Child Maltreatment: Physical (United States)

Description/Etiology
In the United States, physical maltreatment is the second most frequently reported form of child abuse, after neglect. Physical maltreatment is any intentional physical harm of a child by a caregiver. It rarely consists of a single incident and instead often takes the form of a persistent pattern of physical abuse, which likely includes other types of maltreatment such as neglect. Social workers and other professionals who work with children are mandated to report physical maltreatment to child protective services (CPS). Those who are mandated to report and what must be reported vary from state to state.

The psychosocial impact of physical maltreatment on children includes a range of mental health problems, including depression, post-traumatic stress disorder (PTSD), anxiety disorders, substance abuse, eating disorders, and delinquency. Children who are physically maltreated may develop cognitive and learning difficulties, experience developmental regression and disturbed attachments, and have problems regulating their emotions. They may have poor impulse control and increased risk-taking. The biophysical consequences may include brain injury, retinal hemorrhages, burns, bone fractures, neurological damage, and growth delays; physical maltreatment may be fatal. Both young children and adolescents are vulnerable to maltreatment. Adolescent maltreatment is underreported, however, because adolescents are not perceived to be as vulnerable to abuse or neglect.

Perpetrators of physical maltreatment are most likely to be the child’s parents or primary caregivers. Poverty, unemployment, dysfunctional relationships, substance abuse, high parental stress, lack of parent efficacy, and poor mental health characterize the lives of families in which maltreatment takes place. Intimate partner violence (IPV) frequently is present in families in which child maltreatment occurs. Researchers have found that parents who maltreat their children have less empathy and warmth toward them; in addition, they often endure considerable relational conflict with those around them and have deficits in their social coping skills.

Initial interventions focus on the safety of the child and are determined by CPS; they may include removing the child from the home. The detrimental effects of separating children from their parents/caregivers have led to the introduction of home visitation programs over the last three decades. These programs educate parents about their responsibilities, supervise their parental conduct, and monitor the family. They can be combined with education classes to address deficits in parenting skills. In addition, volunteer child advocates are appointed by courts to focus on single CPS cases; they establish a supportive relationship with individual children in the welfare system and their efforts have proven to be successful in reducing some of the psychosocial impacts of maltreatment.

Facts and Figures
The most recent CPS data indicate that 16.6% of all reported cases of child maltreatment are reports of physical abuse (American Humane Association, n.d.). Bruises are the most common symptom of physical maltreatment of children. It is estimated that 1,500 children die from physical maltreatment each year in the United States (American Humane Association, n.d.). Data indicate that maltreatment occurs more frequently than is reported.
Risk Factors
Environments in which a young and/or single parent/caregiver is living with poverty, unemployment, divorce, relational dysfunction, social isolation, IPV, mental health problems, and/or substance abuse put children at risk of physical maltreatment. Whenever any of these conditions is present, there is a risk of abuse. Younger children in families living below the poverty threshold are especially at risk. Families with a history of maltreatment or substance abuse, or in which parents lack knowledge about normal child development, present a risk to children. Premature and/or colicky infants, children with physical or mental disabilities, and children with chronic medical conditions are at higher risk. Children from birth to age 1 are at the highest risk for abuse (U.S. Department of Health and Human Services, 2012).

Signs and Symptoms/Clinical Presentation
Physical signs can be hidden if they are on areas of the body covered by clothing or have healed, but signs include burns; bites; scratches; bruises; broken, fractured or dislocated bones; rope burns; and facial and head injuries. There may be frequent absences from school. A child may appear frightened of his or her parents/caregivers and protest or cry when a social worker leaves him or her with them. A child may show fear when adults approach or may disclose physical maltreatment. Parents/caregivers may provide an explanation that is inconsistent with the extent of the child’s injuries and/or provide conflicting accounts of how the injuries occurred. They may describe the child in very negative ways and believe in the use of harsh physical discipline.

Social Work Assessment
› Client History
  • Social workers suspicious of physical maltreatment of a child should conduct an interview with the parents, although direct questions about maltreatment may result in denial. Ask the parents to describe their child, what they like about their child, and what activities they enjoy sharing with their child. Questions about parental approaches to solving conflict and disobedience may be useful. A biopsychosocial/spiritual assessment, inquiring about family history, any maltreatment, and the child’s medical and developmental history, can also be conducted
  • It can be helpful to interview the child without the parents, caregivers, or the suspected abuser (if not the parents/caregivers) present. Training in interviewing children is advisable. Sensitivity is critical, and the child must be believed. Conduct the interview in a safe, private, and comfortable environment and use age-appropriate, open-ended questions and the child’s colloquial language. If possible, identify whom the perpetrator is during the interview, and photograph any injuries and/or make notes of their size, location, and color

› Relevant Diagnostic Assessments and Screening Tools
  • Screening for child maltreatment may be administered utilizing the following tools: Child Abuse Risk Assessment Scale (CARAS); ISPCAN Child Abuse Screening Tool, Children’s Version (ICAST-C); North Carolina Family Assessment Scale (NCFAS-G); Child Well-Being Scale; the Juhnke, Henderson, Juhnke Child Abuse and Neglect Risk Assessment Scale; eco-maps

› Laboratory and Diagnostic Tests of Interest to the Social Worker
  • Individualized testing, X-rays, CT scans, and MRI may be required to determine injuries

Social Work Treatment Summary
Interventions commonly utilized in the United States emphasize prevention through home visitation programs with parenting skills training as a feature (Guterman & Taylor, 2005). One program demonstrated success using home visitations and regular cell phone contact in conjunction with classes. Weekly visits, regular calls, and text messages twice a day to “prompt and reinforce” the training help achieve success (Bigelow et al., 2008). Home visitations along with mental health treatments have been shown to reduce the incidence of recurrence (Jonson-Reid et al., 2010). Therapies involving the child and/or the entire family can have positive outcomes (Oliver & Washington, 2009). Families often require a range of services and support from various agencies because of the prevalence of coexisting problems. Often it is necessary for parents to receive services for their own issues (e.g., substance abuse, intimate partner violence) before parenting skills interventions can be effective (Pecora et al., 2014). Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.
<table>
<thead>
<tr>
<th>Child has physical signs that may be a result of maltreatment</th>
<th>Establish foundation for suspicions</th>
<th>The social worker should report the case to CPS or call CPS to informally discuss it. An interview with the child may help gather more details on the suspected maltreatment</th>
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</thead>
<tbody>
<tr>
<td>Social worker suspects physical maltreatment</td>
<td>Establish foundation for suspicions</td>
<td>The social worker should report the case to CPS (see above) or call CPS to informally discuss it. An interview with the parent or parents can gather more details on the suspected maltreatment</td>
</tr>
<tr>
<td>Physical maltreatment of a child is confirmed and the child still resides in the home with his or her family</td>
<td>Prevent further maltreatment</td>
<td>The social worker must report the case to CPS. If the child has physical injuries the social worker may need to contact law enforcement to report the abuse. Medical, financial, and therapeutic services and parenting classes will likely be needed along with regular home visits and phone contact</td>
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Applicable Laws and Regulations

› Social workers in the United States are mandated to report child maltreatment. Details on each state’s child abuse statutes are available at the U.S. Department of Health and Human Services website, [http://www.childwelfare.gov/systemwide/laws_policies/state/](http://www.childwelfare.gov/systemwide/laws_policies/state/)
› The Child Abuse Prevention and Treatment Act (CAPTA) is one of the key pieces of legislation in the United States that guides child protection and addresses abuse and neglect of children
› Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) and practice accordingly

Available Services and Resources

› Reports on the maltreatment of children in the United States are available at [http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can](http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can)
› Centers for Disease Control and Prevention, [http://www.cdc.gov/ViolencePrevention/childmaltreatment/](http://www.cdc.gov/ViolencePrevention/childmaltreatment/)


Food for Thought

› Home visitation programs show higher success rates in retaining at-risk families when the visiting professional is younger, has more supervision, and is matched ethnically to the family
› Certain racial and ethnic groups are overrepresented in the child welfare system, most significantly Blacks
› Programs and therapies addressing physical maltreatment have low levels of father involvement; when fathers do attend intervention programs and therapies, they have high attrition rates
› Parents who physically maltreat their children minimize the problems they have with their children by denying the occurrence or seriousness of the maltreatment

Red Flags

› Disparity between a physical injury in a child and the explanation of how it occurred can be a red flag for physical maltreatment
› In some cultures what is considered in the United States to be physical maltreatment may be normative, such as certain disciplinary practices
› Children generally experience more than one form of maltreatment
› IPV can predate as well as co-occur with the physical maltreatment of children
› Childhood physical maltreatment may increase the risk for victimization in dating relationships
› Adolescent maltreatment occurs at rates similar to those among younger children, but is underreported since adolescents are not viewed to be as vulnerable as younger children (Raissian et al., 2014)

Discharge Planning

Medical, financial, therapeutic, and educational services should be sought for the family and, if possible, regular contact should be maintained

References