PEDIATRIC AND ELDER ABUSE: STATISTICS, ASSESSMENT, DIAGNOSIS AND REFERRAL

By

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A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

WASHINGTON STATE UNIVERSITY
College of Nursing
Intercollegiate Center for Nursing Education

May 1998
ACKNOWLEDGMENTS

There have been many people who have helped me in my endeavors as a student in the Master of Nursing program through Washington State University at the Intercollegiate Center for Nursing Education. I would like to thank the following people for their help and encouragement and to acknowledge the very special people they are.

TO:

Kathy Morton, Jolie Ewart, Kim Tinker and Linda Torretta: I wanted to thank each of you for your friendship. You have helped me study, been there to commiserate with when I’m feeling down and just for being wonderful people. Thank you.

Dr. Lorna Schumann for agreeing to be my committee chair, and for all the advice and direction you’ve given me throughout this program. Thank you.

Gail Synoground and Donna Tschida for being members of my committee. Thank you for your support. It’s meant a lot to me.

My family: my father and mother, Donald and Sandra; my sisters, Lorrie and Judy; my brother, Don; my brother-in-law, Bob; and my very special niece, Ashley. Thank you for your love and support and for your belief in me. I wanted to tell you I love you and thank you all.
Abuse is a prevalent part of society today. Two vulnerable populations are children and elders. Abuse among these populations continues to rise and is a major concern for all health care professionals. The primary care provider has an obligation to know what constitutes pediatric and elder abuse in their community and state or practice. The health care professional must know the signs and symptoms of abuse and neglect in order to diagnose and treat victims of abuse.

The elder population, adults aged 65 and older, is the fastest growing population today. The number of elders in America grew from 3.1 million in 1900 to 33.2 million in 1994 (WWW document. URL: http://www.census.gov/socdemo/www/agebrief.html). As the population has grown the problem of elder abuse has grown with it. The National Center on Elder Abuse (NCEA) found that reports of elder abuse increased by 106% from 1986 to 1994 (WWW document. URL: http://interinc.com/NCEA/Statistics/p1.html).

Though reporting has been deemed ineffective by many health care professionals, it is mandated in most states. Even if reporting of elder abuse does not lead to the ideal outcome, it is one of few interventions open to health care professionals.
Child maltreatment increased in every area according to the Third National Incidence Study on Child Abuse and Neglect (1993). Child fatalities due to abuse and neglect have also risen.

A more recently defined and accepted form of child abuse is Munchausen Syndrome by Proxy. This is abuse of a child by their caregiver so the caregiver may assume the sick role in a secondary manner.

It is important to look at the presentation of any health care problem. If the history is inconsistent with the type of injury presented, the health care professional should be suspicious.

As pediatric and elder abuse increases, intervention becomes more important. Knowledge of abuse and neglect, signs and symptoms, is necessary for all health care professionals.
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Pediatric and Elder Abuse: Statistics, Assessment, Diagnosis and Referral

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Abstract

Abuse is a prevalent part of society today. Two vulnerable populations are children and elders. Abuse among these populations continues to rise and is a major concern for all health care professionals. The primary care provider has an obligation to know what constitutes pediatric and elder abuse in their community and state or practice. The health care professional must know the signs and symptoms of abuse and neglect in order to diagnose and treat victims of abuse.

The elder population, adults aged 65 and older, is the fastest growing population today. The number of elders in America grew from 3.1 million in 1900 to 33.2 million in 1994 (WWW document. URL: http://www.census.gov/socdemo/www/agebrief.html). As the population has grown the problem of elder abuse has grown with it. The National Center on Elder Abuse (NCEA) found that reports of elder abuse increased by 106% from 1986 to 1994 (WWW document. URL: http://interinc.com/NCEA/Statistics/p1.html).

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As pediatric and elder abuse increases, intervention becomes more important. Knowledge of abuse and neglect, signs and symptoms, is necessary for all health care professionals.
Introduction

According to the U.S. Bureau of the Census, POPClock Projection, the resident population of the United States at 1:20:59 PM EST on December 13, 1997 was 268,667,537. This figure is based on the statistics that a baby is born every eight seconds, someone dies every thirteen seconds, an international immigrant enters the country every forty-three seconds, and a U.S. citizen returns to the country every 4,108 seconds. Overall, the net gain is one person every sixteen seconds. Of those deaths occurring every thirteen seconds, too high a percentage are due to abuse (WWW document. URL: http://www.census.gov/cgi-bin/popclock). Elders comprise one of two very vulnerable populations in the United States. The second population, subject to the whims of others, is the pediatric population.

The fastest growing population in the United States is the elder population. In 1900, elder Americans accounted for one in twenty-five of the population. That figure rose to one in eight in 1994. The increase was from 3.1 million United States residents age 65 or older in 1900 to 33.2 million in 1994. The U.S. Census Bureau data estimates that by the year 2050, one out of every five Americans will fall into the category of elderly. As the elder population has grown in number, the incidence of elder abuse has grown with it (WWW document. URL: http://www.census.gov/socdemo/www/agebrief.html).

Elder Abuse Statistics

The incidence of elder abuse has increased throughout the nation according to data from the National Center on Elder Abuse (NCEA 1997). In 1986, there were
approximately 117,000 reports of elder abuse in the United States. Reports increased to approximately 241,000 in 1994, a 106% increase. A conservative estimate of abused elders in 1994 was 820,000. This figure excludes those individuals found to be self neglecting (WWW document. URL: http://interine.com/NCEA/Statistics/p1.html).

**Abused and Abuser Characteristics**

Elder abusers are almost equally distributed between men and women. One report shows the incidence of male abusers to be 50.6%, women 49.3%. Women were found to be victims more often then men at 61.4% (WWW document. URL: http://interinc.com/NCEA/Statistics/p2.html), while the percentage in the study by Rounds, 1992 showed women to be abused at 77.8% compared to their male counterparts.

The mean age of abused elders is 78.7, with the abusers tending to be related to the victim (Rounds, 1992). Grown children of the abused elder account for up to 36.7% of elder abuse perpetrators. Other family members account for 14.8% of elder abusers and spouses account for 13.8% (WWW document. URL: http://interinc.com/NCEA/Statistics/p2.html).

Eighty-two percent of abusers were found to be caregivers with no support in their role as caregiver. Problems with elder immobility were found to increase the risk of neglect. Abused elders with mobility limitations were found to be abused at 60%, where their mobile counterparts were found to be abused at 17.6%. Incontinent individuals were found to be neglected up to 81.3%; mentally confused individuals were neglected up to 62.4%; bedridden individuals were found to be neglected in 85.7% of those individuals in the study (Rounds, 1992).
Role of the Primary Care Provider

Awareness

Elder abuse detection is not part of most health care professional’s basic education. Education of emergency department personnel and protocols developed to deal with elder abuse detection and management is required by the Joint Commission on the Accreditation of Healthcare Organizations (Capezuti, Yurkow, and Goldberg, 1996).

The 1996 study, by Uva and Guttman assessed the ability of emergency medicine physician residents to detect and report elder abuse. Of those residents who had not undergone the seminar on elder abuse detection and reporting, only 23% felt confident in their ability to recognize elder abuse in the emergency room. In the same group, only 17.6% were confident in their ability to properly report elder abuse. None of the residents used a protocol or were aware there were protocols dealing with elder abuse in the hospitals they rotated through.

Prevention

The first step in prevention of elder abuse is awareness. Many abused elders are isolated from contact with others. Primary care providers may be the persons, the elder sees on a semi-consistent basis and it is up to the health care provider to screen for abuse (Wesley, 1994). It is essential that the primary care provider be aware of what constitutes elder abuse in their state of practice. Laws pertaining to abuse and reporting of abuse differ from state to state. Legislation for federal funding of elder abuse services has never
passed, but all states have Adult Protective Services and forty-two states have laws requiring mandatory reporting of elder abuse (Capezuti, Brush and Lawson, 1997).

An important step in preventing elder abuse is being able to successfully assess situations conducive to abuse. Vulnerability has been found to be closely related to abuse and neglect. Factors identified to increase vulnerability included low income, more advanced age, physical infirmities, and psychological disabilities. Other factors found to increase elder vulnerability included overworked and chemically dependent caregivers, or caregivers who lacked interest or ability to provide adequate care (Frost and Willette, 1994).

Elders found to be in high-risk situations should have interventions implemented. Respite care and contact with other family members should be initiated to help alleviate caregiver stress. If the elder is in immediate danger, health care professionals have the obligation of contacting Adult Protective Services or local law enforcement. It is also important that the health care professional remember that where one form of abuse exists another is likely to coexist, requiring further detailed investigation (Wesley, 1994).

Abuse Assessment

A qualitative study involving twenty-one district nurses showed that they were not operating with a clear definition of elder abuse (Saveman, Hallberg and Norberg, 1993). In order to assess abuse and neglect the health care professional must have a working definition of what abuse is. Table 1 defines some of the various working definitions of elder abuse.
Abuse that is more obvious, is more likely to be reported. Canadian and Australian nurses polled by Trevitt and Gallagher, 1996, felt more confident and competent in dealing with physical abuse and neglect than with the less obvious sexual abuse. Other problem areas were recognizing and intervening with confinement, emotional abuse and neglect, material abuse and violation of rights.

Assessment

As with assessment of risk, the first step in assessment of abuse is knowing what the signs and symptoms of abuse are. Table 2 offers some of the signs and symptoms that are found with specific forms of elder abuse.

In cases of suspected elder abuse, the primary care provider must have a private interview with the elder. Questions should be simple and direct. Documentation must be accurate and detailed. Throughout the interview it is imperative that the health professional remain objective. If injuries are present, how, when and where the injury occurred is vital information (Humphries, 1997).

Careful assessment of elder/caregiver interactions are also important. Signs to be aware of are caregivers who are uncooperative or aggressive to health professionals, indifferent or angry toward the elder and who are domineering. Elders who are withdrawn or fearful may require further assessment (Humphries, 1997).

A complete head-to-toe physical assessment is required when physical abuse is suspected. All areas of the body should be assessed, especially those areas that usually remain covered (Cammer, 1996).
Treatment

Initial therapy when elder abuse has been determined, is treatment of physical injuries. If the elder is perceived to be in a situation where further harm or death appear to be imminent, then local law enforcement must be contacted immediately. The need for psychological counseling should also be evaluated.

An important point to remember is that the elder is an adult. Unless proven incompetent through the courts, the elder has the right to dictate their own care. If the elder is competent and decides to stay in the abusive situation, there is little that may be done.

Reporting Abuse

As part of a survey of health care professionals, 32% of nurses used adult protective services reporting as an intervention in elder abuse. Only, 35% considered reporting of elder abuse an effective intervention. Physicians were more likely to report elder abuse (45.5%), but were less likely to believe that reporting was an effective intervention (35%) (Tilden, et al., 1994).

Forty-two states mandate that health care providers report physical abuse if the incident is observed, location and nature of injuries is indicative of abuse or the elder complains that they have been abused. In those states where mandatory reporting is required, health care professionals may be fined or prosecuted for not reporting.

Pediatric Abuse Statistics

The Third National Incidence Study of Child Abuse and Neglect (NIS-3) showed major increases in all forms of child abuse and neglect when compared to NIS-2 findings.
Data was judged by two instruments in this study, the Harm Standard (Table 3) and the Endangerment Standard (Table 4). The greatest increase was found in emotional neglect at 333% from NIS-2 data reported in 1986 vs. data reported in NIS-3 results of 1993 (WWW document. URL: http://www.calib.com/nccanch/data/nis3.txt).

The Endangerment Standard and the Harm Standard are two sets of definition standards used in the NIS-3. The Harm Standard, first developed for use in NIS-1, requires an act or omission to happen in order for an incident to be classified as abuse or neglect. The Harm Standard has been used in all three national incidence studies.

The Endangerment Standard was developed for use in the NIS-2. It is used in conjunction with the Harm Standard. The Endangerment Standard adds those children who have not been physically abused or neglected, but are deemed to be at risk for maltreatment.

As the numbers show, the incidence of child abuse is increasing at phenomenal rates. It is the professional and ethical duty of health care providers to screen, treat and properly refer those children who are in neglectful and/or abusive situations. In 1994, there were 1,271 child fatalities related to abuse and neglect. These cases were confirmed by Child Protective Services (CPS) agencies. Up to 88% of child fatalities were children under five years of age, 46% were children under one year of age. Forty-five percent of these fatalities occurred in children who were or had been CPS clients (WWW document. URL: http://info-sys.home.vix.com/pub/men/abuse/studies/child-ma.html).
The 1997 study, by Southall, Plunkett, Banks, Falkov and Samuels, completed in Britain, involved undercover video taping of families under investigation for "apparent life threatening events." Abuse was confirmed in thirty-three of the thirty-nine cases. These children experienced deliberate poisoning, fractures and other forms of physical and emotional abuse.

When reviewing family histories for evidence of abuse, it was found that in the forty-one siblings of the children under investigation, there had been twelve sudden and unexpected deaths. Eleven of the twelve deaths had been attributed to SIDS (Sudden Infant Death Syndrome). As a result of investigation, four parents admitted to suffocating eight of these twelve children. Another child whose death was originally attributed to complications related to Rotovirus, was found to have been deliberately salt poisoned (Southall, Plunkett, Banks, Falkov and Samuels, 1997).

**Abused and Abuser Characteristics**

Perpetrators of abuse and neglect are equally male and female. Aunt’s, uncle’s, mothers, fathers, cousins, siblings and others have been cited as neglectful and abusive.

Hall, 1996 studied family characteristics common among grown women who were reportedly sexually abused. There were a number of commonalities found including scapegoating, economic instability, developmentally inappropriate task expectations, emotional role reversal, and substance abuse. Abuse started anywhere from age three to age thirteen with a mean onset at five years of age. Of the women in the study, it was found that sexual abuse continued for an average of eleven years (Hall, 1996).
NIS-3 statistics found 87% of women and 43% of men studied neglectful of children in their care. Sixty-seven percent of men and forty percent of women were found to be abusive to dependent children. Perpetrators of sexual abuse were predominantly men (89%), but there was a sizable population of women offenders (12%) (WWW document. URL: http://www.calib.com/nccanch/data/nis3.txt).

Sexual abuse was found to occur up to three times more frequently in girls than boys. However, boys were found to have higher rates of emotional neglect and increased incidence of serious injury (WWW document. URL: http://www.calib.com/nccanch/data/nis3.txt).

**Role of the Primary Care Provider**

**Assessment**

In order to competently assess, diagnose, and treat child abuse and neglect, the health care professional must: 1) understand how prevalent child maltreatment is, 2) be aware of what constitutes child maltreatment in their state of practice and 3) know the signs and symptoms of child abuse and neglect. Table 5 presents types of abuse, definitions of the abuse and some of the causes.

**Munchausen Syndrome By Proxy**

Another form of abuse that has garnered more attention in recent years is Munchausen Syndrome By Proxy (MSBP). MSBP has been defined as intentionally causing physical or psychological pain in a dependent person. These symptoms allow the
caregiver to assume the sick role in a secondary manner. Up to 95% of MSBP perpetrators are mothers (Volz, 1995).

Environmental and psychological factors should be considered when the clinical picture does not seem medically plausible. MSBP, as well as other forms of child maltreatment should be considered in cases where the diagnosis reached does not have a typical presentation (Bryk and Siegel, 1997).

The pediatric population at greatest risk of MSBP are infants and preschool children. It is important to get information from several different sources regarding the child’s symptoms and past medical history. Data that is obtained should be confirmed if (Bryk and Siegel, 1997). If MSBP is diagnosed, it is important to contact the proper child protective services.

Treatment

Appropriate treatment should be initiated for the child. Follow-up and monitoring of the child’s welfare may also be important considerations (Bryk and Siegel, 1997).

The first, and possibly easiest area of treatment is the physical. Injuries due to abuse and/or neglect are assessed and cared for. Appropriate treatment modalities should be implemented immediately whether it be initiating burn protocols, stitching lacerations or beginning nutritional assessment. Psychological counseling should also be considered.

All states have laws regarding child abuse and neglect. Health care professionals are responsible to know local, as well as state laws in order to initiate measures to stop
child maltreatment. Reporting of child abuse and neglect is required of health care providers.

It is important to have and maintain a therapeutic relationship with the family of the abused/neglected child. Other children in the family should also be evaluated for similar or dissimilar signs of abuse and/or neglect (WWW document. URL: http://www.ama.assn.org/public/releases/assault/orderfrm.htm).

Repeated abuse after discharge from an inpatient program has been found to be at least, as high as 16.8%. Abuse reoccurred anywhere from one day to 4.91 years after discharge. Neglect was found to be the highest area of reoccurrence at 44%. Neglect was followed by physical abuse at a rate of 34% and sexual abuse at 22% (Levy, et. al., 1995).

Referral

The first contact to be made in cases of child abuse/neglect should be to CPS. Most areas have CPS hotline numbers which may be found in local telephone directories. National hotline services may also be utilized to find local child protective services, if the health care provider does not have the necessary information.

According to NIS-3 (1993) results, the number of children investigated by CPS remained stable compared to NIS-2 (1986) figures. Unfortunately, the number of abused and neglected children has risen. This means that only 28% of cases referred to CPS in 1993, were investigated, as compared to the 44% investigated in 1986 (WWW document. URL: http://wwwcalib.com/nccanch/data/nis3.txt). Despite the lack of manpower to follow up and care for children in potentially dangerous situations, CPS remains one of the most important contacts a health care provider has. In cases where the child is in
immediate danger or has been seriously injured, local law enforcement should be contacted.

Conclusion

Elders and children are uniquely vulnerable to the people who care for them. The incidence of abuse and neglect continues to climb. Health care professionals, and in particular primary care providers, need to be aware of local and state definitions of what constitutes abuse and neglect. Signs and symptoms of abuse and neglect should be evaluated and treated. Cases must be referred to the proper authorities as part of the general treatment.

Further research is necessary in the areas of both pediatric abuse and neglect, as well as elder abuse and neglect. Studies to find effective interventions in treatment would be beneficial to all areas of health care. Better screening tools to assess for potential problem situations are also necessary.

Abuse and neglect of children and elders impacts all levels of health care. The bottom line is, prevention would be less costly in terms of money, resources, contact hours, emotional and physical anguish than treatment after the fact.

In summary:

1. Before being confronted by a possible abuse case the health care professional must know what is considered abuse in their area of practice.

2. Have necessary names and numbers of adult and pediatric protective services in the vicinity of the health care practice, before they are needed.
3. Make a point to find out local law enforcement policy in regards to pediatric and elder abuse.

4. Children or elders suspected of being abused should be interviewed alone.
References


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<th>Category</th>
<th>Definition</th>
<th>Example</th>
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<tr>
<td>Physical Abuse</td>
<td>willfully inflicted pain or injury</td>
<td>beatings, burning, inappropriate physical restraint</td>
</tr>
<tr>
<td>Psychological/ emotional abuse</td>
<td>willfully inflicted mental pain or suffering</td>
<td>threats, intimidation, isolation</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>non-consensual sexual interaction</td>
<td>unsolicited touching, rape, sodomy</td>
</tr>
<tr>
<td>Self Neglect</td>
<td>behavior by the elder which threatens their own safety</td>
<td>lack of food, water, shelter, poor hygiene</td>
</tr>
<tr>
<td>Caregiver Neglect</td>
<td>failure by the caregiver to meet the needs of the elder</td>
<td>failure to provide food, shelter, water, medication</td>
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<tr>
<td>Financial Abuse</td>
<td>illegal or improper use of an elders possessions</td>
<td>unauthorized use and misuse of money, property or assets</td>
</tr>
<tr>
<td>Abuse Type</td>
<td>Signs and Symptoms</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td>lacerations, burns, bruises in various stages of healing</td>
<td></td>
</tr>
<tr>
<td>Psychological/emotional abuse</td>
<td>fear, withdrawal, depression, anger, agitation, helplessness</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>unexplained sexually transmitted disease, soiled underwear</td>
<td></td>
</tr>
<tr>
<td>Financial Abuse</td>
<td>unpaid bills, missing belongings, forged checks</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>poor hygiene, rashes, decubitus ulcers, dehydration, malnutrition</td>
<td></td>
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Table 3

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<tr>
<td>Sexual Abuse</td>
<td>119,200</td>
<td>217,700</td>
<td>83</td>
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<tr>
<td>Physical Neglect</td>
<td>167,800</td>
<td>338,900</td>
<td>102</td>
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<tr>
<td>Emotional Neglect</td>
<td>49,200</td>
<td>212,800</td>
<td>333</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>269,700</td>
<td>381,700</td>
<td>42</td>
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(Seriously injured - increased by 299% - 141,700 in 1986 to 565,000 in 1993)

Table 4

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<th></th>
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<tr>
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<td>311,500</td>
<td>614,100</td>
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<td>Sexual Abuse</td>
<td>133,600</td>
<td>300,200</td>
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<td>Emotional Abuse</td>
<td>188,100</td>
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<td>Physical Neglect</td>
<td>507,700</td>
<td>1,335,100</td>
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<tr>
<td>Emotional Neglect</td>
<td>203,000</td>
<td>585,100</td>
<td>188</td>
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## Table 5

**Child Abuse: Types, Definitions and Causes**

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>inflicted physical pain and/or injury</td>
<td>punching, biting, pinching, burning, shaking</td>
</tr>
<tr>
<td>Physical neglect</td>
<td>failure to provide for a dependent child’s basic needs</td>
<td>failure to meet health care abandonment, failure to provide food and shelter</td>
</tr>
<tr>
<td>Emotional Neglect</td>
<td>failure to provide affection or psychological care</td>
<td>ignoring a child, inattention</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>use of a child for sexual gratification or exploitation</td>
<td>intercourse, incest, rape, sodomy, sexually explicit pictures or video</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>acts or omissions that may cause behavioral, cognitive, emotional or mental disorders</td>
<td>scapegoating, isolation, belittling, threatening</td>
</tr>
</tbody>
</table>