider who does not report abuse will most likely face charges of a criminal or civil nature. The most devastating aspect of child abuse is the death of a child as a result of maltreatment that could have been prevented.

During times of major economic devastation, widespread uncertainty, and disconnection from family, friends, communities, as seen during the coronavirus 2019 pandemic, we must pay attention to the stress levels of families and the effect on children. Increased stress and isolation are risk factors for family violence, including child maltreatment. Caregivers who are stressed may be more likely to respond to child behavior in aggressive or abusive ways, especially when support systems are no longer available due to social distancing. Medical visits via telehealth or masked in-person visits using physical distancing are of utmost importance during these times to provide anticipatory guidance and support to families to mitigate stress and use of harmful discipline practices.

Perhaps even more important than recognizing and reporting child abuse...
is the medical provider’s role in prevention of child abuse and neglect. Prevention begins around birth by counseling the caregivers about infant crying. Infantile crying begins around age 2 weeks and is the most common antecedent to abusive head trauma. A priority in anticipatory guidance is normalizing infant crying for the caregiver and offering strategies they can use to calm the baby. Included in this information is guidance on when to seek medical attention for the crying as well as healthy strategies the caregiver can use when the crying is overwhelming. Reassuring caregivers that it is okay to place their crying baby in a safe crib (employing safe sleep practices) for a few minutes while they take a break or engage in a healthy self-calming strategy can make a huge difference. Screening all primary caregivers for postpartum depression, not just the birth mother, is essential as adjusting to a new baby in the home is challenging. Medical professionals can provide additional resources for families who are struggling by referring them to a home visitation program to receive more intensive support.

The “terrible twos,” which extend into the preschool years, provide another opportunity for anticipatory guidance and child abuse prevention. As the toddler becomes more mobile, their world expands, and they must learn to cope with limits put in place to keep them safe. Often this is a trying time for caregivers as they navigate uncharted waters. Caregivers often look to medical providers to obtain effective behavior management strategies to assist them as they guide and teach their children. We, as medical professionals, can support caregivers during this time by listening, encouraging the use of safe, healthy, evidence-based discipline practices, and counseling about the negative effect of corporal punishment. Additionally, we can refer to evidence-based parent training programs when needed.

Pediatricians can address sexual abuse prevention throughout the lifespan by encouraging caregivers to use anatomically correct names for children’s anogenital area, at a minimum referring to them as “private parts.” Ensuring that if a child discloses sexual abuse to a nonfamily member, it will be recognized and reported. We can relay the importance of teaching children that their anogenital area is their own personal “private” area and what to do if someone does something that makes them feel uncomfortable, namely telling a trusted adult. If a child discloses sexual abuse, we, as clinicians, can aid the nonoffending caregiver in believing and supporting the child if they are struggling with the disclosure. In addition to placing a call to the child abuse hotline, we can also encourage the child and family members to receive therapy when necessary.

Although a bit more difficult to identify at times, medical child abuse can also be prevented. When possible, making time in our busy clinical practices to have frequent check ins with parents can go a long way to allay their worries and fears and provide the attention they may be seeking. Office staff can be used to assist in this manner as well.

Together, through increased awareness, comprehensive evaluations of children suspected to have been maltreated, and referrals for further evaluation and treatment as well as prevention strategies, medical professionals can help to reduce the number of children experiencing child abuse and neglect.

REFERENCES

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