Child abuse and neglect

Child abuse and neglect - Z61.4, Z61.5, Z61.6* (Clinical term: Child abuse ZV612) *This is the coding for sexual and physical abuse; neglect and emotional abuse are not specifically coded under the current ICD-10 classification.

Presenting complaints

Abuse is not usually presented as the problem. Instead, children present with complaints that are the sequelae of abuse or neglect. Most of these are psychological or behavioural, some are physical.

Recognition and diagnostic features

Four forms of maltreatment are recognized:

- neglect - the persistent failure to meet a child's physical and psychological needs by lack of supervision or provision (N)
- physical abuse and non-accidental injury (which includes fabricated or induced illness) (PA)
- sexual abuse (CSA)
- emotional abuse (EA).

Different forms may lead to different sequelae, but there is often co-occurrence of more than one form. All forms include some element of emotional maltreatment, but emotional abuse may occur on its own.

Children with disabilities are particularly vulnerable. Children of all ages may experience abuse and neglect.

- Physical neglect and emotional abuse often continue from early childhood
- Physical abuse in infancy may cause serious injury and occasionally death or lasting disability. Later in childhood, it is associated more with inappropriate and harsh punishment.
- Sexual abuse is more common in adolescence and in girls, although young boys are also abused.

Child abuse and neglect are recognized by:

- ill-treatment that the child receives (including both omission and commission). Neglect and emotional abuse are observable forms of ill treatment
- harm arising from the abuse or neglect.

During routine or unrelated medical examinations, children may be found to have signs of the results of child abuse and neglect. Occasionally, an injured child may be brought for treatment.

Signs of physical harm:

- Multiple superficial injuries of varying ages, for which no reasonable explanation is give - for example bruises (which may resemble the shape of the article used to inflict the bruise), abrasions, cuts or cigarette burns (PA).
- Fractures - rib, metaphyseal and spiral fracture; skull in non-ambulant children (PA).
- Retinal and subdural haemorrhages in non-ambulant children (PA).
- failure to thrive and short stature (EA; N).
- Poisoning, asphyxiation (PA - induced illness).
- Delayed or no immunizations (N).
- Untreated medical conditions (N).
- Sexually-transmitted diseases (CSA).

Indicators of psychological harm:

- Depression - F32# (CSA).
- Anxiety (recent onset) (EA; CSA).
- low self-esteem (PA; EA; CSA).
- Post-traumatic stress disorder - F43 (adult) (CSA)
- Conduct or oppositional-defiant disorder - F91 (PA) (EA)
- Sexualized behaviour inappropriate to age and stage of development (CSA).
- Deliberate self-harm (CSA).
- Substance misuse - F10, F11# (CSA).
- Educational underachievement (N; EA).
- Social isolation (EA).

Recognition of sexual abuse ultimately relies most strongly on the child's verbal disclosures or descriptions. The reliability and credibility of a child's descriptions are often closely scrutinized and challenged, despite the fact that false allegations are rare. Most cases of child sexual abuse have no physical signs and, when found, are rarely conclusive proof of abuse, being regarded as (only) compatible with the child's account of sexual abuse.

Differential diagnosis

Child abuse and neglect is often disputed or denied by the parents or alleged abusers. There may well be a delay in presentation of the child to a doctor, and the history/explanation might be inconsistent, changing and not compatible with the injury or child's development.

Some forms of ill-treatment are readily observable:

- Neglect with lack of supervision leading to accidents or lack of hygiene and provision of basic care
- Emotional abuse, including frequent negativity towards, and excessive punishment of, the child.

What may be in dispute is the extent to which these forms of parent-child interaction are actually harming the child and qualify for the term 'abuse'.

None of the list of possible presentations is caused exclusively by child abuse or neglect, although some patterns of physical injury (eg certain fractures, bruises, retinal and subdural haemorrhages, genital and perianal signs) are strongly suggestive or typical of abuse. They require immediate intervention to safeguard the child, and expert validation.

It is important to exclude likely alternative explanations for the child's difficulties. Mental ill-health of the parent or suspected abuser, or their mental ill-health, substance abuse or domestic violence are risk factors for child abuse and neglect. However, not all troubled adults are responsible for child abuse and neglect.

Essential information for patient and family

- Everyone, particularly those in a professional role, has a responsibility to report any concerns.
- Professionals must work together in partnership with the family to protect the child(ren); there may be a need to override confidentiality in the interests of interdisciplinary communication.
- The child is not responsible for the abuse.
- Child protection procedures and the statutory centrality of Social Services should be explained.

General management and advice to patient and family

(ref 256)

Sharing information and reporting:

- Follow local ACPC (Area Child Protection Committee) guidelines
- If in doubt about possible child abuse and neglect, discuss with health visitor and named or designated doctor in the primary care team
- If suspicious or likely child abuse and neglect, report to Social Services.

Immediate treatment:

- Few children require immediate medical or psychiatric treatment. Exceptions are those who have been seriously injured, infected with a sexually-transmitted disease, are pregnant, or those acutely traumatized by the abuse.

Multidisciplinary response:

- The first step is to determine whether the child and other children in the family need immediate protection. The closer the relationship between the non-abusing caregiver(s) and the (suspected) abuser, the more precarious the position of the child. The term 'close' includes love, fear or dependency.
- This requires a multidisciplinary assessment, led by Social Services usually in collaboration with other agencies - health, police, voluntary organizations (eg NSPCC).
- A strategy discussion may be followed by a Child Protection Conference (CPC). It is important that the GP attends the CPC or sends a report of salient information about the child and family
- ensuring protection may require an emergency protection order and placing of the child's name on the Child Protection Register with a protection plan and sometimes through court proceedings

Supporting the child and family:

- Acknowledge the crisis and distress that investigation and intervention cause to the child and family.

- Acknowledge that there may be conflicting interests between the needs of the child and those of the parents.
- Explain that in law (Children Act 1989) the child's welfare is paramount.
- Facilitate meaningful contact for the child with trusted and familiar persons who are supportive of the child's needs.
- Support the child who discloses abuse not to feel responsible for the abuse or guilty about disclosing it. Beyond the needs of the medical history taking, do not question the child about the concern and do not make unrealistic promises.
- Actively support the non-abusing parent(s), who is often very distressed and who may feel torn between the abuser and child.
- Help the parents to accept that acknowledging responsibility for the maltreatment is a difficult, painful but necessary process in order to achieve positive change for the child and family.

Treatment:

- The GP must ensure treatment is provided for children whose names are not on the Child Protection Register and for whom there is therefore no protection plan.
- A comprehensive treatment plan includes help for the child, the non-abusing caregiver(s), siblings and the abuser.
- Parents may require parenting work and considerable social support. Such help often needs to be maintained for long periods, as change may not be sustained after a short but intensive course of intervention.
- Many abused children require educational remediation for their associated educational underachievement
- Treatment for the child depends on the nature of the maltreatment and the sequelae; there is no unitary post-abuse syndrome, not even following specific forms such as sexual abuse. Treatment needs to be based on an individual's needs at any given time and may be given in groups or individually.
- Group therapy is not appropriate where a case is subject to a criminal inquiry that may result in criminal court proceedings (ref 257).
- Cognitive behavioural therapy is effective for PTSD and sexualized behaviour
- Treatment should be given for Depressive disorder - F32, Substance misuse - F10, F11 and Deliberate self-harm which often develop in adolescence.
- As well as emotional and behavioural difficulties, some maltreated children undergo social disruption as part of the necessary protection process. They experience considerable difficulties arising from separations and impermanence and require active support through this process
- Some children require more intensive psychotherapy for the effects of the abuse.

References

256 Bannon MJ, Carter YH. The Role of Primary Care in the Protection of Children from Abuse and Neglect. A joint position paper with the Royal College of Paediatrics and Child Health and endorsed by the NSPCC. London: RCGP Publications, 2003.

257 Home Office/CPS/Department of Health Practice. Guidance Provision of Therapy for Child Witnesses Prior to a Criminal Trial. URL http://www.doh.gov.uk/scg/therapy/therapybooklet.htm

Liaison and referral

Treating agencies include social services, family centres, child and adolescent mental health services, adult mental health and substance misuse services, and voluntary agencies (eg the NSPCC).

Resources for patients and families

NSPCC (National Society for the Protection of Children) 0808 800 5000 (24-hour child protection helpline)
Email: help@nspcc.org.uk; website: http://www.nspcc.org.uk
This is a charity specializing in child protection and the prevention of cruelty to children.

ChildLine 0800 1111 (24-hour helpline)
Website: http://www.childline.org.uk
A telephone service for all children and young people providing confidential counselling, support and advice on any issue. Parents can also write to ChildLine.

Like it is
Email: likeitis@stopes.org.uk; website: http://www.likeitis.org.uk
Sex education for young people.

Youth2Youth 020 8896 3675
Email: help@youth2youth.co.uk; website: http://www.youth2youth.co.uk
Telephone, email and online chat line run by young people for young people.

Ask Brook 020 7284 6040
Email: admin@brookcentres.org.uk; website: http://www.brook.org.uk
Provides free and confidential sexual health advice and contraception to young people up to the age of 25
Leaflets are available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk):
Domestic Violence: It's Affects on Children, Child Abuse and Neglect: the Emotional Effects

A leaflet is available from the Royal College of General Practitioners (http://www.rcgp.org.uk):
Domestic Violence in Families with Children