

# Managing Child Abuse: General Principles

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Author Disclosure  
Drs Asnes and  
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**Objectives** After completing this article, readers should be able to:

1. Identify their roles as mandated reporters of child abuse.
2. Discuss the approach to evaluating cases of suspected child maltreatment.
3. Know when to become concerned about possible child maltreatment and when and how to seek help in evaluating cases.
4. Recognize the role of the pediatric practitioner in ongoing care of and advocacy on the behalf of maltreated children.

## Introduction

Child abuse is common. In 2007, the year for which the most recent child protective services (CPS) data are available, 3.2 million reports were filed concerning approximately 5.8 million children younger than 18 years of age who were suspected victims of abuse, neglect, or sexual abuse. Also in 2007, 1,760 child deaths were attributed to abuse or neglect. Neglect constituted 59% of all cases of child maltreatment, more than all other forms of substantiated child maltreatment combined. Most maltreatment occurs in children's homes. In 2007, nearly 80% of the perpetrators of child maltreatment were parents.

State laws mandate that pediatric practitioners report suspected cases of child abuse or neglect to local CPS. The process that begins when the clinician first feels concern about a child's welfare and ends when he or she makes a report to CPS is one of the most challenging and disturbing that practitioners must undertake. Because child maltreatment is common, it is likely that all pediatric clinicians will care for abused or neglected children and, therefore, will be obliged to report such children to CPS. For this reason, pediatric practitioners should know and employ a careful, systematic, and thoughtful approach to evaluating all suspected cases of child maltreatment to make the right decision about reporting to CPS.

This article seeks to provide a stepwise approach to thinking about and managing possible child maltreatment. Adhering to the proposed steps should help the practitioner make optimal decisions about reporting to CPS, perform difficult tasks (such as telling a child's parents about a report), and manage the challenging emotions that these cases can generate.

## Step 1: Understand Mandatory Reporting Laws

The first component to this approach is to know and understand mandatory reporting laws. Such preparation is both necessary and helpful to guide best practice in caring for children who may have been maltreated. The mandatory reporting laws state that once a practitioner has reasonable cause to *suspect* that a child has been abused or neglected, he or she is obligated by state law to make a report to CPS. In cases of sexual or physical abuse, CPS usually contacts police to investigate a possible crime. Failure to make a report can result in criminal penalty, action against a practitioner's professional license, or most dire, further injury to or death of a child.

The clinician need not be absolutely certain that a child has been maltreated to make a report to CPS; in fact, waiting for diagnostic certainty can have severe consequences for a child. On the other hand, an investigation by child protection authorities generates significant stress for parents who have not harmed or neglected a child. Taking time to

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gather information thoroughly and think through suspected cases carefully can increase the likelihood of appropriate reports and decrease the likelihood of unnecessary ones.

However, when an allegation of child sexual abuse—as opposed to one of suspected physical abuse or neglect—is brought to the attention of a pediatric practitioner, that practitioner is obligated by mandated reporting laws to convey the allegation to CPS.

Although a child may first disclose sexual abuse to a pediatric clinician, it is considerably more likely that the clinician will hear of a child's disclosure or behavior that led to concern about sexual abuse from an adult caregiver of the child. In this situation, information about what a child said or how he or she behaved should be obtained from the caregiver.

Usually it is not necessary to hear directly from a child about possible sexual abuse. In fact, because what a child says about sexual abuse may be the only evidence that abuse has occurred, it is preferable to refrain from questioning a child until he or she can be interviewed by a professional trained in forensic interviewing techniques. The report of a disclosure of sexual abuse from a child's caregiver should prompt an immediate report to local CPS, even when the pediatric practitioner is not certain that sexual abuse has occurred. The investigation of alleged sexual abuse is undertaken best by both CPS and police to limit the number of times a child is questioned about alleged abuse and to avoid compromising the investigation of a possible crime.

## Step 2: Understand Risk Factors Associated With Child Maltreatment

Poverty, family violence, social isolation, and a household that has many children younger than 5 years of age increase the risk of child abuse or neglect. Parents who have a history of maltreatment as children; those who have mental illness, developmental delay, or substance abuse; and mothers who are younger than 19 years of age at the time of the child's birth are at increased risk of maltreating their children. In addition, children born of undesired pregnancies, those born of multiple gestation (twin) pregnancies, and disabled children (including children who have behavioral and learning problems) are at higher risk of being maltreated.

Taking the time to obtain, update, and document detailed family and social histories with all parents and patients provides a foundation from which to evaluate worrisome physical findings, growth and developmental failures, or other issues of concern that may present during health supervision visits. Gathering such informa-

tion also allows for identification of high-risk families to initiate support services and prevention efforts and help prevent the occurrence of abuse.

Certain patterns of parental behaviors and feelings about children increase the risk of abusive or neglectful behaviors. An example is parents who have inappropriate developmental expectations of their children, such as expecting a newborn not to cry or an 8-month-old infant to be toilet trained. All parents can become frustrated by an infant who cries for hours each day or a toddler who is learning toileting skills. When parents cannot understand their children's behavior as age-appropriate, their frustration may escalate and result in child abuse.

Another example of worrisome parental behavior is a failure of empathy between parent and child or the inability of the parent to understand and participate in the child's emotional experience. It is likely that parents who were not treated with empathy and understanding as children may be at particularly high risk of an inability to show understanding to their own children. Another parental attitude that increases the risk of child maltreatment is the assignment of inherent value to the use of physical punishment. Some families believe that children cannot be brought up successfully without the use of regular spankings or beatings and that to spare such actions will lead to harm.

Finally, parents who reverse parent-child roles and see children as a major source of family comfort are likely to be frustrated and disappointed when faced with the persistent neediness and dependence of children. This mindset also can lead to child maltreatment. Using health supervision visits to learn of parents' feelings about and attitudes toward their children can provide useful information that can be accessed when concerns about a child's welfare arise and can prompt the clinician to implement important family support and prevention services.

## Step 3: Obtain a Careful History and Perform a Thorough Physical Examination

When a child presents with a concerning injury or the clinician begins to suspect neglect, a critical step is to obtain a thorough history and physical examination. In addition to the history of the present illness and past medical history (which may reveal past injuries or evidence of neglect), a complete family and social history should be obtained to provide a framework or context that may explain the injury or suspected neglect. Gathering historical data is particularly important in urgent and emergent settings, when the examining practitioner

does not have the benefit of long-term knowledge of a patient and family that the primary care practitioner has.

When evaluating an injury in a child, it is best for the practitioner to hear exactly what occurred from the parents and witnesses (if possible and only if they were present at the traumatic event). It is imperative to avoid interrupting parents as they relate the history of an event, so their report about what happened is not influenced by the clinician's words or perspective. Once a story is obtained in full, questions for clarification and requests to demonstrate or re-enact events may be useful. However, such questioning should occur only after listening to an initial full explanation.

Crucial additional information may be obtained simply by performing a full physical examination with the child disrobed. Consider an 18-month-old child who presents with a fractured humerus and whose parents report that they have not witnessed a traumatic event. A fully disrobed examination may reveal bruises or other cutaneous manifestations of trauma for which explanations must be sought. Conversely, failing to complete a fully disrobed examination could leave clear signs of physical abuse undetected.

#### Step 4: Seek Out and Use Additional Data

The fourth component of a useful approach to evaluating possible maltreatment is to seek out and use additional data that can aid in establishing the degree of concern about an individual child's presentation. Other sources of data may include an additional interview of an injured child's parents by a different clinician or a social worker, a conversation with the child's primary care practitioner, an examination by an expert (such as a pediatric ophthalmologist), laboratory data (such as coagulation studies), and radiographic studies (such as computed tomography scan of the head).

Consider a 3-month-old infant who has a femur fracture and whose father reports that she rolled from a bed. A radiologic skeletal survey may reveal multiple healing rib fractures. In this case, the decision to report the child to CPS is clear. An interview of the father by a social worker may generate a significantly different history of the child's fall that prompts increased concern for possible physical abuse. A review of a child's medical record (or of his or her sibling's medical records) or a conversation with a primary care clinician may identify a pattern of multiple missed visits or documented social concerns that also may push the practitioner toward a decision to report a questionable presentation.

#### Step 5: Know When to Become Concerned and Use a Clear Approach to Decision-making

Most often, concern about physical abuse is generated by an unexplained or less-than-adequately explained injury rather than by the mere presence of a specific injury. Examples include a 5-month-old infant presenting with unexplained bruises and a 2-month-old infant who has multiple rib fractures and reportedly fell from a mattress 1 foot from the floor. Certain presenting or incidental physical findings always should prompt a consideration of physical abuse. These findings include bruises and oral trauma in children younger than 6 months of age and fractures in nonambulatory infants. Bruising can occur in the setting of a bleeding diathesis, and fractures may be accidental, but abuse must be considered and ruled out carefully when very young children have signs of trauma.

Similarly, the clinician must consider neglect in children who fail to thrive or are developmentally delayed while simultaneously considering other medical explanations for the growth failure. In addition, recognition of a child's developmental abilities is crucial to approaching injuries that may be accidental. Active toddlers who run and play can sustain fractures in many ways. Five-month-old infants who cannot sit alone, crawl, or "cruise" are much less likely to sustain fractures under their own power, but can be injured if a parent falls while carrying the child.

After performing the examination, obtaining an explanation for an injury, and gathering additional data, the practitioner must answer questions related to the mechanism, severity, and timing of injury. First, does the history obtained from parents include a reasonable *mechanism* to explain the child's injury? For example, a 3-month-old child who presents with bruises and multiple fractures and whose parents report a single fall from a bed 2 feet from the floor raises concern about the adequacy of the stated mechanism of injury to explain the child's physical findings.

Second, does the history obtained from parents make sense in terms of the *severity* of the injury? When parents state that a 7-month-old who has seizures, a subdural hematoma, and retinal hemorrhages banged his head on the side of his crib, the history is insufficient to explain the severity of the child's presentation and should cause significant worry.

Third, does the history offered adequately explain the injury with respect to *timing*? A 2-year-old child who is brought for medical attention after a reported fall down stairs but is found to have fractures in various states of

healing has evidence of older, unexplained trauma that must be investigated for suspected abuse.

Lack of an appropriate explanation for serious injury in a child always must raise the practitioner's concern for possible child abuse. In addition, when different parents or witnesses offer significantly inconsistent histories of a reported traumatic event or when individuals offer multiple descriptions of a single traumatic event, child abuse must be considered. Keep in mind, however, that inconsistencies in histories can occur when different people ask questions in various ways and when parents have less than a full understanding of what is being asked. Use of interpreter services with non-English-speaking families is crucial, as is a sense of any cognitive limitations in parents that may affect their understanding of the questions asked.

Employing a framework to help evaluate the child's presentation is helpful when considering an injured child or a child who may have been abused or neglected. All clinical presentations fall along a continuum between those presentations consistent with abuse or neglect and those that can be explained by accidental mechanisms, medical problems, or birth injuries. Graphically, this can be represented by Leventhal's Triangle (Fig. 1). Each side of the Triangle represents a continuum between: 1) an abusive injury and an accidental or medically explained injury, 2) neglect and an accidental or medically explained injury, and 3) an abusive injury and an injury that occurred through neglect. A line can be drawn through the Triangle that represents the point at which an injury or presentation suggests maltreatment and warrants a report to CPS. If a child's presentation along one side of the Triangle falls below the line, a report to CPS is indicated. If the presentation falls above the line, referral is not necessary.

Each injury can be located along the side of the Triangle. For example, a 9-year-old child wearing a bicycle helmet presents to the emergency department (ED) with a fractured wrist after a fall from his bike. The child is verbal and describes what happened: "I took the turn too fast and fell off of my bike." With this history, the child's presentation on the Triangle (Fig. 2) does not warrant a report to CPS.

The injury suffered by a 9-month-old child who has a linear parietal skull fracture after a witnessed fall from a bed falls along the continuum between an accident and neglect (Fig. 3). A report to CPS is not indicated. More careful supervision likely would have prevented the injury. Although it does not reach a level of reporting for neglect, this injury offers an opportunity for the clinician to educate the caregivers about supervision and injury prevention.

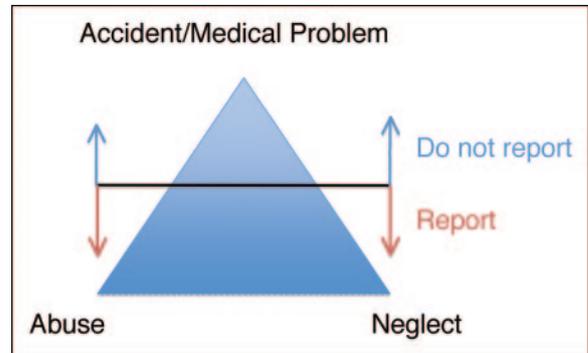


Figure 1. Leventhal's triangle.

The Triangle may be helpful when the clinician evaluates possible neglect by placing a single injury in the context of other child and family factors. When considering a diagnosis of neglect, the practitioner must take into account a pattern of parental behavior. If history-taking for the 9-month-old child who experienced a witnessed fall from a bed and a fractured skull reveals that the child has been injured in two previous falls from the bed, the same injury could be represented differently (Fig. 4), and a report to CPS should be made.

Other factors in the history might influence the placement of the injury along the line. For example, if the mother of the 9-month-old infant who sustained the skull fracture has alcohol on her breath at 8:00 AM when the child is being evaluated, the clinician would be more worried about neglect (or abuse). In this instance, the injury is placed well below the reporting line, and a report to CPS should be made. It is important to remember that injuries happen in a context, and the context influences both how clinicians evaluate an injury and where the designation of the injury should be placed on the Triangle.

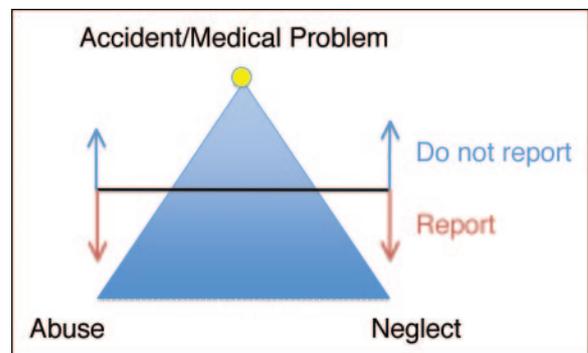


Figure 2. Child states, "I took the turn too fast and fell off of my bike."

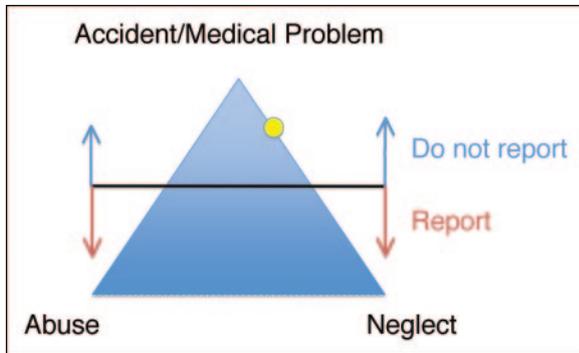


Figure 3. Child has a linear parietal skull fracture after a witnessed fall from a bed.

Many pediatric practitioners struggle with how to handle parental use of physical punishment. Although the American Academy of Pediatrics is clear in its evidence-based opposition to the use of physical punishment, most states allow for some degree of physical punishment within legal limits. The Triangle may be adapted slightly to help the clinician determine whether a child has been physically disciplined or has been abused. If Accident/Medical Problem at the top of the Triangle is replaced with Acceptable Parental Behavior, the Triangle may be used to consider whether a child has been treated within the spectrum of acceptable behavior. For example, a 2-year-old child who has been spanked lightly on clothed buttocks for playing with the stove may be placed in the triangle as in Figure 5. No report is made. In contrast, the same 2-year-old child who has been punched in the stomach for having a toileting accident would be represented differently (Fig. 6) and a report to CPS made.

### Step 6: Know When and How to Get Help

Even after careful consideration and application of the decision-making tools described previously, the clinician

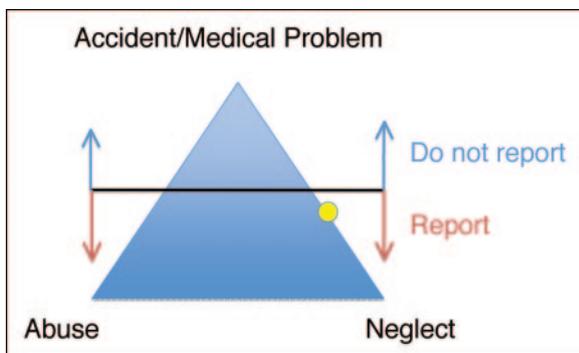


Figure 4. Child has third witnessed fall from a bed.

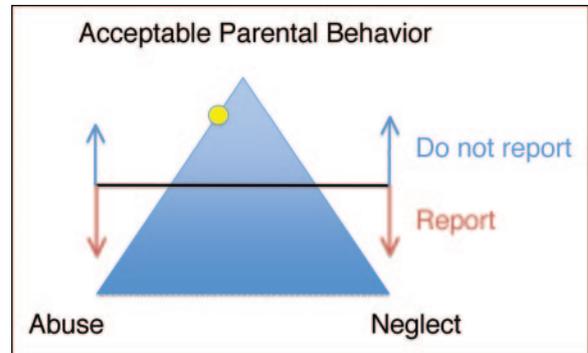


Figure 5. Two-year-old child who has been spanked lightly for playing with the stove.

may not yet be clear about whether to make a report to CPS. For this reason, the sixth step is knowing when and how to get help. Such help may be obtained from key support staff such as social workers or nurses. Obtaining a careful family and social history in the setting of a busy ED is a challenge; working with a social worker may allow the gathering of important information to help the practitioner decide whether to report an injury. Information should be gathered in four key areas: exposure to violence, substance use or abuse, mental health, and previous CPS involvement. Nurses may witness parents attempting to “get their stories straight” and should be asked about what they have observed; nurses often make important observations about parent-child, parent-sibling, and parent-parent interactions.

When available, a pediatric child abuse expert can be a valuable resource for cases in which a decision to report to CPS is particularly difficult. Such experts may be available for telephone consultation, to review photographs and radiographs, or to evaluate children personally. They can offer extremely useful input in difficult cases.

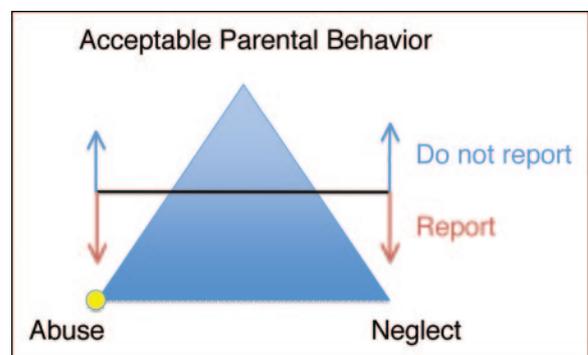


Figure 6. A child punched in the stomach for having a toileting accident.

Confronting possible child maltreatment can generate multiple emotions in the clinician, including anger, sadness, disgust, and anxiety. It may be helpful for the practitioner to discuss worrisome cases with a trusted partner or senior clinician, so that such emotions may be identified, supported, and managed. Consultation with another person can provide support to the clinician and may prevent difficult emotions from interfering with his or her ability to act in the best interest of the children for whom he or she cares.

### Step 7: Consider Hospital Admission

Arranging an inpatient evaluation for a child who appears to have been abused or neglected may be especially helpful. Admission may allow the input of pediatric specialists (including child abuse experts, orthopedists, hematologists, and trauma specialists) and simultaneously provide immediate safety for the child while a decision about reporting to CPS is made. In situations in which a practitioner is especially concerned, transportation by ambulance may be arranged from the primary care setting to the hospital. If parents refuse to comply with a suggested evaluation in the ED or inpatient unit, local law enforcement may need to be notified. If the practitioner does not opt for hospital admission, careful follow-up must be assured and current contact information for the family confirmed in addition to mandatory CPS notification about possible abuse.

### Step 8: Remember That a Child May Have Siblings

Hospital admission may secure the safety of an individual child, but that child may not be the only one at risk. The eighth component of a successful approach is to remember that an abused child may have siblings or live in a household with other children, a circumstance that may accelerate the timing of a report to CPS in less clear cases. When a child is an only child, time may be taken during a hospitalization to gather and weigh facts before making a report. When a child has siblings who remain in the care of possibly abusive or neglectful parents, however, an immediate report of suspected maltreatment is warranted.

### Step 9: Tell Parents When a Report is Made

Once the clinician decides to report a child to CPS, the next challenge is when, where, and how to tell the child's parents. Many practitioners identify the act of telling a child's parents that a report to CPS has been or will be made as being among the most difficult tasks they face. However, the person making a report (or causing a report to be made) is the best person to inform a child's

parents about it. It may be helpful to recall the mandatory reporting laws when communicating with parents about a report to CPS. Remembering that a legal mandate goes into effect when concern for a child is raised (and communicating that legal obligation) may help the practitioner face the challenging task of informing parents of his or her suspicion of abuse.

It is acceptable and advantageous to assure a child's safety first, but there should be no additional delay in telling parents about a report beyond the time that a child's safety is assured. Hospital admission (Step 7) may be employed best in this setting. For example, an infant presenting with multiple bruises may be safest if sent directly to the ED or inpatient unit before his or her family is informed about a report to CPS. The conversation may take place in the hospital with the support of available hospital services, such as on-site social workers and security personnel.

Deciding how to tell parents that the report will be made is a particular challenge to primary care or subspecialty practitioners who have longstanding relationships with the children and families. A CPS report is likely to be perceived as a severe threat to a partnership between the clinician and the family that may have been built over a period of years. Remembering the mandated reporting law once again may be helpful. The practitioner should recall that the law must guide his or her actions, which can be stated to parents.

For example, consider a 4-month-old child found to have bruises over her face and ears during a health supervision visit. Bruising in this age group is never normal, and although it may be the presenting sign of a bleeding diathesis, the bruising may have been caused by trauma. This infant may be sent to the ED for simultaneous evaluations of a possible bleeding problem and possible abuse. Because abuse is suspected, a report to CPS should be made. Once the child's safety is assured, her parents may be told that because her bruising could represent possible child abuse, state law mandates a report to CPS.

The practitioner may say something such as, "Whenever we see bruises like this in an infant, we have to worry about possible abuse. When that happens, I am mandated by state law to make a report to child protective services." Parents then can be assured that the practitioner will maintain contact with the family and continue to be a source of support while the CPS investigation progresses: "I will stick with you throughout this process and answer any questions along the way."

Parents also can be assured that other, possibly medical, causes of a child's presentation will be ruled out

scrupulously by the practitioner even as the CPS investigation proceeds. The anxiety that can be generated by reporting suspected maltreatment may cause the practitioner to distance him- or herself from a child and family after making a report. Ongoing communication with families, however, such as the delivery of the results of laboratory and radiographic tests, must be preserved, even when these results increase the practitioner's concern about abuse.

### Step 10: Continue to Advocate and Care for the Child and Family After Making a CPS Report

Although making a report to CPS for a child may feel like the final step in an assessment process, it should not be so. The practitioner should make every effort to continue to advocate for children and families after making a report to CPS. This action comprises the tenth and final step in a successful approach to managing suspected child maltreatment. An understanding of what is likely to happen after a CPS referral can help the practitioner provide support to families.

The pediatric clinician provides and interprets medical data to CPS personnel and to the investigating law enforcement officers. Police detectives and prosecutors who seek to determine if a crime has been committed may have particularly challenging questions. They may request an ironclad diagnosis of abuse, ask the practitioner to explain exactly what mechanism led to a child's injuries, or ask the clinician to "time" the injuries definitively. It is important to remember that the answers to these questions may not be available immediately (because a medical evaluation is ongoing) or that they may never be available (identification of an exact mechanism of injury and specific timing of injuries may not be possible).

When speaking with law enforcement personnel, the clinician should be guided by adherence to what can be said with certainty and avoid speculation. Medical terminology also should be explained carefully to both law enforcement and CPS personnel. The practitioner should take time to explain a child's medical findings in clear, jargon-free language to CPS personnel as they work to determine a safe disposition for the child and to law enforcement personnel as they seek to identify, investigate, and prosecute possible crimes.

Only a fraction of CPS reports result in removal of a child from his or her home. Removal is most likely to occur in cases of suspected serious injury or serious neglect. Even when removal occurs, reunification is always a goal and is considered in every case. Many families who are reported to CPS do not lose custody of their

children; instead, they receive services through the auspices of CPS. For example, the infant of a depressed mother who has failed to thrive because of caloric restriction may remain with his or her parents if intensive services, including mental health care, can be provided. Removal is an option of last resort and is used only when a child's safety cannot be assured.

When CPS decides that a child's safety is in imminent danger because of suspected abuse or neglect, the agency has two means by which to obtain custody of a child. The first is a temporary custody order. To obtain a temporary custody order, CPS must present evidence to a judge in court (called juvenile, family, or dependency court in different states) that a child's safety is at continued imminent risk. If the temporary custody order is granted, CPS takes temporary custody of the child, and a future court date is specified, at which time the judge hears additional evidence and reevaluates whether to continue custody with CPS or reunite the child with his or her parents (with or without specified services). At the hearing, evidence is presented by a CPS attorney and attorneys for the individual parents and the child. In some states, the child is assigned a guardian *ad litem* who tries to understand the child's situation and advises all involved parties about what would most benefit the child.

The second option is used on weekends, holidays, or after work hours, when a judge is not available. In this situation, CPS still may take temporary custody of a child for several days under what usually is called a "hold." In Connecticut, this period is 96 hours, but the duration of the hold may vary from state to state. Within whatever time frame a given state prescribes for a hold, CPS must go to court to provide evidence about the reason the hold was invoked and the necessity that the child not be allowed to be cared for by his or her parents.

For both a temporary custody order and a hold, CPS usually requests that the practitioner caring for the child or consulting on the case provide documentation (often in the form of an affidavit) describing, in lay terms, the child's medical condition, the types of injuries seen, and the reasons that abuse or neglect is suspected. In addition, the documentation states that the child's safety is at imminent risk if he or she is allowed to return to the home.

Many practitioners identify a concern about what may happen to children after a CPS report is made as a reason for choosing not to report suspected maltreatment. Concerns about the CPS underreacting (failing to substantiate a report) or overreacting (seeking removal of a child not believed by the clinician to be at high risk) often are cited as barriers to reporting to CPS a worrisome injury or behavior. It is helpful to remember that CPS investigators often have

far more information at hand than the medical practitioner. For example, the parents of an infant suspected of being a victim of neglect may have had other CPS reports in the past that resulted in out-of-home placements of children. The parents may not share this information with the primary care practitioner. Similarly, CPS investigators routinely perform home visits that can offer a wealth of information. Odd mechanisms of injury that may prompt practitioner concerns may be confirmed when the parent re-enacts the event at the site where the injury occurred. On the other hand, home investigations may reveal inadequate resources to care for children far beyond what the practitioner may have imagined.

A particular challenge occurs when a clinician is extremely concerned about a child and makes a report, but CPS fails to substantiate abuse or neglect and closes the case. This outcome may occur for a variety of reasons. A child who disclosed sexual abuse may retract the disclosure in the face of family pressure. An infant who has missed many continuity appointments but has no specific medical problem may not be judged to be at risk by CPS investigators. An unsubstantiated report to CPS does not mean that abuse or neglect did not occur. When a report is unsubstantiated and the degree of worry is high, the practitioner should be reminded that additional reports may be filed in the face of new or ongoing concerns.

In addition, a concerted effort on the part of the practitioner to speak directly with a CPS investigator or supervisor about concerns is likely to make a powerful contribution during an investigation. Many practitioners feel that the only call possible is the initial report to CPS; in fact, continued discussions with the CPS personnel investigating alleged maltreatment are both possible and extremely useful.

Similarly, when a practitioner believes that CPS has overreacted in its handling of a report, continued advocacy is possible. The practitioner may reach out to CPS in an effort to share observations about a parent's strengths that may encourage authorities to consider keeping a child in the care of his or her family, perhaps with additional support. In either case, the practitioner may serve the children in his or her care best by continuing to provide advocacy long after making a first report to CPS.

If a child is placed in foster care as a result of a CPS report, the practitioner may continue to advocate for that child and offer the services of a medical home if he or she continues to provide primary care to the child and the foster family. Even if this arrangement is not possible, as is the case when a child is placed with a family who lives too far away from the practitioner's office, the practi-

tioner can ease a child's transition by making medical records available to the newly identified clinician.

Although the foster care system offers safe haven for abused and neglected children, it is not a perfect solution. Even children who have been maltreated suffer consequences from being removed from their parents' custody. Unfortunately, some children may suffer harm, including abuse and neglect, in foster care. The ongoing care of a concerned pediatric clinician can offer continuity to children who may benefit greatly from it.

## Summary

- The management of child maltreatment is never easy, but considering and reporting suspected cases of child abuse and neglect are important clinical skills and obligations of a pediatric clinician.
- Use of the stepwise approach and the conceptual framework set forth in this article is likely to help the pediatric practitioner move from concern to action in a way that assures children's safety and also serves families best.
- The clinical approach described in this article is based not on research evidence, but rather on the practical experience gleaned from years working as pediatric experts in child abuse.

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## PIR Quiz

Quiz also available online at <http://pedsinreview.aappublications.org>.

1. Which of the following statements regarding the reporting and investigation of suspected child maltreatment is true?
  - A. Allegations of child sexual abuse should be reported to the police and CPS only if physical evidence of abuse is present.
  - B. If a health-care practitioner suspects child maltreatment but does not report it to CPS, his or her medical licensure could be at risk.
  - C. In cases of suspected child sexual abuse, the family, rather than the health-care practitioner, is responsible for filing a report with the police.
  - D. Investigators should interview children for whom parents allege sexual abuse as many times as possible to be sure to get an accurate history.
  - E. To be protected by the law, health-care practitioners should wait until they are certain that child maltreatment has occurred before reporting it to CPS.
2. Which of the following conditions always should prompt the health-care practitioner to strongly consider child maltreatment or abuse?
  - A. Bruises on the abdomen of a 5-month-old girl who has no reported history of trauma.
  - B. Bruises on the anterior legs of a 2-year-old boy who has normal development.
  - C. Failure to thrive in an infant who has large, bulky stools and noisy respirations.
  - D. Fracture of the tibia in an 18-month-old girl who just learned to walk.
  - E. Linear skull fracture in a 10-month-old girl who was dropped from her parent's arms in a fall.
3. You are evaluating an 11-month-old boy for decreased right arm movement. His mother is extremely upset and reports that he fell from her bed after a nap that morning. Except for bruising and pain over his right upper arm, his physical examination findings are normal, and his development is consistent overall with that of a 7-month-old. He is just beginning to support his weight on his legs. A skeletal survey reveals an acute fracture of his right humerus and two healing fractures of the left ribs. His mother states that she is unaware of the rib fractures and denies previous trauma. Which piece of information is *most* likely to prompt an additional evaluation and report to CPS?
  - A. Acute injury inconsistent with the history given by the mother.
  - B. Developmental delay of unclear cause.
  - C. Fracture of an extremity in an infant younger than 1 year of age.
  - D. High distress level in the mother.
  - E. Presence of old healing fractures.
4. You suspect neglect in one of your clinic patients, who has severe failure to thrive and some unexplained bruises, and you file a report with CPS. Which of the following techniques for disclosing this report to the family should be employed?
  - A. Admit the child to the hospital and ask the hospital social worker to tell the family.
  - B. Advise the family that you are unable to participate further in the child's care.
  - C. Refer the child to a child abuse specialist so that he or she can explain the process to the family.
  - D. Tell the family that you are obligated by law to report the case but that you will fully investigate other causes for the child's symptoms.
  - E. Wait to tell the family about the report until all organic causes have been ruled out.

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