A Teaching Program for Nurse Practitioners in Preventing, Identifying, and Reporting Child Abuse

By

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A Project Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements For the Degree of

MASTER OF SCIENCE IN NURSING

In the Graduate College

THE UNIVERSITY OF ARIZONA

2003
STATEMENT BY AUTHOR

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AKNOWLEDGEMENTS

This project was possible with the encouragement and cooperation of many people. A heart felt thank you to my committee members: Dr. Mary Jo Gagan and Katherine Watson for their continued support, patience and guidance.

And a special thanks to my family, my father Jim Gentry, my brother James (Judi), my husband Brian, and our children Maureen (Paul), Angel, Alexandra, Michael, and James. Their encouragement, sacrifice and tolerance helped make this dream come true a reality.
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ABSTRACT

Providing instruction on preventing, diagnosing, and treating victims of child abuse is a challenge in health care education. Currently at the University of Arizona, College of Nursing, there is a deficiency in the education for graduate students or future nurse practitioners regarding child abuse. The purpose of this project was to create an educational program for students in the graduate program and other health professionals; to increase the awareness of the risk factors leading to child abuse; the health care providers’ role in prevention, identification, reporting, and interventions for child abuse victims and their families.

The theoretical framework for this project was Pender’s Health Promotion and Health Protection Model. Nurse Practitioners can utilize the Health Promotion Model to provide an organized framework for developing and implementing interventions that address the individual needs of the diverse victims and families of child abuse. In addition, the Health Promotion Model will be able to assist other health professionals in providing information to other individuals that work closely with children in the effort to encourage health promoting behaviors and prevent abuse. Evaluation of this project will be ongoing. Ongoing evaluation is designed to enhance teaching techniques in the prevention, recognition and interventions for child abuse and to assist families in establishing healthier lifestyles.
CHAPTER I

Introduction

Nationally, an estimated 2,974,000 children are victims of child abuse or maltreatment annually (U.S. Department of Health and Human Services, 1999). In Arizona alone, there were 33,458 reports of maltreated children from October 1, 2000 – September 30, 2001 (Arizona Department of Economic Security, Division of Children, Youth and Families, 2001). On average there are 89 reports of alleged child abuse and neglect made to Arizona’s Child Protective Services each day. Of these reports, 59% are attributed to neglect, 33% physical abuse, 6% sexual abuse, and 2% emotional abuse.

In addition to the immediate effects of physical abuse, there are the long term consequences of maltreatment which may include emotional and developmental problems such as low self esteem, problems with bonding or forming relationships, depression, post-traumatic stress disorder, difficulty in school, poor attendance or misconduct, learning disorders, and cognitive impairment. A study by Pelcovitz, Kaplan, and DeRosa (2000) explored the relationship between abuse and psychopathology in a sample of 89 physically abused adolescents recruited from a social service department in comparison with 96 nonabused adolescents. The physically abused adolescents had significantly higher rates of psychiatric disorders of major depression, anxiety, oppositional defiant disorder and post traumatic stress disorder than the non-abused group (Pelcovitz, et al, 2000). In a study performed by the National Institute of Justice (NIJ), “Cycle of Violence” (2001) researchers found that childhood abuse increased the odds of future juvenile delinquency by 59%, adult criminality by 29%, and violent crime by 30% (Widom, 2002).
The consequences of child abuse and the extensive treatment of repairing broken bones and broken psyches continue long after the abused child grows up. Society will continue to absorb the expenses of law enforcement officials, judges, rehabilitation and legal costs of the criminals that are the by-products of child abuse. In a study by a Chicago-based group, Prevent Child Abuse America, it was estimated that these hidden lifelong problems cost the nation $94 billion dollars every year, or $258 million dollars a day (Levine, S, 2001).

**Purpose**

The purpose of this teaching project was to design a program to broaden the nurse practitioners' knowledge and awareness of children at risk for abuse, and identifying, reporting and managing strategies for child abuse. Specifically, the program will enable participants to:

1. Demonstrate an understanding of child abuse and its definitions.
2. Recognize the risk factors, physical and/or behavioral indicators present in child abuse.

2. Understand the reporting laws, who is mandated and how to report child abuse.

4. Describe the various management strategies and interventions to be taken when child abuse is suspected.

Nurse practitioners are in a unique position to identify children at risk and to initiate primary interventions directed at high-risk families. It is through the education of nurse practitioners and other health professionals who will assist families through immediate interventions, empathy, education, counseling, support and referral that may prevent further child abuse or maltreatment.
Definition of Terms

Child is defined by The Federal Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C.A. statute 5106g), as a person who has not attained the lesser of: the age of 18; or except in cases of sexual abuse, the age specified by the child protection law of the State in which the child resides.

Physical abuse is defined by the National Clearinghouse on Child Abuse and Neglect (2002) is characterized by the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking, or otherwise harming a child. The parent or caretaker may not have intended to hurt the child; rather, the injury may have resulted from over-discipline or physical punishment.

Child Neglect is defined by the National Clearinghouse on Child Abuse and Neglect (2002) as a failure to provide for the child’s basic needs. Neglect can be physical, educational, or emotional. Physical neglect includes refusal of, or delay in, seeking health care; abandonment; expulsion from the home or refusal to allow a runaway to return home; and inadequate supervision. Educational neglect includes the allowance of chronic truancy, failure to enroll a child of mandatory school age in school, and failure to attend to a special educational need. Emotional neglect includes such actions as marked inattention to the child’s needs for affection; refusal of or failure to provide needed psychological care; spouse abuse in the child’s presence; and permission of drug or alcohol use by the child. The assessment of child neglect requires consideration of cultural values and standards of care as well as recognition that the failure to provide the necessities of life may be related to poverty (National Clearinghouse on Child Abuse and Neglect, 2002).
Sexual Abuse is defined as the fondling a child’s genitals, intercourse, incest, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the productions of pornographic materials (National Clearinghouse on Child Abuse and Neglect, 2002).

Emotional Abuse (psychological/verbal abuse/mental injury) includes acts or omissions by the parents or other caregivers that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders. In some cases of emotional abuse, the acts of parents or other caregivers alone, without any harm evident in the child’s behavior or condition, are sufficient to warrant Child Protective Services (CPS) intervention (National Clearinghouse on Child Abuse and Neglect, 2002).

Risk Factors are behaviors and conditions present in the child, parent, and/or family that will likely contribute to future occurrence of child maltreatment. According to Bethea (1999) in a study of the causes of child abuse, by the National Research Council’s Panel on Research on Child Abuse and Neglect, some of the examples of parental risk factors included poverty, young parental age, substance abuse, and a history of domestic violence. Children under the age of 3 years are more prone to the battered child syndrome (U.S. Department of Health and Human Services, 1999). Other risk factors may include the child’s prematurity, congenital deformities, childhood illnesses, and behaviors such as prolonged crying or colic, and frequent soiling of underwear (Chaney, 2000).

Primary Prevention as defined by Shi and Singh (2001) refers to the prevention of disease before it occurs, e.g. health education to a specific population (advocacy for policies of protection with funding). Primary prevention strategies would aim to avert...
abusive acts to children before they occur. An example of a primary prevention strategy would include nurse home visitation programs to provide anticipatory guidance to first time mothers who are predominantly young, unmarried, or poor.

**Secondary Prevention** is defined as an effort to detect disease in early stages to provide a more effective treatment (Shi *et al.*, 2001). Secondary prevention strategies would aim to prevent further abuse to children who have been identified as high risk. School programs would educate children about safety skills while promoting disclosures from children who have already been abused. Children would learn to recognize, resist, and report sexual abuse or violence.

**Tertiary Prevention** treatment efforts to prevent the progression of a disability to a state of dependency (Shi *et al.*, 2001). Activities would be tailored to address situations in which child abuse has already occurred with the goal of preventing any further child abuse as dealing as well with its effects.

**Treatment** the stage of the child protection process whereby specific treatment services geared to the reduction of risk of child abuse are provided by mental health and other social services professionals.

*Significance to Nursing*

Child abuse is a major health problem in the United States today that is not a new phenomena. NPs and other health professionals are in a unique position to identify families at risk, and initiate plans for primary prevention. Nurse Practitioner’s (NP’s) are in an ideal position to identify and treat child abuse within a variety of settings. They often have insight into family circumstances or dynamics and are key witnesses to parent child interactions. NP’s are often the only other adult besides parents or caregivers to be
able to physically examine a child. With such privileged information, nurse practitioners have a crucial role in the identification and or prevention of abused children. NPs not only have the responsibility to identify families at risk for child abuse; but must be able to recognize the clinical manifestations of abuse, diagnose/report abuse, provide education and anticipatory guidance for families, and provide management of children diagnosed with abuse. This teaching project’s ultimate goal is to develop an effective teaching module that will increase NP’s and other health professional’s awareness of child abuse and to implement interventions necessary to prevent, detect and treat child abuse.

The significance of this project is to assist nurse practitioners and other health professionals in developing the requisite knowledge and skills in identifying child abuse and its risk factors. NP’s are in a unique position to help prevent and possibly stop child abuse, by reporting suspected child abuse and providing interventions to families at risk. It is through the education of NP’s and other health professionals that maybe the only positive approach in preventing child abuse.

Background Literature

Child Abuse

According to the Arizona Department of Economic Security, Child Protective Services (1999) over 3 million children are abused nationally each year. Child abuse reports have maintained a steady growth for the past ten years, with the total number of reports nationwide increasing 45% since 1987 (Nation Committee for the Prevention of Child Abuse (NCPCA)2000 Annual Fifty State Survey). Whether these statistics actually reflect an increase incidence of child abuse or an increase in detection and/or reporting is debatable. According to Sedlak and Broadhurst (1996), the significant increase in
severity of injuries from child abuse suggests an actual increase in the incidence of child abuse.

Consequences

The tragedy of child abuse is difficult to quantify. Not only do children suffer from the physical and mental cruelty of child abuse but they endure many long term consequences as well. The problems associated with child abuse are varied and associated with a large number of interpersonal, cognitive, emotional, behavioral, and substance abuse problems and psychiatric disorders (Kaplan, Pelcovitz, Labruna, 1999).

While there is no single behavior that is characteristic of abused children, the presence of problems of victims of child abuse is well documented and may range from either passive withdraw behavior to active and very aggressive behaviors (Kaplan et al, 1999). Abused children often find it difficult to express themselves’ and tend to channel their depression into action, which may be aggressive in nature. Their social skills are lacking compared with their peers, and they have problems making friends. According to Bethea (1999) other consequences include an increased likelihood of future substance abuse, aggressive behaviors, high-risk health behaviors, criminal activity, somatization, depressive and affective disorders, personality disorders, post-traumatic stress disorder, panic attacks, schizophrenia and abuse of their own children or spouses.

In one study by Farber and Joseph (1985), six different patterns of behavior were identified: acting out, depression, generalized anxiety, extreme adolescent adjustment, emotional-thought disturbance, and helplessness-dependency. More specifically, seventy percent had academic performance difficulties. Further consequences of abuse may include psychiatric symptoms (such as bedwetting, tantrums, hyperactivity, and bizarre
behavior), low self-esteem, school learning problems, social withdrawal, oppositional behavior, hypervigilance to adult cues, compulsivity, and pseudoadult behavior (Martin and Beezley, 1977). Brown, Cohen, Johnson, Smailes (1999) found that adolescents with a history of child abuse were three times more likely to become depressed or suicidal compared with individuals without a history.

Risk Factors

There are no single personality traits that characterize an individual who abuses children. Child abuse is derived from multiple complex interactions of a variety of psychosocial components. According to Reece (2000), some of the risk factors that correlate with the most abusive behaviors for child abuse are as follows: 1) History of having been abused or neglected as a child. 2) Young age (between 18 and 30), 3) Low income or poverty, 4) Stressful life events. 5) Social isolation and lack of social support, 6) Experiencing or witnessing violence as a child, and 7) Alcohol and or substance abuse.

One must also consider the characteristics of children that are high risk for abuse. According to Nester (1998), children with special needs are more likely to be abused. Children considered high risk may include preterm infants born to young inexperienced parents, colicky infants, children with chronic medical conditions and behavioral problems (Nester, 1998). Abuse is more likely to occur when high-risk parents are responsible for a high-risk child. It is the knowledge of these risk factors that play in the occurrence of child abuse that will guide nurse practitioners while assessing families and children and planning primary interventions.
Prevention strategies

A variety of programs have been instituted to identify and serve children at risk for abuse and to prevent abuse. According to Anderson (1999) The Parenting Profile Assessment (PPA) screening tool is a reliable source for identifying the initial risk of mothers with a validity estimate of 97.18%. Another program that utilizes its own screening instrument for identifying families at risk is the Hawaii Healthy Start Program. It has been successful with no reports of abuse occurring while families were enrolled in the program and no instances of domestic homicide recorded since the programs inception (Earle, 1995).

Home visitation programs such as the Prenatal/Early Infancy Project, a visiting nurse program launched 20 years ago in Elmira, N.Y., reduced child abuse and neglect up to 80 percent during a 15 year period among a group of low-income, single women visited during their pregnancies and the first two years of their babies lives (Lang, 2001).

School programs have child abuse prevention programs such as the “good touch, bad touch” sexual abuse prevention programs. Previous participants of the sexual abuse prevention program were surveyed and only 8% of the participants reported an experience of sexual abuse. This is small in comparison to the 16% reports of sexual abuse experienced of those that did not participate in the sexual abuse prevention program (Toomey & Bernstein, 2001).

Identifying

First and foremost a complete history and physical assessment of all children is necessary for the identification of child abuse. Physical examination findings suggesting abuse should be documented in objective and specific terminology. The NP may want to
use a body diagram or color photographs to validate physical findings. Some of the physical findings associated with child abuse include lacerations, bruises, burns, fractures, bite marks, injury and bleeding of external genitalia, abdominal injuries, and head injuries (Chaney, 2000). Patterns of injury may indicate the use of a tool to inflict abuse (Chaney, 2000).

The National Center on Child Abuse and Neglect (1992) lists the following physical and behavioral indicators as red flags to assist in recognizing and identifying the possibility of abuse. These physical indicators may include a series of unexplained bruises or welts, burns, fractures, sprains, head injuries, lacerations, abrasions, poisoning, inappropriate drugs, food or drink and confinement of the child. While many children's injuries can occur while at play, physical abuse is suspected if the explanations do not fit the injury or a pattern or frequency is apparent (Child Protective Services (CPS), 2002). Again a complete history and physical examination will confirm or rule out any suspicions.

Behavioral indicators of physical child abuse may include school absences that correlate with the appearance of injury, behavioral extremes, i.e. overly compliant, passive, aggressive, or withdrawn (CPS, 2002). The child may be easily frightened, fearful, or wary of physical contact or touch, poor in social relations, afraid to go home, destructive to self and/or to others, complain of soreness or move uncomfortably, and wear clothing inappropriate to weather to cover the body (CPS, 2002). Also the child may be developmentally lagging or have increased school absenteeism. Behavioral indicators of the child’s caretaker may include any of the following: harsh disciplinarian,
substance abuser, talks about child in a consistently negative manner, defensive, and conceals or provides misleading information about the child’s injuries (CPS, 2002).

Physical neglect may include refusal or delay in seeking health care, abandonment, inadequate supervision, expulsion of child from the home, and failing to provide for the child’s safety, physical and emotional needs. Child Protective Services (2002) considers the physical indicators of physical neglect to include lack of personal hygiene, torn, dirty, inappropriate clothing for the weather, developmental lags, underweight, and perhaps flat, bald spots on an infants head. The behavioral indicators of a child suffering from neglect may include a dull and listless child, begging or stealing food, constant fatigue, and alcohol or drug use (CPS, 2002). The child’s caretaker behavioral characteristics may include substance abuse, chaotic lifestyle, apathetic, and one that expects too much from the child (Dubowitz, 2000).

Sexual abuse may include rape, incest, molestation, fondling, sodomy, oral penetration, anal or vaginal fondling or penetration. The first and foremost reliable indicator of sexual abuse is the child’s verbal disclosure. CPS lists other possible physical indicators of sexual abuse to include a diagnosis of venereal disease, recurrent urinary tract infections, bedwetting, pelvic inflammatory disease, pregnancy under the age of 16 years of age, foreign matter in the bladder, rectum or urethra, physical injury to genitals or rectum, bleeding underclothing, and difficulty or pain in walking or sitting. Suspicious physical findings include lacerations, abdominal masses (forceful blows to the abdomen may have ruptured organs), anal dilation of the rectum to more than two centimeters in boys or girls, and signs of pregnancy in pubescent girls (Chaney). The finding of gonorrhea, chlamydia, or syphilis in children is diagnostic of sexual abuse.
(Hay, Hayward, Levin, & Sondheimer, 1999). The most frequent sexually transmitted disease found in sexually abused children is Neisseria gonorrhea (Chaney, 2000).

Possible behavioral indicators or red flags of children that have been sexually abused would include any of the following: aggressive and overt sexual behavior, withdrawn with fantasy’s or unusually infantile behaviors, clinging, whining, hysteria, lack of emotional control, crying with no provocation, poor self-esteem, self devaluation, suicide attempts, avoidance of bathrooms, cruelty to animals, premature knowledge of explicit sexual acts, sleep disorders, eating disorders, sudden school difficulties, and role reversal with an overly concern for siblings well being (CPS).

According to the organization Prevent Child Abuse Indiana (PCAIN), 2003 behavioral characteristics of the caretaker may include a possessive or jealous caretaker that is extremely protective of family privacy and does not allow the child to be involved in extra-curricular activities. Other characteristics may include someone with a history of sexual abuse in childhood, substance abuse, immature with childlike impulse control and may perceive that the child enjoys the sexual relationship, or is an indicator of love and affection.

Emotional abuse and neglect is a pattern of behavior that can interfere with the child’s positive development by attacking the child’s psyche and self-concept. It is often less obvious then other forms of child abuse and difficult to prove. However there are several physical indicators that are associated with emotional abuse and neglect (Dubowitz, 2000). Much of what is known about the physical indicators of emotional abuse and neglect come from the Minnesota Mother Child Project, a study of 267 children born into low income families with multiple sociological risk factors (Black,
2000). These children were evaluated with a comprehensive assessment which included measures for cognitive and emotional functioning, academic performance, peer interactions and behavior (Black). The physical indicators found for children that were found to be emotionally abused or neglected included mental developmental delays, sleep disturbances, nightmares, failure to thrive, and speech disorders (Black). Behavioral indicators for children suffering from emotional abuse or neglect would include a low self-esteem, difficulty with forming relationships, eating disorders, elimination problems, self-destructive behaviors, apathetic, suicidal, withdrawn, anxious, fearful, and reports of emotional maltreatment (Black). According to Dubowitz (2000) the behavioral characteristic of the caretaker may include unrealistic expectations of the child, a low self-esteem, lack of concern for the child's well being, threatening, name calling, rejecting, ignoring, terrorizing, isolating and corrupting.

**Reporting**

All professionals dealing with children are directed by laws in their states to report suspicion of child abuse to local authorities such as Child Protective Services. According to the National Clearinghouse on Child Abuse and Neglect (2002), individuals that have frequent contact with children are mandated by law to report child abuse. Individuals designated as mandatory reporters includes health care workers; school personnel; day-care providers; social workers; law enforcement officers and mental health professionals or any other individuals responsible for the care of children (National Clearinghouse on Child Abuse and Neglect Information, 2002). Failure to report suspicion may result in legal consequences. In the state of Arizona it is a class one misdemeanor to fail to report suspected abuse or neglect (Statute 13-3620).
Failure to comply with these laws is punishable by up to six months in jail, a fine of $1000, or both, in addition to criminal charges or disciplinary action by the state board of nursing. As long as a report is made in good faith, the individual reporting is immune from civil or criminal liability even if the report turns out to be invalid.

A report is generally made when there is reasonable cause to believe that a child has been abused, neglected, exploited or abandoned. The individual making the report is not required to prove the abuse (Arizona Department of Economic Security, 1999). A report can be made to Child Protective Services toll free hotline, or any law enforcement agency. In Arizona, the twenty-four hour statewide toll free child abuse hotline number is 1-888-SOS-CHILD (Arizona Department of Economic Security, 1999).

**Interventions**

Many different types of interventions have been implemented over the years to reduce the risk of child abuse and address existing problems within abusive families. These interventions incorporate most forms of individual, dyadic, group and family therapy.

One program that has been very successful in working with at risk families of newborns is the Hawaii Healthy Start Program by providing comprehensive home visitation services. The Hawaii Healthy Start program was designed to serve all families with newborns at risk. This program would follow newborns at risk to the age of five years, link all the infants to a medical home that would serve them through childhood, focus on parent-child attachment and interaction, child health, and child development (Earle, 1995). Data collected from this project were used to estimate that 42 cases of child abuse were prevented during a four year period (Earle, 1995).
In a study by Uriquiza and McNeil (1996), the Parent-Child Interaction Therapy (PCIT), was found to be highly a highly effective parent training program for conduct-problem children and their families. The PCIT incorporates both parent and child within the treatment sessions, and provides a mechanism to change the patterns of the dysfunctional parent-child relationship. The treatment involves both parent and child throughout the treatment sessions. The parents are instructed in both relationship enhancement and discipline strategies and are given the opportunity to practice during the sessions. One of the strengths of this program is that it emphasizes the development and reinforcement of positive affect and behavior on the part of the parent throughout the treatment program (Urquiza et al., 1996).

Other interventions for abused children may include crisis nurseries or day care programs. These interventions are designed to protect children from further maltreatment and to address the major elements associated with child abuse (Green and Meersand, 1994). According to Green and Meersand (1994) treatment would focus on both the antecedents and consequences of child abuse and neglect: Psychological, social, developmental, and environmental factors are addressed. A multidisciplinary team which includes psychiatrists, psychologists, social workers, and early childhood specialist would conduct a full family assessment and implement the treatment plan. Graduates are monitored for at least one year from post treatment and families may be followed for longer periods of time and are allowed to visit or request assistance in times of crisis for several years (Green et al., 1994).
Summary

Child abuse is a highly complex phenomenon with multiple etiological variables and indicators. A list of behavioral and physical indicators was presented. The nurse practitioner needs to take into account the types of interventions appropriate for the individuals and problems identified, and plan accordingly.
CHAPTER II

Theoretical Framework

Theory and the Project

The theoretical framework of Pender's Health Promotion Model guided this project. Health Promotion is described by Pridham (1998) as a major function of professional nursing that is directed towards the growth, development, improved wellbeing, adaptability to stressors, and the enhancement of the environment in which children live. Health promotion not only presupposes the prevention of disease but aids in the development of preventive interventions to counteract risk factors and strengthen protective factors (Pridham).

Pender's Health Promotion Model is the framework selected for this teaching project (see Appendix A). The projects focus is to provide nurse practitioners and other health professionals with a coherent and organized framework for intervening with clients in increasing health promoting behaviors and a safe environment for children. The project's aim is to provide nurse practitioners with the knowledge to assess and develop interventions that will address these personal influences relevant to each and every client.

The Health Promotion Model portrays the multidimensional nature of individuals interacting with their interpersonal and physical environments as they pursue optimum health. According to Pender (2002) this model accomplishes this by integrating a number of constructs from expectancy value theory and social-cognitive theory, within a perspective of holistic human functioning. Pender defines the major concepts and definitions of the Health Promotion Model as follows:
Prior Related Behaviors – Frequency of the same or similar behavior and the
direct or indirect effects of the likelihood of engaging in health behaviors.

Personal Factors – These include biological, psychological, and socialcultural
factors predictive of behavior and shaped by nature of the desired behavior being
considered. These factors are subcategorized as follows:

Personal Biological Factors- Includes age, gender, body mass index,
pubertal status, menopause, aerobic capacity, strength, agility or balance.

Personal Psychological Factors – Includes self esteem, self motivation,
personal competence, perceived health status.

Personal Sociocultural Factors – Includes variables such as race,
ethnicity, acculturation, education and socioeconomic status.

Perceived Benefits of Action – Anticipated outcomes.

Perceived Barriers to Action – Anticipated, imagined, or obstacles and expenses
to undertake a given behavior.

Perceived self-efficacy – Judgment of personal capability to organize and execute
a health promoting behavior.

Activity Related Effect – Subjective positive or negative emotions that occur
before, during or after behavior based on the stimulus properties of the behavior itself.

Interpersonal Influences – Cognitions concerning behaviors, beliefs, or attitudes
of others. Interpersonal influences include family, peers, and healthcare providers. One
of the assumptions of the Health Promotion Model is that health professionals exert
influence on persons throughout their life span (Pender 2002).
Situational Influences – Individual or personal perceptions and cognitions of any given situation or context that can facilitate or impede behavior.

Commitment to a Plan of Action – Planned strategy leads to the implementation of a desired health behavior.

Immediate Competing Demands and Preferences – Competing demands is an alternative behavior over which an individual has little control over due to environmental contingencies such as work or family care responsibilities.

Health Promoting Behavior – Endpoint or action outcome directed toward attaining positive health outcomes such as optimal well being such as providing a safe environment for children.

Summary

Nola Pender’s Model of Health Promotion was used in the development of this project as it is easy to understand, it applies to a variety of settings, and it provides a good framework for teaching health promotion regarding child abuse. The model’s concept of personal factors includes all dimensions of children at risk or abused children and their families such as biological, psychological, interpersonal, social, and cultural domains of their environment. The other concept of prior related behavior may alert the nurse practitioner to the increase risk for abuse for children that are witness to domestic violence or victims themselves. Incorporating these concepts of the Health Promotion Model into the teaching project will provide health professionals with a thorough understanding of the physical, emotional and behavioral manifestations and causes of abuse. This understanding will assist the nurse practitioner in designing beneficial activities or interventions to best meet the needs of a diverse population. The ultimate
goal of this teaching project is to maintain or enhance the health status and well being of all children by educating nurse practitioners and other health professionals in preventing or identifying child abuse.
CHAPTER III

Teaching Project

Introduction

This section describes the following resources used in the development of the teaching project, a) the specific audience this project is designed for, b) the source of the educational materials and, c) a table outlining the actual teaching plan with specific objectives as related to the concepts of Pender's Health Promotion Model.

The PowerPoint presentation utilized in the project is provided by Jane Schorzman, the program coordinator with The University of Arizona's Child Abuse InfoCenter and enhanced by the author. A copy of the letter authorizing the use of this power point presentation is provided in Appendix B. The InfoCenter is a clearinghouse for information, consultations, and training opportunities for professionals dealing with child abuse issues throughout Arizona. The material from this presentation is used extensively to promote cross-disciplinary expertise in the prevention and management of child abuse to professionals from a variety of backgrounds. A copy of the power point presentation utilized is included in Appendix C.

Specific Audience: This teaching project is for all levels of nursing students, registered nurses, nurse practitioners’, other health care providers from multiple health settings, and others individuals interested in this topic. The participants or learners ages may vary from the early twenty’s to late sixties and come from various backgrounds.

Learner Readiness: Learner readiness is defined as the need to learn in order to cope more satisfyingly with real-life tasks or problems (Knowles, 1980). Learner readiness is accepted by self selection of the workshop by participants.
**Setting:** May include a quiet college classroom or conference room in a professional setting. The room must be able to accommodate a small group of individuals and have the equipment to display electronic presentations. The equipment would include laptop computer, a projection device compatible with the power point software and hardware.

**Instructional Goal:** To provide a broad overview of child abuse education to health care providers or others. The overview will include risk factors, prevention strategies, signs and symptoms, reporting and various interventions related to child abuse.

**Context for teaching:** The teaching project will be presented in a lecture/discussion format along with PowerPoint to provide visual representation to supplement the oral presentation. Information will be provided in a step-by-step progression to convey cognitive information and to emphasize the details of child abuse assessment and management. Handouts will be provided by Child Protective Services with the Arizona Department of Economic Security to participants with important contact and referral information for reporting suspected or actual child abuse.

**Outcome Evaluation:** At the end of the presentation, participants will be given a questionnaire designed to evaluate their ability to identify risk factors, prevention strategies, signs and symptoms of abuse/neglect and where to report suspected/actual abuse (Appendix E).

The table in Appendix B presents the actual framework of the teaching plan. Included are the learning objectives, actions, and student evaluation of learning for each objective.
CHAPTER IV

Evaluation

On March 8th, 2003 at the Pima College Community Campus, a pilot Study was done to test the efficacy of the teaching project. The aim of the project was to update the nurse practitioners or other health care professionals’ ability to prevent, identify, report and plan interventions for child abuse or families at risk. There were 12 students present from a variety of professional backgrounds which included 2 nurse practitioners, one school administrator, and 9 registered school nurses. The oral presentation lasted approximately 50 minutes with a 10 minute class discussion at the end. After the presentation, outcome evaluation forms were handed out to the participants to determine whether or not the objectives for the teaching project had been met. The evaluation form used is included in Appendix E. Ten of the evaluation forms were returned with 100 percent of the objectives met; two of the evaluation forms were not returned for unknown reasons. One of the more interesting findings of the pilot study was the majority of the participants felt that education was the first and foremost primary intervention.

Summary

Nurse practitioners and nurses are in a unique position to help prevent and possibly stop child abuse. Education of health professionals is a positive approach to prevent or stop child abuse by increasing the awareness and knowledge of risk factors for child abuse, physical and behavioral indicators, reporting, and services available to parents or families at risk. A possible solution to preventing or stopping child abuse may be in the hands of all health care professionals.
References


Arizona Department of Economic Security; Division of Children, Youth and Families, Semi-Annual Report.


Widom, Cathy , S.Maxfield, Michael G, An Update of the “Cycle of Violence”,

Appendix A

Diagram of Nola Pender’s Revised Health Promotion Model (1996).
### Appendix B

#### Teaching Plan

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Actions</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pender's Concept of Personal Factors</td>
<td>1. List seven risk factors that correlate with the most abusive behaviors of child abuse.</td>
<td>Risk Factors for child abuse.</td>
</tr>
<tr>
<td>Biological</td>
<td></td>
<td>a. History of having been abused as a child.</td>
</tr>
<tr>
<td>Psychological</td>
<td></td>
<td>b. Young age between 18-30.</td>
</tr>
<tr>
<td>Sociocultural</td>
<td></td>
<td>c. Low income or poverty</td>
</tr>
<tr>
<td>Sub-objective #1 Identify the risk factors of child abuse.</td>
<td></td>
<td>d. Stressful life events.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. Social isolation or lack of social support.</td>
</tr>
<tr>
<td>Pender’s Concept of Perceived Benefits of Action</td>
<td>1. List two prevention strategies that are utilized to serve children at risk for abuse and to prevent abuse.</td>
<td>Programs instituted to identify and serve children at risk.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Sub-objective #1 Describe prevention strategies for children at risk.</td>
<td></td>
<td>a. The Parenting Profile Assessment Screening Tool.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Home visitation programs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. School Programs (Good touch, bad touch).</td>
</tr>
<tr>
<td></td>
<td>1. Accurately name</td>
<td>1. Physical indicators of</td>
</tr>
<tr>
<td><strong>Perceived Self-efficacy.</strong></td>
<td><strong>at least seven physical indicators of child physical abuse.</strong></td>
<td><strong>physical child abuse may include a series of unexplained bruises or welts, burns, fractures, sprains, head injuries, lacerations, abrasions, poisoning, inappropriate drugs, food or drink and confinement.</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Sub-objective #1</strong></td>
<td>1. Accurately name five behavioral indicators of physical child abuse.</td>
<td>1. Behavioral indicators of physical child abuse may include school absences that correlate with the appearance of injury, behavioral extremes, i.e. overly compliant, passive, aggressive, withdrawn, easily frightened, fearful, ware of physical contact or touch, afraid to go home, destructive to self or others, and</td>
</tr>
<tr>
<td><strong>List physical indicators of physical child abuse.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-objective #3</td>
<td>1. Accurately name at least ten physical indicators of child sexual abuse.</td>
<td>1. Physical indicators of child sexual abuse may include a diagnosis of venereal disease, pregnancy under the age of 16 years of age, foreign matter in the bladder, rectum or urethra, physical injury to genitals or rectum or urethra, physical injury to genitals or rectum, bleeding underclothing and difficulty or pain in walking or sitting.</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>List physical indicators of sexual child abuse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-objective #4</td>
<td>1. Accurately name four behavioral indicators of child sexual abuse.</td>
<td>1. Behavior indicators of children that have been sexually abused may include an aggressive and overt sexual</td>
</tr>
<tr>
<td>List behavioral indicators of sexual child abuse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>wears clothing inappropriate to weather to cover the body.</td>
<td></td>
</tr>
<tr>
<td>Sub-objective #5</td>
<td>1. Accurately name five physical behavior, withdrawn with fantasy's or unusually infantile behaviors, clinging, whining, hysteria, lack of emotional control, crying with no provocation, poor self-esteem, self devaluation, suicide attempts, avoidance of bathrooms, cruelty to animals, premature knowledge of explicit sexual acts, sleep disorders, eating disorders, sudden school difficulties, and role reversal with an overly concern for siblings.</td>
<td>1. Physical indicators of neglect of children may</td>
</tr>
<tr>
<td>Sub-objective #6</td>
<td>1. Accurately name five behavioral indicators of neglect of children.</td>
<td>1. Behavioral indicators of neglect of children may include the lack of personal hygiene, torn, dirty, inappropriate clothing for the weather, developmental lags, underweight, and perhaps flat, bald spots on the infants head.</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>List behavioral indicators of neglect of children.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-objective #7</th>
<th>1. Accurately name five physical indicators of emotional abuse of children.</th>
<th>1. Physical indicators of emotional abuse of children may include mental developmental delay, non-organic failure-to-thrive, eating disorders, speech</th>
</tr>
</thead>
<tbody>
<tr>
<td>List physical indicators of emotional abuse of children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching Program</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
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<td></td>
</tr>
</tbody>
</table>

### Sub-objective #8
List behavior indicators of emotional abuse in children.

#### 1. Accurately name
five behavioral indicators of emotional abuse of children.

#### 1. Behavioral indicators of emotional abuse of children may include:
- Low self-esteem,
- Difficulty forming relationships, fear of adult contact,
- Self-destructive behavior,
- Chronic academic underachievement,
- Cruel behavior, seeming to get pleasure from hurting people and/or animals.

### Pender's Concept of Commitment to a Plan of Action

#### Sub-objective #1

#### 1. Accurately name

#### 1. Individuals mandated by
<table>
<thead>
<tr>
<th>List individuals that are mandated by law to report child abuse.</th>
<th>four types of individuals that have frequent contact with children and are mandated by law to report child abuse.</th>
<th>law to report child abuse includes health care workers, school personnel, day-care providers, social workers, law enforcement officers and mental health professionals.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-Objective #2</strong></td>
<td><strong>1. Name two resources where a report can be made when there is reasonable cause to believe that a child has been abused.</strong></td>
<td><strong>1. Report child abuse to any law enforcement agency or Child Protective Services toll free hotline.</strong></td>
</tr>
<tr>
<td>Understand the action to be taken by nurse practitioners when child abuse is suspected.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pender’s Concept of Health Promoting Behavior</strong></th>
<th><strong>Sub-objective #1</strong></th>
<th><strong>1. Accurately list three different types of interventions to reduce the risk of child abuse and address existing problems.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify interventions for abused children.</strong></td>
<td><strong>1. Discuss the different interventions for child abuse and how they differ.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Individual.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Dyadic.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Group or family.</td>
</tr>
<tr>
<td>-------</td>
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<td>---------------------</td>
</tr>
</tbody>
</table>


Appendix C

Letter of Authorization for use of Power Point Presentation

Arizona's Child Abuse InfoCenter
Arizona Health Sciences Center
1501 N. Campbell Avenue
Tucson, AZ 85724-5073
520/626-8056

January 16, 2003

The University of Arizona
College of Nursing
P.O. Box 210203
Tucson, AZ 85721

The University of Arizona, College of Nursing, faculty and students, are welcome to use the Arizona's Child Abuse InfoCenter power point presentation, titled "Child Abuse and Neglect" provided the Arizona's Child Abuse InfoCenter title page, references and contact information at the end of the presentation are retained.

Signed:

Jane Schorzman
Senior Program Coordinator

JS/ms
Appendix D

Power Point Presentation

Agenda
- Scope of Child Abuse, definitions, and risk factors.
- Possible Indicators of Abuse and Neglect in Children
  - Physical Abuse
  - Sexual Abuse
  - Neglect
  - Emotional Abuse
- Why Children with Disabilities are at Greater Risk
- Arizona Reporting Laws.
- Reporting Child Abuse in Arizona
- Prevention & Intervention Strategies.

Scope of Child Abuse
- Nationally, an estimated 2,974,000 children are victims of child abuse (U.S. Dept of Health and Human Services, 1999).
  - Nationwide increase of 45% since 1987.

Consequences of Child Abuse
- Immediate: Physical abuse can cause neurological impairments as in Shaken Baby Syndrome.
- Long Term: Emotional and developmental problems such as low self esteem, depression, anxiety, post-traumatic stress disorder, difficulty in school, poor attendance, substance abuse, criminal behavior, violent behavior, and poor interpersonal relationships (Milner & Crouch, 1993).

Definitions
- Child is any individual under the age of 18 years.
- Child abuse is defined as any non-accidental injury or an act of omission by the child’s parent, caretaker or guardian that results in injury or an imminent risk of serious harm or substantial risk of death, impairment of health, or loss of impairment of function to the child.
### Physical Abuse
- Is characterized by the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking, or otherwise harming a child.
- The parent/caretaker may not have intended to hurt the child, however injury may have occurred as a result of over-discipline or physical punishment.

### Neglect
- Child neglect is defined as the failure to provide for the child’s basic needs.
- May be physical, educational, or emotional.
  - Physical - abandonment, inadequate supervision
  - Educational - allowance of chronic truancy, or failure to attend to special educational need
  - Emotional - spouse abuse in the child’s presence, permission of drug or ETOH use by the child

### Sexual Abuse
- Includes the fondling of a child’s genitals, intercourse, incest, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the product of pornographic materials.

### Emotional Abuse
- Includes acts or omissions by the parents or other caregivers that have caused, or could cause serious behavioral, cognitive, emotional, or mental disorders.

### Risk Factors
- History of family violence
- Parental use of substances or ETOH
- Parent's unwillingness to provide information
- Historical data that does not conform with physical findings
- Unrealistic expectations of the child
- Parent that had an unwanted pregnancy
- Minimal knowledge of child's development
- Early adolescent parent
- Environmental stressors
- Multiple school absences
- Child with learning or developmental disabilities
- Multiple unexplained illnesses, hospitalizations, or accidents
- General appearance (poor hygiene, malnourished, inappropriate clothing)

### Why are young children with disabilities more likely to be victims of abuse and neglect?
Young children -- those less than five years of age -- are most at risk for abuse and neglect. When a young child also has a disability, he or she is even more likely to be a victim. Here are some reasons why:

- As infants, they may cry more or be harder to soothe than other babies. Some babies need almost constant care. These are stressful situations for parents.
- Injuries with disabilities may not smile, give eye contact, or enjoy cuddling. These things usually help parents to enjoy their babies. When they don't happen, it may be hard for parents to develop a strong, loving connection toward their children.
- Long hospital stays, especially soon after birth, take away important time parents usually have with their new child. This is when parents normally develop loving and protective feelings.
- Young children with disabilities may not display developmental milestones as early as other children. Some of these milestones are walking, talking, potty training, or getting dressed without help. If the child does not do these things when a parent or other caregiver expects, the adult may feel frustrated, helpless, or angry.
**Appendix D – Continued**

**Power Point Presentation**

### Why are young children with disabilities more likely to be victims of abuse and neglect? (continued)

- Young children with disabilities may have behaviors that are difficult to handle. They may be less able to communicate that something is "right" or "wrong" behavior.
- Children with special needs may be less able to "go along with" activities that are not appropriate. They may be less likely to complain if someone were to hurt them.
- Compared to other children, they may be less able to physically defend themselves.
- Children who have developmental delays or other disabilities may have less understanding of what is "right" or "wrong" behavior.
- Many young children with disabilities are less able to communicate that something "bad" has happened to them. Sometimes a child who can communicate is not believed.

"Yes Are Not Abuse",
Council on Child Abuse and Neglect of Columbia, SC

### Possible Indicators Of Abuse and Neglect In Children

Indicators should be considered together with the explanation provided, the child's developmental and physical capabilities, and behavioral changes.

**REMEMBER As You Read The Lists That These Are Signs Of Possible Abuse or Neglect. It Is Possible For A Child To Show One Or More Of These Signs And No Maltreatment Has Occurred.**

### Physical Abuse

Non-accidental injuries that may include beatings, shaking, burns, human bite marks, with resulting bruises, broken bones, scars, or internal injuries.

**Physical indicators of Child Physical Abuse:**

- Breathing difficulties
- Unusual vomiting, especially if it contains blood
- Blood in diapers
- Bulging or recession of an infant's soft part of the scalp known as the "soft spot"

Immediate medical attention may be required if any of the above signs are observed. All of the above may have other serious medical causes as well.

### Physical Abuse (continued)

- Unexplained bruises or welts often found on torso, buttocks, back or thighs
- Wrap-around injuries; injuries on several different surface areas
- A variety of injuries in various stages of healing

### Physical Abuse (continued)

- Deep burns and those with a clear shape. (A child's natural tendency to pull away will keep many accidental burns from being deep or clearly shaped.) Burns found on palms, soles, buttocks, genitals and back. They can reflect patterns indicative of cigarettes, irons or incinerator burns (smoke blister, glove-like, doughnut shaped on buttocks or genitals)
- Bruises on soft tissue such as the upper ear or ear lobes, upper arms (grab marks), cheeks, mouth and lips (force feeding injuries)

### Physical Abuse (continued)

- Injuries that regularly appear after weekend, vacation or after not seeing child for a while.
- Human bite marks
- Hair loss from violent pulling
- Any marks that take the shape of an object commonly used to punish (belt buckle, electric cord, hand print)
- Restrain injuries commonly found around wrists, ankles, mouth, neck or mid-section
Appendix D – Continued

Power Point Presentation

Physical Abuse (continued)

Non-accidental injuries that may include beatings, shaking, burns, human bites, with resulting bruises broken bones, scars, or internal injuries.

Behavioral Indicators of Child Physical Abuse:
- Sudden or dramatic change in slowness or appropriateness
- Extreme agitation toward self or others, places or objects
- Unexplained loss of cooing or attempts at language
- Less or bale sailing, eye contact or exploring
- Inappropriate dressing of a child, which could be covering physical evidence
- Older children reluctant to change clothes for gym activities
- Child complains of soreness or moves uncomfortably
- Child reports injury

Physical Abuse (continued)

Behavioral Indicator of Child Physical Abuse: continued
- Child is unable to explain injury or gives explanation inconsistent with injury
- Sudden frightedness of (shy side from the caregiver and protests or cries when
- It is time to go home
- Sudden agitation toward self or others places
- Extreme withdrawal or aggressiveness
- Child requests extreme punishment for self or others
- Child appears to fear any disciplinary action; excessive crying when scolded

REMEMBER As You Read The Lists That These Are Signs Of Possible Abuse or Neglect. It is
Possible For A Child To Show One Or More Of These Signs And No Mistreatment Has Occurred
(Compiled by Arizona's Child Abuse InfoCenter)

Sexual Abuse

Exploitation of a child for sexual gratification of another person. Includes intercourse, sodomy, oral-genital stimulation, fondling, child prostitution, and child pornography.

Physical Indicators Of Child Sexual Abuse:
- Bruises, marks, lesions, bleeding around the genital areas or the mouth
- Genital irritation, swelling, redness, itching or pain
- Strange or unpleasant odors from the genitals, even after bathing
- Torn, stained or bloody underwear
- Child has unexplained difficulty walking or sitting
- Regression in toilet habits
- Loss of appetite
- Unexplained gagging
- Sexually transmitted disease
- Frequent, unexplained yeast or urinary infections
- Frequent headaches, stomach aches, and overall not feeling well
- Pregnancy

Sexual Abuse (continued)

Behavioral Indicators Of Child Sexual Abuse:
- Excessive masturbation
- Child demonstrates bizarre, sophisticated or unusual sexual knowledge or behavior beyond developmental level: "sexy" language, precocious or seductive play, excessive curiosity about sex matters
- Discomfort or extreme sensitivity to physical contact
- Avoidance of undressing or wearing extra layers of clothes
- Verbal disclosure
- Sudden change in behavior, regression to more childish behavior
Appendix D – Continued

Power Point Presentation

Sexual Abuse (continued)

Behavioral Indicators Of Child Sexual Abuse:
- Excessive clinging behaviors
- Fears and phobias such as fear of closed doors, showers or bathrooms
- Disturbed sleeping patterns; new and pronounced fear of sleeping alone
- Withdrawing from friends and family
- Depression, explosive outbursts
- Chronic running away
- Drug or alcohol abuse
- Acquaintances of unsuitable toys; menony or clothes
- Role reversal; overly concerned for siblings

Remember As You Read The Lists That These Are Signs Of Possible Abuse or Neglect. It is Possible For A Child To Show One Or More Of These Signs And No Malreatment Has Occurred. (Compiled by Arizona's Child Abuse InfoCenter)

Neglect

Physical Indicators Of Neglect Of Children:
- Height and weight significantly low
- Inappropriate clothing for the weather
- Unattended bruises or injury
- Significant loss of needed dental care
- Lack of nails, skin/shahy shdlter
- Appears continuously dirty or has severe body odor
- Lack of supervision

Remember As You Read The Lists That These Are Signs Of Possible Abuse or Neglect. It is Possible For A Child To Show One Or More Of These Signs And No Malreatment Has Occurred. (Compiled by Arizona's Child Abuse InfoCenter)

Neglect (continued)

Behavioral Indicators Of Neglect Of Children:
- Dull, apathetic appearance; tall, thinness, no energy
- Stunted responses to discomfort
- Constant hunger; begging, stealing or hoarding food
- Falling asleep in school
- Poor school attendance, frequent tardiness
- Developmental lags not associated with disability
- Feels unwanted, describes self negatively
- Repetitive acts of vandalism
- Child reports no caretaker in the home
- Assumes adult responsibilities

Remember As You Read The Lists That These Are Signs Of Possible Abuse or Neglect. It is Possible For A Child To Show One Or More Of These Signs And No Maltreatment Has Occurred. (Compiled by Arizona's Child Abuse InfoCenter)

Emotional Abuse

Chronic patterns of behavior such as beatflying, humiliating or ridiculing a child. It is evidenced by severe anxiety, depression, withdrawal and/or aggression as by diagnosed by RLD or Ph.D. and caused by the demulation or restriction by the parents.

Physical Indicators Of Emotional Abuse Of children:
- Non-organic Failure-to-Thrive
- Eating disorders
- Speech disorders, stuttering
- Sleep disturbances, night terrors
- Bedwetting
- Regressive behaviors that are sudden or pronounced

Remember As You Read The Lists That These Are Signs Of Possible Abuse or Neglect. It is Possible For A Child To Show One Or More Of These Signs And No Maltreatment Has Occurred. (Compiled by Arizona's Child Abuse InfoCenter)

Emotional Abuse (continued)

Behavioral Indicators Of Emotional Abuse Of children:
- Habit disorders such as biting, rocking, head-banging
- Fear of adult contact
- Overly compliant or demanding
- Poor friendship skills
- Makes negative comments about self
- Self-destructive behavior
- Chronic academic under-achievement
- Developmental lags not associated with a disability
- Cruel behavior, seeming to get pleasure from hurting people and/or animals

Remember As You Read The Lists That These Are Signs Of Possible Abuse or Neglect. It is Possible For A Child To Show One Or More Of These Signs And No Maltreatment Has Occurred. (Compiled by Arizona's Child Abuse InfoCenter)
Appendix D – Continued

Teaching Program  

Power Point Presentation

Arizona's Child Abuse Reporting Laws

Arizona Revised Statute 13-3620. Duty and authorization to report:

Any physician, hospital, intern, resident, surgeon, dentist, osteopath, chiropractor, podiatrist, county medical examiner, nurse, psychologist, school personnel, social worker, peace officer, parent, counselor, clergy, or priest or any other person having responsibility for the care or treatment of children whose observation or examination of any minor discloses reasonable grounds to believe that a minor is or has been the victim of injury, sexual abuse, sexual exploitation, incest, child prostitution, death, abuse or physical neglect which appears to have been inflicted or inflicted on such minor by other than accidental means shall immediately report or cause reports to be made of such information to a peace officer or to the child protective services in the department of economic security.

Arizona's Child Abuse Reporting Laws

When such telephone or in-person reports are received by the peace officer, they shall immediately notify child protective services in the department of economic security and relay the information available to them. When child protective services receives these reports by telephone or in person, it shall immediately notify the peace officer in the appropriate jurisdiction.

A person furnishing a report, information or records required or authorized under this section shall be immune from any civil or criminal liability unless the person acted with malice or unless the person has been charged with or is suspected of abusing or neglecting the child or children questioned.

Arizona Revised Statute 13-3620.01: False reports.

A person acting with malice who knowingly and intentionally makes a false report of child abuse or neglect or a person acting with malice who coerces another person to make a false report of child abuse or neglect is guilty of a class 1 misdemeanor.

Information For Report of Suspected Child Maltreatment

- Your name, title, agency
- Family members’ names (correct spelling), age, gender
- Addresses, telephone numbers
- Daytime location of child: school, day care, etc.
- Parent’s work location
- Specific description of suspected abuse or neglect
- Along with any statements in child’s own words
- Child’s current condition
- Relatives, if known
- Any services already in place for the family
- Drug use, domestic violence, or injuries present in the home
- Any other sources with pertinent information

To Report Child Abuse and Neglect in Arizona:

Call Toll Free: 24 Hours a Day
1-888-767-2445
1-888-SOS-CHILD

In an Emergency, Call 911

Prevention & Intervention Strategies

- School programs that teach “Good Touch, Bad Touch” in preventing child abuse.
- Provide support and education to at-risk parents.
- If a family appears taxed and socially isolated, nurses can intervene by referring the family to a social worker and identify community resources.
Appendix D – Continued

Power Point Presentation

References

The previous materials were compiled from the following sources:

- Arizona Department of Economic Security
- Pacer Center of Minneapolis, Minnesota
- Pima County Health Department, Arizona Department of Health Services, Office of Women’s and Children’s Health
- Project Prevent, the Council on Child Abuse and Neglect, the Center for Developmental Disabilities, and Prevent child Abuse of South Carolina
- Texas Council for Developmental Disabilities

Questions
Appendix E

Outcome Evaluation Form

Preventing, Identifying and Reporting Child Abuse

Purpose: To present an overview of the risk factors leading to child abuse, and the health care providers role in preventing, identifying, reporting and interventions for child abuse victims and their families. Objectives: After the presentation, participants will be given a 8 item questionnaire designed to evaluate their ability to: 1. Identify risk factors. 2. Signs and symptoms of abuse/neglect. 3. Reporting guidelines for suspected/actual child abuse. 4. Prevention strategies.

1. List five risk factors that correlate with the most abusive behaviors of child abuse.__________________________________________

2. Name five physical or behavioral indicators of physical child abuse.____________________________________________

3. List five physical or behavioral indicators of sexual child abuse._____________________________________________

4. Accurately name five physical or behavioral indicators of neglect of children.______________________________

5. Name five physical or behavioral indicators of emotional abuse of children.___________________________________________

6. Who are the mandatory reporters of child abuse in Arizona?__________________________

7. Where can you report child abuse?_________________________________________
8. List one intervention used to reduce the risk of child abuse.

---

**Evaluation:** Listed below are statements about the presentation. Please circle the number that best indicates your response.

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I met objective 1.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>2. I met objective 2.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>3. I met objective 3.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>4. I met objective 4.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>5. The objectives related to the purpose of the presentation.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>6. The learning method was effective for me.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

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