Uncovering child abuse

By Catherine Lyden, BSN, RN, CCRN

Child abuse is defined as the physical or emotional injury, sexual abuse, negligent treatment, or maltreatment of a child under age 18 by a person responsible for the child’s welfare. Healthcare providers are expected (under The Joint Commission’s 2008 standards) to recognize signs of possible abuse when a child enters the facility, report any identified abuse internally and externally, and make appropriate referrals.

Defining abuse

Abusers can be the child’s parent or other caregiver. For simplicity, in this article, I’ll use the term parent. So, what is abuse?

Physical abuse is an impulsive reaction to environmental stressors in which the perpetrator causes physical injury to a child, including anything from bruises and fractures to brain damage.

Emotional abuse is more difficult to pinpoint because the abuse involves a child’s unmet emotional needs, such as for affection, nurturing, and positive attention. Instead of meeting these needs, the parent rejects, terrorizes, verbally assaults, and attempts to destroy a child’s self-esteem. This type of abuse can be tied to the parent’s poor knowledge of normal child growth and development—the parent expects the child to do or understand things beyond his or her years, even expecting the child to take on the parental role in the relationship.

Sexual abuse is less common than other types of abuse, with a higher incidence occurring in girls under age 18. Sexual abuse is identified as any form of sexual contact or attempted contact between a child and a caregiver (or another adult) for the purposes of the adult’s sexual gratification or financial benefit, including any injuries related to the sexual activity. Usually, the perpetrator is male, but females also sexually abuse children, both with and without coercion by their partner. Anyone who knows that sexual abuse is occurring to a child is considered as guilty as the perpetrator in a court of law.

Neglect is considered the failure to provide for the child’s minimum physical needs, or the lack of appropriate supervision based on the child’s age and developmental stage. Minimal needs include food, shelter, clothing, and heat, and for those children with health problems, any medications, treatments, and follow-up appointments that they require for ongoing care. For families living in poverty, the definition of neglect includes choosing not to take advantage of community services such as food stamps and emergency shelter, and leaving children with inappropriate supervision.

An uncommon form of abuse or neglect is Munchausen syndrome by proxy, in which the parent or caregiver causes or fabricates a child’s illness, subjecting the child to unnecessary medical evaluation and treatment that result in hospitalizations, morbidity, or death. By far, the most frequent parent involved in Munchausen by proxy is the mother, who has some medical knowledge, either from education or from the Internet. The mother uses that knowledge to fabricate a history and alter the child’s test results to facilitate a longer length of hospital stay. The mother and child have usually visited multiple physicians and facilities, and the story is slightly different at each visit. If the mother can’t stay with the child in the hospital, she’ll be less likely to be able to continue to produce the same signs and symptoms that the child exhibited on admission. A mother who stays with her child in the hospital can more easily tamper with food or test results so that the signs and symptoms continue, unless the staff has a high level of suspicion and finds a way to restrict her ability to continue this practice.
Inflicted traumatic brain injury (ITBI), commonly known as shaken baby syndrome, is a malicious and increasingly prevalent injury that typically occurs during the first 2 months of life, but can occur up until the child is age 2. A computed tomography scan or magnetic resonance imaging will diagnose a subdural hematoma, other intracranial bleeding, and/or the single or bilateral retinal hemorrhages characteristic of ITBI. The baby may have bruises on the chest or extremities where he was held, but often has no other marks. As soon as the child is stable, a skeletal survey should be performed. Fresh fractures and those in various stages of healing can be associated with ITBI.

**Characteristics of child abuse**

Child abusers often were abused themselves or observed abuse in their families. The abusers have limited understanding of normal child growth and development, poor social support, may be young, may feel isolated, and may live at or below the poverty level. They often have low self-esteem (whether they have a history of abuse or not), poor impulse control, and limited coping mechanisms at their disposal as they care for the child. The honeymoon of pregnancy and giving birth to a child who will “love” them unconditionally has worn off, and they begin to realize the responsibility, hard work, and the stress involved in being a parent.

The abuser usually identifies the victim as “special” or “different,” not necessarily in a good way. The child may be the result of an unwanted pregnancy or of the “wrong” sex, or may provide a constant reminder of a person that the parent would sooner forget.

Another group of parents at high risk for becoming abusers are those with poor mother-infant bonding from birth. Poor bonding may be caused by the delivery of a preterm infant, multiple infants, or one with a disability who has a prolonged stay in the hospital.

The interaction between the parent and child may be distant, with the child appearing fearful, or the child may cling to or run to the abusive parent for comfort, protection, or support.

The environmental characteristics of an abusive situation often reflect a family in crisis, whether through death, divorce, or financial problems related to unemployment or relocation; the family often is living at or below the poverty level. Both national and international surveys on abuse and neglect reinforce the strong relationship between poverty and child abuse. The most common stressors include mental or physical health problems, alcohol or drug abuse by the parent, and family violence. The current economic crisis due to loss of employment and home foreclosures may mean that the number of children who live below the poverty level will increase, placing more children at risk for abuse.

**Mechanisms of injury**

Accurate documentation of injuries is vital. Document the size, depth, and location of the child’s injuries. When documenting location, use definitive landmarks such as umbilicus, bony prominences, or bones, with accurate descriptors (for example, 2 inches to the right of the umbilicus). Another method is to use the clock face or compass point as descriptors to reduce any confusion regarding location of injuries.

Sharp and blunt injuries are different mechanisms with different distinguishing characteristics. Sharp injuries include cuts (long and relatively shallow) and stab wounds (deep and narrow).

Blunt injuries include four main subdivisions:
- abrasions, including scratches and grazes, in which the outermost layer of skin has been removed by a compression or sliding force. The skin may or may not be broken depending on force and severity of injury.
- bruises (contusions), which result from blood leaking into the tissues after sufficient force has been applied to the area. Young children and infants bruise easily, except for those who have been subject to frequent trauma—scar formation means bruising is less likely to occur.
- tears (lacerations), or blunt injuries to soft tissues that cause tearing, ripping, crushing, shearing, and overstretching. Typically, a laceration has an irregular margin with incomplete separation as the tissue is torn apart by the force of impact.
- bone fractures.

**Identifying possible forensic cases**

The pediatric ICU (PICU) nurse and advanced practice nurse need to know what situations or conditions are likely to require forensic management. Forensic cases include patients whose hospitalizations have medicolegal implications, including injuries or conditions associated with any insurance claim, personal liability, or acts of violence.

Examples of cases that have medicolegal implications include:
Children may be admitted into the PICU because of trauma, with multiple wounds that you’ll need to document accurately. Usually, the history given by the parent and the injuries tell the same story, although you need to maintain a level of suspicion as you interact with the family. Other children are admitted with a history of increasing irritability, hypothermia, poor feeding, vomiting, failure to thrive, and lethargy or a change in sleep patterns with difficulty arousing for normal care. With this history, the child could have sepsis, an inborn error of metabolism, a cardiac defect, or ITBI.

Every nurse, but especially those who work in the PICU, needs to have a high “suspiciousness factor.” This comes from the knowledge and expertise you develop as you care for a number of patients with similar injuries and work with many different families. You develop a sense of knowing when something doesn’t add up about a child’s history, injuries, or relationships with significant others. Using intuition, you should act and remain curious, asking questions until you’re satisfied that the truth has been revealed. If you still have questions, or aren’t satisfied with the answers, talk to the other healthcare providers and, if necessary, notify child protective services as per facility policies; it’s better to be overprotective than to miss an abused child. You have a one-time window of opportunity to observe, question, and listen, which disappears as the child improves, transfers, or dies. During this time, ask questions carefully while observing and listening to conversations between the parents and the child. You can be around the child unobtrusively as you monitor, assess, and provide patient care. No one will question a nurse constantly at the bedside of a sick child in the PICU.

Identifying pattern injury

The mechanism of physical abuse may leave behind a pattern or configuration that can be used to identify how the injury was inflicted. In children, this may include bite marks, hand or shoe prints, and burn injuries. The burns of a child who accidentally falls into hot water or is splashed are different from those inflicted by immersion burns. Immersion burns may appear as a “doughnut” pattern, with the central area spared because the child was wearing a diaper; a “stocking or glove,” with a line of demarcation where the child’s hand or foot was held in the water; or a “tripod” effect if the older child attempts to raise his or her body out of the hot water.

Burns may have patterns that indicate the method used—for example, a cigarette or hairdryer. If a child walks into a lit cigarette, the burn may be on the arms or face, and the child moves away quickly. A cigarette burn

- suicide attempt
- extent or type of history inconsistent with caregiver’s (or patient’s) explanation
- frequent admissions to the PICU or ED
- multiple injuries in various stages of healing
- malnutrition or dehydration
- unusual pattern of injuries (hand imprint, shoe prints)
- evidence of sexual assault
- signs of physical neglect (inadequate clothing for season, unwashed appearance)
- drug toxicity or overdose
- fecal impaction
- nonadherence to medication
- emotional abuse or family discord observed by staff
- trauma or accident victims.

When patients are admitted under any of these conditions, you must assume a forensic role as part of your role as patient advocate. Complete a careful assessment; precise documentation; and, if possible, include photographs of any wounds.

In the PICU

The normal admission route for pediatric patients into the hospital is through the ED into the PICU, although some patients are admitted directly from outlying hospitals through pediatric transports or clinics and physicians’ offices.

As part of its history-taking assessment, the ED will pick up obvious abuse cases, but some may be missed. Whether the patient comes to the PICU through the ED or a physician’s office, the bedside nurse, nurse practitioner, or clinical nurse specialist is often the first person able to complete a thorough head-to-toe assessment of the patient. This intimate exam can reveal a large amount of information regarding history, as well as the current situation in the form of scars, wounds, or abrasions that may require careful forensic assessment and documentation.

Caring for any patient in the PICU requires a multidisciplinary team approach including physicians, advanced practice nurses, nurses, and social workers. Each team member has an important part to play in the health and well-being of the patient and family. Abuse is a family-centered problem that reveals poor parental or caregiver coping skills that affect the entire family. Healthcare providers in the PICU are more comfortable working with families in crisis, as most of the families seen in the unit are in a crisis situation, whether from an intentional or unintentional event or a new diagnosis. A nurse’s vigilance in the PICU can identify cases of abuse that might otherwise be missed.
Another form of patterned injury is bite marks, which are seen as an elliptical or ovoid pattern of ecchymoses, abrasions, or lacerations, as they usually compress but don’t puncture the skin. They’re distinct, and with the use of photography, the perpetrator can be found because teeth leave distinct patterns of injury, often with a central area of ecchymosis. Bite marks also are commonly associated with sexual abuse, so perform a thorough exam of the patient and swab possible bite marks for DNA. Also take photographs of the wounds and document them using body diagrams.

Sexual abuse is found in many forms, including penetration and nonpenetration that may involve the oral or anal orifices. This type of abuse occurs in all socioeconomic levels. The victim’s wounds are most often hidden, and it takes a nurse with good assessment skills and knowledge regarding normal anatomy and physiology to identify the signs and symptoms of abuse. Any bite wounds should send up a red flag. An important point to note about female sexual abuse is that unless the injuries are severe, they heal rapidly. For example, in prepubertal girls, hymenal petechiae disappear in about 48 hours; and in pubertal girls, at 72 hours after abuse. An early exam should be completed on any child thought to be the victim of sexual abuse.

A sexually transmitted infection in a child is a red flag for abuse and should alert staff to investigate further. Children underreport rather than overreport abuse, so if a child claims to have been abused, there is a strong likelihood that the child is telling the truth irrespective of what the parents say. Providing the proof that abuse happened isn’t your responsibility, but you are legally mandated to inform physicians and legal authorities of any suspicions of abuse.

Collecting evidence
Advanced practice nurses need to know the correct method of evidentiary collection, chain of custody, and who to call with questions. Institutions with forensically trained master’s-prepared nurses on staff are able to provide both the education and assistance to staff in busy units who aren’t familiar with the correct methods to collect specimens or who are busy providing lifesaving care and are aware that evidence is being destroyed. Nurses need to work with law enforcement officers to provide care for victims and suspected perpetrators of crimes and to collect evidence obtained in the provision of care. Typically within 24 hours of the child’s hospital admission, the state Department of Health and Human Services (DHHS) assigns caseworkers who work with the family and assess other members of the household.

DHHS also works with the hospital staff, reviewing the case and making legal decisions regarding who can visit, who needs supervision, and how things will be handled so that staff can focus on the patient. Ideally, any medicolegal case should have consistent healthcare providers on consecutive days, as changes in bruises and wounds are more likely to be identified by a nurse who has previously cared for the patient. The continuity of patient care makes interactions with law enforcement and DHHS easier, and also lets family members begin to build a relationship with staff. In the case of an innocent parent, the staff can provide support in a nonjudgmental, nonthreatening manner that lets the parent cope with the situation. This is especially important if the perpetrator is the male in the household, as the female and any other children in the home may have also been abused (or at the very least have watched or heard it occur).

Documentation
One of the most important aspects of patient care and advocacy is accurate documentation. Clear, specific, concise, detailed, and legible notes regarding patient condition, family, and family-staff interactions all need to be objectively detailed. Nursing documentation should record accurate observations, concerns, and treatments provided and should also be a way to communicate significant findings and information. Thorough nursing documentation is a vital part of clinical documentation, allowing for efficient interdisciplinary communication and cooperation.

In an abuse case in England, the reviewer found several areas of concern when auditing the nurse’s paper documentation: illegible records, missing patient identifiers, lacking or unidentifiable signatures, and missing date or time on documentation entries. Computerized documentation automatically adds this information, allowing immediate staff identification and organizing data chronologically. Yet, whether documentation is handwritten or completed on the computer, each method is just a tool and is only as good as the nurse using it. Another problem area of documentation is terminology. Nurses may be unfamiliar with forensic terminology, and
thus any records describing wounds when taken into court cause confusion regarding injury. To reduce any confusion, nurses need education about forensic terminology and preferably the assistance of a forensically trained nurse to ensure that accurate information is placed in the medical record.

Nurses are called to be objective and unbiased witnesses in the court of law, yet most nurses are frightened about the possibility of being called into court. In an abuse or any other case, the testimony you’ll be called to give is based on what you saw, heard, smelled, or palpated. Your best friend is the documentation made about the case in question, as usually several months or years have gone by before the case is called into court. Even if the patient is memorable to you, memory is inadmissible in court unless it’s in writing. Photographs, diagrams, and written words are ways to permanently capture injuries. PICUs should have whole body diagrams and diagrams of more detailed areas including the face and genital area (for both genders) so that the staff can draw and document concisely and accurately what they see.

Save the children
Every child admitted into the PICU deserves nursing care that’s thorough, well-documented, and delivered by a nurse who’s willing to act on intuition when indications are that something about the story isn’t quite right. A child requiring admission into the PICU may be admitted for an unrelated problem and coincidentally found to have signs of abuse. Careful history-taking, initial and ongoing assessment with documentation that’s accurate, detailed, and legible may be the patient’s best chance of attaining safety and the innocent parent being given freedom.

Abuse is a social problem that occurs on a continuum, meaning that verbal abuse may lead to physical abuse or neglect may change to emotional abuse. A parent in crisis or one who experienced these patterns of behavior as a child may not realize that it’s wrong or may not be able to change the patterned behavior toward his or her own children. You don’t need to be a forensic specialist to effectively identify children at risk, but forensic education and increased awareness can help you collect the appropriate evidence and document accurately. By understanding how to care for a child abuse victim, you may be able to stop the “cycle of violence” one life at a time.

REFERENCES


Catherine Lyden is a level III staff nurse at Maine Medical Center in Portland, Maine.


DOI:10.1097/01.NURSE.0000396601.75497.26