Child Maltreatment: Screening and Anticipatory Guidance CE

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ABSTRACT

Child maltreatment is a problem of epidemic proportions in the United States. Given the numbers of children affected by child maltreatment and the dire consequences that can develop, prompt identification of child maltreatment is crucial. Despite support of the implementation and development of protocols for child maltreatment screening by professional organizations such as the National Association of Pediatric Nurse Practitioners and American Academy of Pediatrics, little is available in the literature regarding the screening practices of pediatric nurse practitioners and other pediatric health care providers. This Continuing Education article will help pediatric nurse practitioners incorporate this vital screening intervention into their practice. Practical examples of when and how to incorporate screening questions and anticipatory guidance for discipline practices, crying, intimate partner violence (domestic violence), physical abuse, and sexual abuse will be discussed. J Pediatr Health Care. (2013) *27*, 242-250.

KEY WORDS

Child maltreatment, screening, guidance

OBJECTIVES

Based on the content of the article, you will be able to:

1. Identify negative consequences to children resulting from child maltreatment.
2. Describe when and how to provide screening and anticipatory guidance related to discipline, infant crying, intimate partner violence, sexual abuse, and physical abuse.
3. Recognize the impact on children of witnessing intimate partner violence.
4. State when to report a concern of suspected child maltreatment to child protective services.
5. Recognize the link between corporal punishment use and physical abuse.
6. Identify historical indicators of physical abuse.

Child maltreatment is a problem of epidemic proportions in the United States. During 2010, approximately 754,000 children were victims of child maltreatment (U.S. Department of Health & Human Services, 2012). An estimated 1,560 children die nationally each year because of child abuse or neglect, a rate of 2.07 deaths per 100,000 children. Reports indicate that in 2010, 78.3% of victims suffered neglect, 17.6% were physically abused, 9.2% experienced sexual abuse, and 8.1% were psychologically maltreated. Additionally, 3.3 to 10 million children witness domestic violence each year. In nationally representative samples of 2,030 children and 4,053 children, Finklehor, Ormrod, and Turner (2007) and Turner, Finkelhor, and Ormrod (2010) found that 69% and 66% of the children, respectively, had experienced more than one form of child maltreatment.

Given the numbers of children affected by child maltreatment and the dire consequences that can develop,

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prompt identification of child maltreatment is crucial. Health care personnel were responsible for only 8.2% of the estimated 3.3 million referrals to child protective service agencies in 2010 (U.S. Department of Health & Human Services, 2012). The importance of early identification of child maltreatment led the National Association of Pediatric Nurse Practitioners (NAPNAP) to issue a position statement that supports the implementation and development of protocols for child maltreatment screening (NAPNAP, 2011). When developing protocols for child maltreatment screening, it is important to realize that any one form of child maltreatment rarely occurs in isolation. If only one form of child maltreatment is assessed, providers may fail to recognize the full burden of victimization and leave children unprotected and inadequately treated. Despite the recognition of the need to identify and intervene in cases of child maltreatment as soon as possible to decrease trauma to children, little is available in the literature regarding the screening practices of pediatric nurse practitioners (PNPs) and other pediatric health care providers, screening for child maltreatment, and psychosocial risk factors for maltreatment, including intimate partner violence. This article will help PNPs incorporate this vital screening intervention into their practice.

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REVIEW OF LITERATURE

Consequences

Consequences of child maltreatment can be physical and/or psychological, and short-term and/or long-term. Immediate consequences of physical abuse can range from minor cutaneous injuries such as abrasions or bruises to more severe injuries such as fractures, abdominal trauma, inflicted head injury, or death. Long-term consequences of physical abuse include residual mental and/or physical disabilities resulting from the initial injuries and psychological problems related to experiencing trauma such as posttraumatic stress disorder, anger, and aggression. Springer, Sheridan, Kuo, and Carnes (2007) and Greenfield (2010) found child physical abuse to be associated with negative health outcomes in adulthood, including an increased likelihood of reporting more diagnosed illnesses such as heart disease, stomach ulcers, and hypertension. Adults who experienced physical abuse were also found to report more physical symptoms, along with anxiety, anger, depression, and drug/alcohol abuse.

Sexual abuse has been linked with a variety of behavioral concerns, including sexualized behaviors in young children, symptoms similar to attention deficit disorder, and violent behaviors (Hornor, 2010). Child sexual abuse can also result in the development of posttraumatic stress disorder, depression, suicide, substance abuse, and adult revictimization. Furthermore, exposure to domestic violence can have negative physical, developmental, and psychological effects on children (Hornor, 2005). Children who witness domestic violence are at risk for the development of behavioral and mental health consequences such as posttraumatic stress disorder, anxiety, depression, withdrawal, attention problems, and aggression (Thackeray, Hibbard, & Dowd, 2010). Experiencing corporal punishment (CP) has been linked to a number of negative consequences for children. The use of CP has been linked to increased risk of physical abuse (Sanapo & Nakamura, 2011). Physical abuse often begins as an act of discipline that morphs into abuse at the hands of a frustrated caregiver who loses control of himself or herself. Higher rates of externalizing behavioral problems are seen in children who are spanked (Mackenzie, Nicklas, Waldfogel, & Brooks-Gunn, 2012). Decades of research have implicated CP in the etiology of criminal and antisocial behavior in children and adults (Gershoff, 2002). Children who are spanked demonstrate slower development of receptive verbal capacity (Mackenzie et al., 2012). Experiencing any form of child maltreatment can have negative affects on future parenting ability (Currie & Widom, 2010; Hornor, 2010). Experiencing childhood physical abuse and/or exposure to domestic violence has been linked with perpetrating physical abuse as an adult. A parent who has experienced child sexual abuse is at increased risk to have a child who is sexually abused, not by sexually abusing the child themselves, but by placing the child in high-risk situations and exposing him or her to persons who are likely to abuse.

Risk Factors for Child Maltreatment

Child maltreatment crosses all economic, ethnic, racial, and religious boundaries. However, certain psychosocial factors place a parent at increased risk of perpetrating child maltreatment and place a child at increased risk for victimization. Parental risk factors include poverty, a childhood history of abuse/neglect, social isolation, being an adolescent or young parent, having unrealistic developmental expectations, having poor impulse control, substance abuse, domestic violence, mental illness/depression/mental retardation, and previous involvement with child protective services or law enforcement (Hornor, 2005; Sidebotham & Heron, 2006). Factors placing children at increased risk include young age (for physical abuse), developmental delay,