Child Maltreatment

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KEYWORDS

• Child maltreatment • Child abuse • Pattern of injury • Mandatory reporting

KEY POINTS

- Abuse of children is generally decreasing in the United States; however, negligence is increasing.
- Craniofacial fractures are uncommon in children younger than 2 years of age and are rare due to falls less than 4 feet.
- Patterns of bruising, particularly the face and ear regions, are hallmarks of physical battering in young children.
- All health professionals are held to a higher standard of surveillance and screening for abuse in children with unexplained or injuries from conflicting causes. Oral and maxillofacial surgeons are mandatory reporters by law for suspected abuse and negligence of children.

INTRODUCTION

Child maltreatment (abuse) is a disturbing component of public health domain and cost because it exerts its influence across many facets of family life, social-cultural concerns, education, and burden to the health care system. Traumatic injury is the leading cause of death in children over 1 year of age in the United States, and child abuse in all of its forms is a significant component of pediatric mortality and morbidity. Since longitudinal records were first kept by the federal government in 1979, there had been a steady increase of reported cases of child abuse until the mid 1990s when reported abuse began to plateau as recorded by medical, social service, and law enforcement officials.[1,2]

Child maltreatment includes several categories all of which overlap in relationship and intensity: physical (violence to a child by the parent or caregiver), verbal or emotional (attacks on the psychological well-being of the child), and sexual (direct and indirect harm visited on the sexual development, psyche, and body of a child).[3] Given the cultural tolerance of violence displayed on so many levels and the change of the family and domestic dynamic, it is not surprising that this has translated into the tragic outcome of abuse visited on children.

EPIDEMIOLOGY AND ECOLOGY OF CHILD MALTREATMENT

Maltreatment of children has been reported at around 1.2 million annually in the United States, of which approximately 303,000 cases are due to physical abuse.[2] The National Center on Child Abuse and Neglect estimated that 37% of abused children will develop a chronic disability or special need that will require ongoing therapy.[3] The heightened awareness of caregivers, medical personnel, and educational institutions about pediatric abuse no doubt led to increased identification and reporting of abuse.[4] Reported maltreatment occurs across all social strata and ethnicities although there are factors that have been identified as leading to increased incidence of abuse: prematurity, teenage mother, poor bonding with caregivers, special needs (learning disability, attention-deficit/hyperactivity disorder, etc), child being perceived as different or "not normal."[5]

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DiScala and colleagues[6] reviewed records from the National Pediatric Trauma Registry (1988–1997) and determined that children who were physically maltreated were younger (12.8 months) than those accidentally injured (25.5 months), they were primarily injured by battering (53%), and they were more likely to have a chronic medical condition, such as delayed development or physical anomaly.

Over the last 20 years, the incidence of both physical and sexual abuse of children has steadily declined; however, the incidence of neglect and emotional abuse remains high and slightly increased over the same period (**Fig. 1**).[2,7,8] Recent evidence supports the tendency of certain observed domestic and caregiver characteristics that may contribute to this latter form of abuse and, for some children, lead to direct physical violence.[5] These characteristics include (1) caregiver's anger and uncontrolled disciplinary actions, (2) caregiver's mental illness, (3) children left with abusive babysitters, (4) caregiver's use of substances that disinhibit appropriate behavior, and (5) caregiver's own experience of domestic violence.

Neglect is considered an element of abuse.[8–10] It is difficult to adequately address child neglect in all of its forces and spectrum. The complex interactions of child health, caregiver knowledge and skill, socioeconomic status, and domestic and community or cultural environment combine to provide a child's welfare or lack of it.[11] The price everyone pays for the magnitude of child neglect is tragically great and indeterminable.

Negligent care is difficult to define but we recognize it when we see it as health professionals. Neglect ranges from poor parenting to obvious criminal behavior and negligence. Child neglect is basically defined as, "when a child's basic needs are not met, regardless of the circumstances leading to the inadequacy of care."[11] Negligence can be observed in the acute care setting and outpatient visit in several forms, including obvious unhygienic dress and personal care, exposure of children to an environment of domestic violence and stress, poor living conditions, frequent missed medical appointments, and putting children at obvious risk with activities of great danger. Evidence of chronic dermatologic ailments[12] (open sores, bites or infected bites), rampant dental decay and gum disease,[13] and not using safety devices or precautions during sport or recreation[14] are indications of neglect of a child's well being.

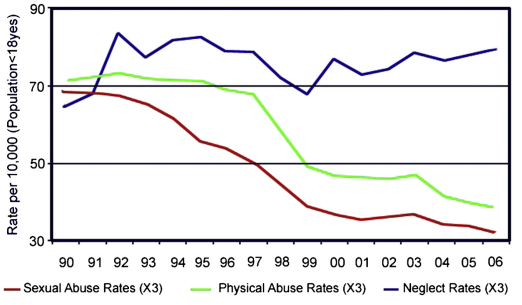

Fig. 1. Trends in child abuse and neglect in the United States, 1990 to 2006. (*Data from* US Department of Health and Human Services. National Center of Child Abuse and Neglect.)

For the maxillofacial surgeon this may present variably as signs of poor oral health, nutritional deficiencies as manifested by poor tissue healing or open skin-mucosal sores, delays in seeking treatment for obvious orofacial pathologic conditions, and so forth. Avoiding prescribed medical care is a frustrating element of some families that have a child with a craniofacial anomaly, cleft lip or palate, severe deformational plagiocephaly with accompanying occipital sores, or a chronic pathologic condition. Often times the child will have missed many appointments that are directed at optimal care during a particular developmental period, compromising the ultimate result of function, aesthetics, and a sense of well being and health for that child. Poverty, high medical costs, transportation issues, low parental health IQ, and even the child's own condition can negatively affect the sequence of obtaining good care.[11] This, sadly, is negligence and must be addressed—first as an expression of support and concern on behalf of the child and later, if clearly there is no affirmative parental or caregiver response, with child protective services and welfare agencies. The first order of business when facing noncompliance with medical treatment is to come alongside the family to inform and clarify treatment goals, inquire as to caregiver resources to comply, and voice support to the parent. These steps in providing care are necessary elements for the well-being of many children who come under the care of the pediatric maxillofacial surgeon.

Although many maxillofacial surgeons may feel that time is a limiting factor in pursuing these signs of neglect and endangerment, the law is clear that certain health practitioners (physicians and dentists are mandated reporters) are held to a higher standard in the care of patients at risk.[13,15,16]

PRESENTATION AND WORKUP

Identifying the injured child is always a highly emotional event for all involved. This is increased if battering is suspected (**Fig. 2**). As in any traumatic event, the ABCs of initial evaluation and treatment are undertaken. When the injured child