



Domestic Violence, Abuse, and Neglect

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Introduction

The Centers for Disease Control and Prevention defines intimate partner violence (IPV) as “physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)” [1]. Specifically, physical violence is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm and includes scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one’s body, size, or strength against another person. Sexual violence is defined as a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. Stalking is a pattern of repeated, unwanted attention and contact that causes fear or concern for one’s own safety or the safety of someone else (e.g., family member, close friend), and psychological aggression is the use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally, and/or exert control over another person [1].

Over the course of a lifetime, more than one in three women and more than one in four men in the US experience rape, physical violence, and/or stalking by an intimate partner [2]. Approximately one third of homicides of women are committed by intimate partners [3]. Because victims of IPV tend to have high rates of physical and mental health morbidity, they are frequent users of the health care system. IPV is

thus a condition that physicians and other providers can expect to encounter frequently in their care settings.

The Child Abuse Prevention and Treatment Act was enacted in 1974, which defines child maltreatment as “any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm” [4]. While federal legislation sets minimum standards for states, each state provides its own definitions of maltreatment within civil and criminal statutes. Each year in the US, Child Protective Service (CPS) agencies receive more than three million reports of suspected child maltreatment and investigate more than two million of these reports; more than 650,000 children are substantiated by child welfare as maltreatment victims [5]. Most maltreated children are victims of neglect (78.5%), 17.6% are victims of physical abuse, and 9.1% are victims of sexual abuse. More than 1500 child deaths are attributed annually to child abuse or neglect.

A substantial body of research indicates that child maltreatment and IPV are public health problems with lifelong health consequences for survivors [6]. A landmark project, the Adverse Childhood Experience study, demonstrated a gradient risk among adults for both health risk behaviors and chronic diseases based on the number of childhood adversities and trauma experienced. For example, those with greater adversity had 4–12 times greater risk, compared to those with less adversity, for alcoholism, drug abuse, and suicide attempt. Similarly, those with greater adversity had higher rates of cancer, heart disease, lung disease, and liver disease compared to those with less adversity [7]. Not all childhood adversities are traumatic events. For example, living with a household member with mental illness may be stressful but not-traumatic. The Centers for Disease Control and Prevention defines trauma as “an event or series of events that causes a moderate or severe stress reaction ... characterized by a sense of horror, helplessness, serious injury, or threat of serious injury or death” [8]. People who experience or witness traumatic events may have stress reactions. Most

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stress reactions resolve in a short period of time, but some people develop post-traumatic stress disorder. Many victims of child maltreatment and IPV will have post-traumatic stress reactions and post-traumatic stress disorder.

At the other end of the life course is elder mistreatment. An expert panel convened by the National Academy of Sciences defines elder maltreatment broadly as the intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trusted relationship to the elder, or failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm [9]. Multiple types of elder maltreatment exist, including physical abuse, psychological abuse, sexual assault, neglect, and financial exploitation. Estimates of elder abuse vary between 2% and 10%. In a probability sample of elderly people living in Boston, the overall abuse rate was 3.2% [10]. The extent of elder abuse is sufficiently large that physicians who care for elderly adults are likely to encounter it routinely.

Physicians and other care providers play a key role in identifying and treating maltreatment and family violence, as well as understanding physical and mental health problems in their patients in the context of challenging life events, such as chronic illness. This chapter will first provide general guidelines for clinicians who may encounter IPV, child maltreatment, and elder mistreatment. The next section will outline evaluation approaches for patients who may present for medical care, and will be followed by management strategies. The chapter will close with future trends in this important area.

General Guidelines

Because maltreatment and family violence are widely prevalent, all health care providers will encounter patients who have experienced this trauma. Furthermore, although there are subspecialists with expertise in the evaluation and management of child maltreatment and family violence, the vast majority of identification and treatment occurs by primary care clinicians. The identification of abuse can be difficult for many reasons; abuse is rarely witnessed, disclosure by the perpetrator is uncommon, and victims are often non-verbal, too severely injured, or too frightened to disclose. Furthermore, injuries may be non-specific in the case of physical abuse or absent in the case of sexual abuse.

Intimate Partner Violence (IPV)

Assessing for IPV in the clinical setting can be universal or selective, based on presentation or risk factors. The United States Preventive Services Task Force (USPSTF) recommends screening all women of childbearing age and refer-

ring those who screen positive for intervention services [11]. This recommendation is based on evidence that IPV can be accurately detected using currently available screening instruments, that effective interventions can mitigate the adverse health outcomes of IPV, and that screening causes minimal harm [11].

Physicians and other providers should be aware of the clusters of symptoms that are common in victims of IPV. When patients present with signs and symptoms suggestive of IPV (e.g., frequent somatic complaints, unexplained injuries, injuries to the face or trunk, frequent mental health complaints), clinicians should inquire about IPV, not only because intervention may be beneficial, but also because knowledge of IPV may inform the treatment plan or help the clinician understand barriers to treatment. A physician perception of poor adherence to medical recommendations may in fact be associated with the abuse a patient is experiencing, since impeding access to health care may be part of the control that abusers exert in their partners' lives [12]. Physicians who diagnose IPV, and therefore begin to understand the barriers that their abused patients face, may be able to develop more effective therapeutic relationships. Identifying IPV also provides an important opportunity for providing the patient with empathic support; educating them regarding the dynamics of IPV and the future risks it poses to the patient and their children.

Several questionnaires for assessing for IPV have been validated in a variety of settings and are practical in primary care, such as HITS, Woman Abuse Screening Tool (WAST), the Ongoing Violence Assessment Tool (OVAT), and the Partner Violence Screen [13]. Whether a clinician uses a structured instrument or simply asks questions informally in the context of a patient interview, several principles are important to follow. Physicians should ensure a private setting, without friends or family members present. They should assure patients of confidentiality, but notify them of any reporting requirements. It is often helpful to preface questions about IPV with normalizing statements, for example, "Because violence is a common problem, I routinely ask my patients about it," or "Many people with [condition] have worse symptoms if they have been physically, emotionally, or sexually abused in the past."

Child Abuse

Existing instruments designed to screen for social determinants of health often inquire about parental concern for child abuse [14]. Asking a caregiver about abuse is important and underscores the centrality of these problems to child health. A negative response, however, should not preclude an evaluation for abuse if other concerns are identified. Indeed, the best available screen for child abuse at this time remains a high index of suspicion and a thorough physical examination.

Although the maltreatment of children has been recognized for decades, there are ongoing challenges in identifying and ensuring the health and safety of abused and neglected children. There is abundant evidence that physicians often miss opportunities for early intervention of injuries that are concerning for physical abuse [15–17]. Sentinel injuries are minor injuries such as bruises or intraoral injuries that are noted before more severe injuries lead to a diagnosis of child abuse. Such injuries are often identified by physicians, but are incorrectly attributed to accidental trauma or not reported to CPS for investigation despite physician suspicion for abuse [15, 16, 18].

There is considerable variability in the diagnostic evaluation for physical abuse. All children younger than two years of age in whom physical abuse is suspected, for example, require a skeletal survey, the standard tool for detecting occult fractures [19]. However, race and socioeconomic status appear to influence a physician's decision to obtain skeletal surveys when children younger than two years present with skeletal trauma or traumatic brain injury, leading to both the over-reporting and under-reporting of abuse in different populations [20–22].

Variability has also been observed in performing recommended testing for sexually transmitted infections (STIs) and pregnancy, and administering recommended prophylaxis and emergency contraception when adolescents present to pediatric emergency departments following acute sexual abuse [23]. Studies have also shown that many physicians have not been properly trained in anogenital examination of children [24, 25].

Although neglect is by far the most widespread form of child maltreatment and results in significant morbidity and mortality, the focus of public and professional attention is largely on physical and sexual abuse. A greater and ongoing challenge is that neglect is difficult to define. For instance, although a health care provider might view repeated non-adherence to medications as neglect, this may not meet a state's CPS statute for neglect unless harm has resulted from this inaction. Neglect can involve failure to supervise a child resulting in harm or increasing risk of harm. Neglect can also involve failure to provide food, housing, education, medical care, or an emotionally supportive environment. In some states, child neglect statutes exclude failure to provide when that failure is due to poverty or inadequate resources. In other states, these statutes are not related to intent, but only to the needs of the child.

Toxic Stress, Child Maltreatment, and IPV

The lifetime consequences of early trauma are substantial and enduring. Researchers have found that most causes of morbidity and mortality, including obesity, heart disease,

alcoholism, and drug use, are directly associated with child maltreatment and childhood exposure to IPV [7, 26, 27]. Children need an environment in which a responsive, attentive caregiver meets their basic needs, including nurturance, love, and protection for normal growth and development. In this fundamental caregiver–child relationship, the child also depends on the caregiver to mediate and buffer life's stressors [27]. When stressors are overwhelming, or when caregivers are unable to help children buffer them, significant adversities can challenge the normal development of healthy coping mechanisms, learning, emotional health, and physical health [26, 27].

Stress that is unbuffered and overwhelming leads to potentially maladaptive neuroendocrine changes that impede a child's capacity to protect themselves from threats that are experienced and perceived in their world. When a child faces profound and chronic adversity such as abuse, neglect, and household IPV, significant biologic changes can occur. Excessive activation of the physiologic stress response system can lead to changes to: hypothalamic–pituitary–adrenal gland axis activation; epigenetic gene translation; altered immune response; and impaired neurodevelopment involving brain structures responsible for cognition, rational thought, emotional regulation, activity level, attention, impulse control, and executive function [27]. These biological processes manifest in specific behavioral, learning, and health problems which are seen in many children who have been maltreated or exposed to IPV. Adverse childhood experiences are closely link conceptually and empirically with toxic stress [28].

In the health care setting, physicians and other providers may address some of the changes in bodily function associated with trauma's influence on the brain. Sleep problems may include difficulty initiating or maintaining sleep, or experiencing nightmares. Children who have experienced trauma may demonstrate rapid eating, lack of satiety, food hoarding, or loss of appetite. Toileting problems include constipation, encopresis, enuresis, and regression of toileting skills [29]. Neuroendocrine changes can impact the immune and inflammatory response. In addition, an increased risk of infection and rates of asthma and allergy, and an increased risk of metabolic syndrome can all be linked to trauma [30, 31].

There has been increasing interest in screening for adverse childhood experiences since screening identifies a large percentage of children who experience one or more adversities [32]. What remains less clear is the right type of intervention to ameliorate the impact of these adversities. Some experts have, for example, advocated for focusing on prevention rather than screening for adversities that have already occurred. Another approach is to screen for unmet social care needs or social determinants of health, such as transportation challenges, food or housing insecurity, or barriers to

medical care [33]. Increasingly, health care systems, providers, and insurers seek to find ways to help people get services to address these unmet needs as a path to improved outcomes and lower costs. Social determinants of health are a concept closely aligned with adverse childhood experiences, and typically include experiences of violence. It is important that screening for adverse events or social determinants be undertaken only when there are evidence-informed interventions available to the family [34, 35].

Elder Mistreatment

There are no validated instruments for the screening or evaluation of elder mistreatment. Clues about potential mistreatment frequently come from ancillary staff members or home care nurses who observe the abuser–victim dyad away from the health care provider [36]. A general sense that something is concerning in the patient’s environment such as an abrasive interaction between the elder and the caregiver, poor hygiene, frequently missed medical appointments, or failure to adhere with a clearly designated treatment strategy can all be important indicators.

There are no diagnostic signs or symptoms of elder abuse and clinicians need to consider elder mistreatment in the differential of many clinical presentations they encounter. Significant injuries and severe neglect are obvious, but many prevalent chronic diseases that afflict the elderly also have clinical manifestations of abuse and vice versa. For instance, fractures may result from osteoporosis or physical abuse. Malnutrition may be the result of progressive malignancy or the withholding of nourishment. Most often, chronic disease and elder abuse co-occur making the identification of elder mistreatment one of the most difficult clinical challenges in geriatric medicine.

Patient Evaluation

Suspected IPV

When IPV is detected in the clinical setting, clinicians should respond in a way that builds trust and sets the stage for an ongoing therapeutic relationship. Key components of an initial interaction should include validation of the patient’s concerns, education regarding the dynamics and consequences of IPV, safety assessment, and referral to local resources. A growing body of evidence suggests that a variety of counseling and advocacy interventions are effective at reducing violence and mitigating its negative health effects [37]. IPV is usually a chronic problem that will not be mitigated in one or two visits, but rather addressed overtime [38].

An initial response to a disclosure of IPV should include listening to the patient empathically and non-judgmentally, expressing concern for their health and safety, and affirming a commitment to help them address the problem. Victims of abuse may believe that the abuse is their fault. Health care providers can help counter this belief, reassuring patients that although partner violence is common, it is unacceptable and not the fault of the victim. Clinicians should also convey respect for IPV victims’ choices regarding how to respond to the violence. Victims of IPV may have a clearer understanding than their health care providers about what courses of action may result in increased danger. If patients need to move slowly, frequent office visits can be helpful by providing ongoing support and addressing medical problems.

Suspected Child Abuse

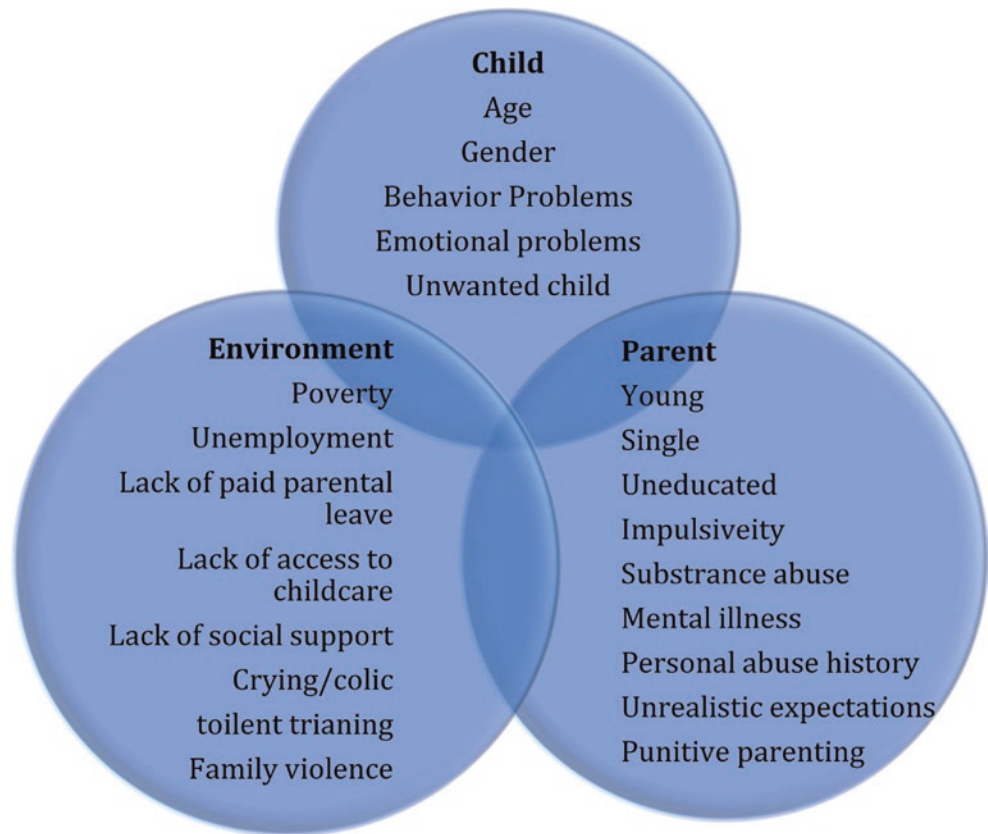
Child abuse and neglect result from a complex interaction of child, parent, and environmental factors (Fig. 8.1). Most often multiple factors coexist and are interrelated and increase the child’s vulnerability to maltreatment [39]. Even if there is no single factor that overwhelms the caregiver, a combination of several stressors may precipitate an abusive crisis [40].

Individual characteristics that predispose a child to maltreatment include those that make a child more difficult to care for, or may be at odds with parental expectations. Adolescents are more likely than younger children to suffer physical abuse and neglect, however infants and toddlers are particularly vulnerable to severe and fatal maltreatment because of their smaller size and developmental phase [41]. Girls may be at higher risk for sexual abuse, although this may be in part because boys are more likely to delay disclosure of sexual abuse [42]. Children with physical or developmental disabilities, special health care needs, or chronic illnesses may also be at increased risk [43]. Physical aggression, resistance to parental direction, and antisocial behaviors also more commonly characterize maltreated children [44].

Parent characteristics associated with child maltreatment include young age, being a single parent, and low educational achievement [45]. Factors that decrease a parent’s ability to cope with stress and increase the potential for maltreatment include low self-esteem, poor impulse control, substance abuse, and mental illness [46]. In addition, parents who were themselves victims of child maltreatment are more likely to have children who are abused or neglected [47]. Parents who maltreat their children are more likely to have unrealistic developmental expectations for child behavior, and to have a negative perception of normal behavior. In addition, parents with punitive parenting styles are more likely to maltreat their children [47].

Poverty and unemployment are also associated with maltreatment [48]. When low-income working parents have

Fig. 8.1 Factors that place a child at risk for maltreatment



challenges accessing affordable and safe childcare, substandard childcare can present an elevated risk for child abuse [49]. The absence of a robust family social support system places the child at increased risk for maltreatment [48]. Young children who live in households with unrelated adults are at exceptionally high risk for abuse [50]. Children living in homes with IPV are at increased risk of being physically abused, in addition to suffering the negative emotional, behavioral, and cognitive consequences from exposure to this family violence [51–53].

High-stress situations can increase the potential for child abuse. Circumstances that occur during the course of normal child development, including colic, nighttime awakenings, and toilet training, are potential triggers for maltreatment [39]. In particular, crying is a common trigger for abusive head trauma [54]. Infant crying generally peaks between two and four months, and the incidence of abusive head trauma parallels this crying trajectory [55]. Accidents surrounding toilet training are another potential trigger. Immersion burns may be inflicted in response to encopresis or enuresis when a caregiver believes that children should be able to control these bodily functions [56]. The average age of children who have been intentionally burned is 32 months, by which time abusive parents may have expected their children to have mastered bodily functions [39].

Physical Abuse

Almost no injury is pathognomonic for abuse or accident without careful consideration of the history, a thorough physical examination, and targeted radiographic or laboratory analysis. When an accidental history is offered by the caregiver, the clinician must consider if the accidental mechanism is a plausible explanation for the identified injury/injuries, and whether the mechanism is consistent with the child's developmental abilities. When abuse is suspected as the cause of an injury, the clinician may conduct tests to screen for other injuries, and to identify potential medical etiologies in the differential diagnosis of abuse. The extent of diagnostic testing depends on several factors, including the severity of the injury, the type of injury, and the age and developmental level of the child. Table 8.1 summarizes tests that may be used during a medical assessment for suspected physical abuse.

Skin Injuries

Bruises are universal in active children. Bruises are also the most common injury resulting from physical abuse, the most easily recognized sign of physical abuse, and the most common direct sign of physical abuse to be missed. For these reasons, it is critical that children's skin be fully examined during medical encounters. Patterned bruises, such as slap marks or

Table 8.1 Laboratory and radiologic testing for the evaluation of suspected physical abuse

Injury	Laboratory Testing	Radiologic Testing
Bruises	CBC PT, INR, PTT VWF antigen, VWF activity Factor VIII level, factor IX level	Skeletal survey for non-ambulatory infants with bruises Skeletal survey for children <2 years with suspicious bruising CT head/MRI head for infants <6 months or infants with suspicious bruising
Fractures	Calcium, phosphorous, ALKP Consider 25OHD, PTH Consider DNA analysis for osteogenesis imperfecta	Skeletal survey CT head/MRI head for infants <6 months
Abdominal injury	AST, ALT	CT abdomen with contrast Skeletal survey in children <2 years
Head injury	CBC PT/INR/aPTT Factor VIII level, factor IX level Fibrinogen, d-dimer Review newborn screen Consider urine organic acids	CT head MRI head and spine Skeletal survey in children <2 years

CBC complete blood count, *PT* prothrombin time, *INR* international normalized ratio, *PTT* Partial thromboplastin time, *VWF* von willebrand factor, *ALKP* alkaline phosphatase, *25OHD* 25-hydroxy vitamin D, *PTH* parathyroid hormone, *DNA* Deoxyribonucleic acid, *AST* aspartate aminotransferase, *ALT* alanine transaminase, *CT* computed tomography, *MRI* magnetic resonance imaging

marks caused by a looped cord, are highly suggestive of abuse. Bruises in healthy children tend to be distributed over bony prominences; bruises isolated to the torso, ears, cheek, or neck should raise concern [57]. Bruises in non-ambulatory infants are unusual and are highly concerning for physical abuse [58]. Many diseases are associated with bruises, including coagulopathies and vasculitis, and children who present with suspicious bruises may require screening for these hematologic disorders [59]. Bite marks are characterized by ecchymoses, abrasions, or lacerations that are found in an elliptical or ovoid pattern [60]. Bite marks can be inflicted by an adult, another child, an animal, or the patient.

Approximately 6–20% of children hospitalized with burns are victims of abuse [61]. Abusive scalds due to neglect outnumber those due to intentional injury by a factor of 9:1 [62]. Inflicted burns can be the result of contact with hot objects such as irons, radiators, stoves, or cigarettes, and from immersion injuries. Although both inflicted and accidental contact burns may be patterned, inflicted contact burns are characteristically

deep and leave a clear imprint of the hot instrument. In contrast to accidental scald injuries, inflicted scald burns have clear demarcation, uniformity of burn depth, and a characteristic pattern [63]. Dermatologic and infectious diseases can mimic abusive burns, including toxin-mediated staphylococcal and streptococcal infections, impetigo, phytophotodermatitis, and chemical burns of the buttocks from laxatives [64].

Fractures

Unexplained fractures, fractures in non-ambulatory infants, and the presence of multiple fractures raise suspicion for physical abuse [65]. Certain fracture types also have a higher specificity for abuse, such as rib fractures and classic metaphyseal lesions. Skeletal survey is the standard tool for detecting occult fractures in possible victims of child abuse [19]. Repeating skeletal surveys 2–3 weeks after an initial presentation of suspected abuse improves diagnostic sensitivity and specificity for identifying skeletal trauma in abused infants [66, 67]. Expert consensus guidelines recommend obtaining a skeletal survey in the setting of a fracture: (1) if a fracture is attributed to abuse, IPV, or being hit with a toy; (2) when there is no history of trauma; and (3) in children younger than 12 months regardless of the fracture type or reported history, with rare exceptions [68]. Vitamin and mineral deficiencies, and genetic diseases may be considered in the differential diagnosis of unexplained fractures when appropriate [69].

Abdominal Injuries

Abdominal injury is the second leading cause of mortality from physical abuse [70]. Compared with children who sustain accidental abdominal trauma, victims of abuse tend to be younger, more likely to have hollow viscera injury, more likely to have delayed presentations to medical care, and have a higher mortality rate [71, 72]. Symptomatic children can present with signs of hemorrhage or peritonitis, but many children will not display overt findings. Therefore liver enzymes are important to obtain in all children who present with serious trauma, even if they do not display acute abdominal symptoms [73]. Contrast-enhancing computed tomography (CT) is warranted if these screening laboratory tests indicate possible abdominal trauma and in all cases of symptomatic injury.

Head Injuries

Abusive head trauma is the leading cause of mortality and morbidity from physical abuse [74]. Multiple mechanisms contribute to the cerebral, spinal, and cranial injuries that result from inflicted head injury, including both shaking and blunt impact [74]. For symptomatic children, CT of the head will identify abnormalities that require immediate surgical intervention and is preferred over MRI for identifying acute hemorrhage and skull fractures and scalp swelling from blunt injury. MRI is the optimal modality for assessing intracranial injury, including cerebral hypoxia and ischemia, and

is used for all children with abnormal CT scans and asymptomatic infants with non-cranial abusive injuries [75].

An examination using indirect ophthalmoscopy is indicated in the evaluation of abusive head trauma because severe retinal hemorrhages are highly associated with abuse [76]. Conditions that may be confused with abusive head trauma include accidental/birth trauma, and metabolic, genetic, or hematologic diseases with associated vascular or coagulation defects [77]. Many of these can be ruled out through careful medical, developmental, and family history, and thorough physical examination.

Suspected Neglect

Neglect occurs when a child's basic needs are not adequately met. Physical neglect, the most common form of neglect, includes failure to provide food, clothing, stable housing, supervision, or protection. Educational neglect occurs when a child's educational needs have not been met, often by failure to enroll a child in school or by chronic truancy. Emotional neglect refers to exposing a child to conditions that could result in psychological harm such as ignoring a child's need for stimulation, isolating a child, threatening a child, or verbally ridiculing a child. Medical neglect refers to lack of appropriate medical or mental health care or treatment. The general examination, including careful measurement of growth parameters, may reveal evidence of neglect, including malnutrition, extensive dental caries, or neglected wound care.

Sexual Abuse

Sexual abuse is rarely discovered because it is witnessed or due to a physical exam finding or STI diagnosis. In the vast majority of cases, suspicion for sexual abuse arises from the child's disclosure. In fact, the child's disclosure is the most important evidence in making a diagnosis of sexual abuse and therefore must be carefully documented in the medical record. Many communities have child advocacy centers where children can be referred when concerns of sexual abuse arise. Depending on the community services available, the physician should be prepared to conduct a basic medical interview with a verbal child when there is a concern regarding sexual abuse. Any disclosure should be recorded word for word in the medical record [78]. If the sexual abuse occurred in the distant past and the asymptomatic child is going to be referred to a specialty center for medical evaluation, examination might be deferred. However, if the abuse is recent and the child is reporting genital or anal pain or bleeding, examination should be performed to rule out injury.

Most sexually abused children have normal anogenital examinations [79]. The sexual abuse of children may not result in injury and when injury does occur the anogenital tissue often heals quickly and completely [80]. A normal examination of the genitalia and anus does not rule out sexual abuse [81].

Sexually abused adolescents should be tested for chlamydia, gonorrhea, trichomonas, and pregnancy [82, 83]. In addition, the CDC suggests hepatitis B testing in unimmunized victims and consideration of human immunodeficiency virus (HIV) and syphilis testing in populations in which there is a high incidence of infection, or when the victim requests these tests [84]. STIs in pre-pubertal children evaluated for abuse are rare and thus a targeted approach is recommended [85]. Factors that may prompt testing include vaginal or anal penetration, abuse by a stranger, abuse by a perpetrator infected or at risk of infection with an STI, having a household contact with an STI, or signs or symptoms of an STI. Positive results should be confirmed using additional tests in populations with a low prevalence of the infection or when a false-positive test could have an adverse outcome. If diagnosed with an STI, the child should be treated promptly. Children who have had recent sexual contact should be immediately referred to a specialized clinic or emergency department capable of forensic evidence collection [86]. Most states recommend that forensic evidence be collected in less than 72 or 96 hours since the assault.

Suspected Elder Mistreatment

Spouses and adult children are the most common perpetrators of elder abuse [87]. Living with another adult is a major risk factor for elder abuse, perhaps due to increased opportunities for contact and conflict in a shared living arrangement [10, 87]. An exception to this pattern is financial abuse, for which victims are more likely to live alone [88]. Several studies have reported higher rates of physical abuse in patients with dementia [89, 90]. A likely mechanism is the high rate of disruptive and aggressive behaviors of patients, which are a major cause of stress and distress to caregivers. Social isolation has been identified as a risk factor for elder abuse [91]. There are certain perpetrator-specific risk factors as well, including mental illness and alcohol misuse [89, 92]. Finally, elder abusers tend to be heavily financially dependent on the person they are mistreating [93].

Once the possibility of elder abuse has been raised, a comprehensive assessment is necessary. If there are no cognitive limitations, the patient should be interviewed alone and asked directly about the etiology of any concerning findings [94]. Often patients are initially unwilling to speak openly about being an elder abuse victim due to embarrassment, shame, or fear of retribution from the perpetrator who is frequently a caregiver [94]. Interview of the suspected abuser is a potentially hazardous undertaking and not necessary [94]. Elder abusers who are presented with an empathetic, non-judgmental ear to describe their stresses and actions will sometimes describe their situations at great length and in great detail. However, all forms of domestic

abuse share a pattern wherein abusers gain and control access to their victims. An elder abuser confronted with allegations of mistreatment may move to sequester a victim in such a way that a fragile, isolated adult loses access to critically needed medical, and social services [94].

Management Strategies

Mandated Reporting

In every state, health care providers are mandated by law to identify and report all cases of suspected child abuse and neglect. Yet, much of the abuse that is recognized by physicians does not get reported to CPS for investigation [16]. In part this is because clinicians may incorrectly believe that making a report requires certainty in their diagnosis of child abuse, rather than having a *reasonable suspicion* for maltreatment as the law requires. In addition, many clinicians believe that reporting to CPS is not an effective intervention and distrust the ability of the child welfare system to protect children [17]. In all states, the law provides immunity for good faith reporting. However, failing to report may result in malpractice suits, criminal offenses, licensing penalties, and continued abuse to the child. Mandated reporters must become familiar with their state-specific reporting procedures and laws. Most states, for example, have specific language about threat of harm or substantial risk to health or welfare in physical abuse statutes. Failure to educate is included in neglect statutes in about half of states, while medical neglect is defined in ten states [95].

Prenatal exposure to some drugs may cause a neonatal abstinence syndrome or neurodevelopmental consequences. Evidence of substance exposure at birth or prenatal exposure to illegal substances is considered child abuse in about half of states. Parenting after birth can be profoundly impacted by substance use, leading to risk for abuse, neglect, and exposure to production and distribution of illegal substances. Sixteen percent of child abuse reports include alcohol abuse as an additional risk factor and 29% include drug abuse as an additional risk factor [5]. In addition, alcohol or drug abuse is one of the reasons for child removal from the home in 39% of cases [96]. Most states have specific laws regarding maltreatment reporting and additional penalties for parent substance use and related exposures, but the laws vary by state [97].

Health care provider cooperation with CPS investigations is critical to effective decision making by investigators. Health Insurance Portability and Accountability Act rules allow disclosure of protected health information to CPS without authorization by a legal guardian when the clinician has made a mandatory report, but state laws differ regarding the release of health information during and after investigations are complete [98]. More than half of states specify cir-

cumstances of the child witnessing IPV that constitutes maltreatment. These statutes often include language around witnessing that includes a child within sight or sound of the IPV, and/or IPV that is escalating or involves a weapon [99]. Clinicians should know their specific state's reporting requirements before screening and inform the caregiver accordingly. In most states cases of elder abuse must be reported to adult protective services. Websites such as www.endabuse.org, <http://www.childwelfare.gov>, or <http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx> provide information on state-specific laws about mandated reporting and available resources.

Trauma-Informed Care

About half of adults report one or more adverse child experiences, experiences that can contribute to a variety of acute and chronic health conditions. Because of the important role of adversity in health and well-being, there has been steady advocacy, research, change in reimbursement, and practice to support trauma-informed care. Trauma-informed care is defined by the National Traumatic Stress Network as "medical care in which all parties involved assess, recognize, and respond to the traumatic effects of stress on children, caregivers, and healthcare providers" [100]. The American Academy of Pediatrics has published recent guidance for practitioners in delivering trauma-informed care. Understanding the role stress plays in emotional and behavioral symptoms, evidence-based screening for such symptoms using validated tools to screen for depression and anxiety, treatment for disorders when diagnosed, and avoiding re-traumatization by the use of non-threatening language and exam procedures are all important components of trauma-informed care [100]. The training required for a truly trauma-informed practice can be a barrier to providing this care.

Many experts encourage screening for adverse childhood experiences as a part of trauma-informed care with the rationale that adversities are common and are linked to a variety of acute and chronic health conditions. However, adverse childhood experiences screening tools are quite varied, not validated, and may screen for events that occurred in the past and do not need to be addressed in the present. There is also a lack of tools to address these events, such as neighborhood violence [35]. The state of California reimburses practices for adverse childhood experience screening and recently passed legislation to require commercial insurers to reimburse for adverse childhood experience screening [101]. Other states may follow this example. Screening for recent or ongoing trauma as well as unmet social needs such as food and housing insecurity represents an alternative approach to adverse childhood experience screening that can be incorporated in trauma-informed care [35].

Approaching Intimate Partner Violence

Clinicians should educate patients on the dynamics of partner violence and potential effects on victims and their children, helping them understand that once violent dynamics are established in a relationship, the violence generally continues and escalates over time. Health care providers can convey concern to patients regarding the negative physical and mental effects that IPV may have on patients and their children. Although addressing IPV is usually a long-term process, health care providers should be alert to crisis situations that indicate imminent danger (e.g., escalating violence, use of or threat with a weapon, drug or alcohol use). Assessing for these risk factors provides an opportunity to educate patients about what situations indicate increased risk.

Health care providers should refer victims of IPV to local resources that can provide advocacy and support. Physicians and others should be familiar with organizations in their communities that provide assistance to victims of IPV, including organizations' capacity to accommodate specific populations such as immigrants, specific ethnic or cultural groups, teens, lesbian, gay, bisexual or transgender clients, or persons with disabilities. Resources can also include community-based advocacy groups, shelters, law enforcement agencies, or social workers. The National DV Hotline (800-799-SAFE) can serve as an information source. If immediate concerns for safety exist, the health care providers can offer to contact these resources for the patient directly from the office. A follow-up visit should be scheduled, and IPV should be readdressed at future visits.

Approach to Child Maltreatment

The treatment of child maltreatment is complex and challenging. Many of the approaches developed by child welfare agencies, health care providers, therapists, and others have not been rigorously tested, and many families suffer from chronic dysfunction and a multitude of challenges that require broad approaches to management.

Abuse-Focused Cognitive Behavioral Therapy (AF-CBT) and Parent–Child Interaction Therapy (PCIT) are considered “best-practice” interventions for the treatment of physical abuse [102]. Both are dyadic interventions designed to alter specific maladaptive patterns of interaction in parent–child relationships. AF-CBT represents an approach to working with abused children and their offending caregivers based on learning theory and behavioral principles that target child, parent, and family characteristics related to the maltreatment [103]. The approach is designed to promote the expression of appropriate/prosocial behavior and to discourage the use of coercive, aggressive, or violent behavior. PCIT is a highly

Table 8.2 Trauma resources

Resource	Website
AAP Healthy Foster Care America	www.aap.org/fostercare
AAP Cope with Trauma Guide	www.aap.org/traumaguide
AAP Medical Home for Children and Adolescents Exposed to Violence	www.aap.org/medhomecev
National Child Traumatic Stress Network	http://nctsn.org
SAMHSA National Center for Trauma-Informed Care	www.samhsa.gov/ntic/trama.asp

specified, step-by-step, live-coached behavioral parent training model. Immediate prompts are provided to a parent by a therapist while the parent interacts with their child. Over the course of 14–20 weeks, parents are coached to develop specific positive relationship skills, which then results in child compliance to parent commands [104, 105].

When abused children develop post-traumatic stress disorder symptoms, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is effective [106]. TF-CBT has been most widely used for children who have been sexually abused or have witnessed IPV and involves structured individual and parent trauma-focused models with skills-based components followed by more trauma-specific components with gradual exposure integrated into each component [106].

Clinicians should become familiar with programs in their geographic area of practice, which provide evidence-based interventions for children who have experienced abuse or IPV exposure. Additional information on trauma-informed care resources is listed in Table 8.2.

Enhanced Health Care Needs of Maltreated Children

Maltreated children, particularly those in foster care, exhibit high rates of acute and chronic physical, developmental, and mental health conditions [107–110]. In fact, nearly 80% of children in foster care have significant physical, mental, and developmental health care needs [111]. Exposures such as insufficient prenatal care, prematurity, or in-utero toxins as well as chronic abuse/neglect have direct and indirect effects on the health and well-being of this population.

The interplay of chronic or prolonged stress, physiologic response to that toxic stress, and behavioral adaptations to this stress impact the health of children over the life course. Maltreated children may require more frequent preventive health visits due to multiple environmental and social issues that can adversely impact their health. Furthermore, this medically vulnerable population requires intensive, integrated behavioral and medical care.

Approach to Elder Mistreatment

There are no evidence-based interventions regarding treatment for elder abuse and clinicians should view elder abuse as multifactorial rather than as a homogeneous condition. However, clinicians can offer interventions that may mitigate the impact of the abuse. Table 8.3 lists potential interventions to be considered in the treatment of elder maltreatment. Resources for clinicians and families who are dealing with elder mistreatment can be found at Area Agencies on Aging (<http://www.n4a.org>).

Prevention of Family Violence

More focus is needed on the prevention of family violence, child maltreatment, and elder mistreatment. Within the social–ecological context, prevention of family violence can be targeted to the individual level, the family/relationship level, the community level, and the societal/policy level. For instance, on the individual level, addressing known risk factors for family violence within an individual at risk of perpetrating abuse such as depression or substance addiction, may be an effective prevention strategy. Parent education programs, parenting programs that focus on strengthening parent–child relationship and positive parenting skills, and intensive home visiting are among the most evaluated programs for family/relationship level interventions [112–115]. Intensive home visiting has a substantial evidence base in the

prevention of child maltreatment. Despite this demonstrated track record, it remains poorly disseminated, engagement and retention in this type of program is limited, and outcomes are hard to reproduce.

Community-based programs that seek to change social norms around parenting and family dynamics have also been shown to be successful [116]. These programs are often implemented in combination with some level of individual or family level intervention. Finally, at the societal level, there are untapped opportunities for prevention. Large societal factors influencing family violence include the health, economic, educational, and social policies that help to maintain economic and social inequalities between groups in society. For example, policies addressing Medicaid expansion, paid family leave, earned income tax credit, and lack of waitlists to access subsidized child care have each independently been associated with decreases in child maltreatment [117–119].

Future Directions

Child abuse, family violence, and elder mistreatment are tied to substantial burdens of suffering and associated costs to communities (e.g., health care, criminal justice, mental illness, substance use). These conditions and maladaptations should ultimately be viewed as problems of the individuals involved, as well as the family, the community, and the greater social environment. For health care providers, there is ample opportunity to: (1) identify families at risk, (2) provide resources and referral, (3) treat the sequelae, and (4) advocate for the most constructive programs and policies to reduce the burden of suffering.

The most important frontiers in research will be the development, adoption, and sustained implementation of programs—prevention and intervention—for families across the life course who are at risk and victimized by violence. The most effective types of intervention for child maltreatment, for example, is intensive home visiting [115, 120], however, these programs are available to relatively few families who may benefit, and recruitment and retention rates are low. In addition, although these approaches require significant resources per person, they can be adapted and scaled across a broader range of settings, such as primary care, early care and education, schools, and long-term care. Finally, research is needed on how to most effectively engage and retain families in effective prevention and treatment programs.

The COVID-19 pandemic created and amplified multiple risk areas for family violence, including unemployment, social isolation, disruptions of childcare, and stress associated with loss, illness, and death. These stressors contributed to a remarkable increase in substance use, with more than one in ten adults reporting they started or increased the use of alcohol or drugs to cope with the pandemic [121]. Rates of depres-

Table 8.3 Interventions to consider for elder abuse

Abuse Trigger to Target	Potential Interventions
Alleviating caregiver stress	Respite services Adult daycare Caregiver education program Recruitment of other family, informal, or paid caregivers to share burden of care Social integration of caregiver to reduce isolation
Treating specific caregiver deficiency	Treatment for caregiver depression or mental illness Referral to alcohol or drug misuse rehabilitation program
Aggressive symptoms in patient with dementia	Geriatric medical assessment of causes of underlying behavior and treatment of aggressive symptoms
Long-standing spousal violence	Marital counseling Support groups Shelters Orders of protection Victim advocacy
Financial exploitation by family member	Guardianship proceedings Power of attorney Adult Protective Services
Financial exploitation by paid caregiver	Legal services Law enforcement Adult Protective Services

sion also increased with 32.8% of US adults experiencing elevated depressive symptoms in 2021 compared to 8.5% pre-pandemic [122]. In spite of these increased risks, there was not a significant rise in child maltreatment related to COVID-19 [123–125]. The sharp decrease in reports of maltreatment to child protective services at the beginning of the pandemic was initially thought to be attributed not to an actual decrease in maltreatment, but to surveillance bias because children were at home, with limited access to mandated reporters (e.g., teachers, daycare providers). However, large increases in reporting were not observed with the return to in-person school and multiple studies indicate that abuse-related hospitalizations did not increase during the COVID-19 pandemic [123–125]. Although this paradox is not fully understood, it may provide insight into family violence prevention, indicating that federal financial assistance to at-risk families was protective or contributed to increased parental presence at home, leading to stronger parent–child relationships. At this time, there has been limited research that has examined the impact of the pandemic on IPV or elder mistreatment.

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