Abuse of Children and Dependent Adults

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Contact Hours: 4

Price: $29

Course Summary

This course provides a comprehensive look at abuse in our society. It discusses vulnerabilities of both children and dependent adults and provides indicators of abuse along with its risk and protective factors, suggesting best practices for healthcare workers who confront these populations.

Course Objectives

When you finish this course, you will be able to:

1. Describe abuse in 3 ways: type, consequences, and incidence and prevalence.
2. Identify at least 3 risk and 3 protective factors for victims and perpetrators of abuse.
3. State 4 categories of perpetrators.
4. List at least 4 physical and 4 behavioral indicators of possible abuse.
5. Relate 6 ways to ask about abuse.
6. Explain the obligation to report abuse if you are a mandated reporter.
7. Name 1 intervention and prevention strategy for addressing abuse.

Instructions for Mail Order

Once you've finished studying the course material:

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1. Exposure to Abuse

Illness, age, and disability render people vulnerable to abuse by those on whom they depend for care and protection. Abuse is an age-old crime that takes many forms: physical, psychological, sexual, and financial. It is a *hidden* form of mistreatment, occurring in private homes, adult daycare, and long-term care institutions. Adult abuse is far less likely to be reported than child abuse because of lack of public awareness. Abuse is "an intergenerational concern, as well as a health, justice, and human rights issue" (Lowenstein, 2009).

The maltreatment of children and of **dependent adults** (elders and other vulnerable adults) is a social issue as well as a public health issue and it presents problems for the entire community. Achieving the goals of intervention, protective services, and prevention requires the coordination of many resources. Both types of abuse share many things in common but there are some distinctions that will be discussed throughout the course.

Child Abuse and Neglect

Federal legislation lays the groundwork for state laws on child maltreatment by identifying a minimum set of actions or behaviors that define child abuse and neglect (CWIG, 2019).

The Federal Child Abuse Prevention and Treatment Act (CAPTA) (amended and reauthorized in 2010), defines child abuse and neglect as, at a minimum, "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation (including sexual abuse as determined under section 111), or an act or failure to act which presents an imminent risk of serious harm" (42 U.S.C. 5101 note, § 3) (CWIG, 2019; ACF, 2017).

Additionally, it stipulates that "a child shall be considered a victim of 'child abuse and neglect' and of 'sexual abuse' if the child is identified, by a State or local agency employee of the State or locality involved, as being a victim of sex trafficking (as defined in paragraph (10) of section 7102 of title 22) or a victim of severe forms of trafficking in persons described in paragraph (9)(A) of that section" (42 U.S.C. § 5106g(b)(2)) (CWIG, 2019).

Most federal and state child protection laws primarily refer to cases of harm to a child caused by parents or other caregivers; they generally do not include harm caused by other people, such as acquaintances or strangers. Some state laws also include a child's witnessing of domestic violence as a form of abuse or neglect (CWIG, 2019).

Types of Child Abuse

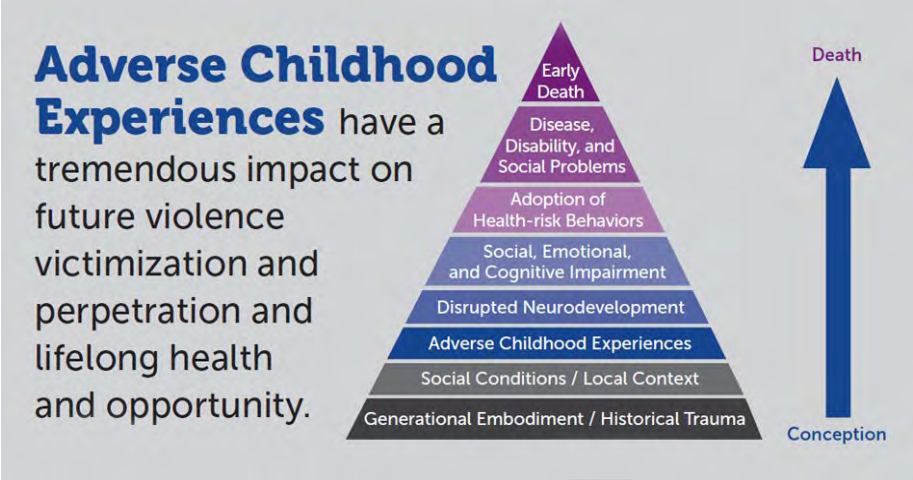
Abuse and neglect of a child by a parent, caregiver, or other person in a custodial role (eg, clergy, coach, teacher) are actions that result in harm, potential for harm, or threat of harm to the child. The four common types of abuse and neglect are:

- **Physical abuse**—intentional use of physical force such as hitting, kicking, shaking, or burning
- **Sexual abuse**—pressuring or forcing a child to engage in sexual actions including fondling, penetration, or exposure to other sexual activities
- **Emotional abuse**—behaviors that harm self-worth or emotional well-being such as name calling, shaming, rejection, withholding love, threatening
- **Neglect**—failure to meet basic physical and emotional needs of housing, food, clothing, education, and access to medical care (CDC, 2019; CWIG, 2019; ACF, 2017).

Most states recognize these four major forms of maltreatment. Many also classify abandonment, parental substance use, and human trafficking as abuse or neglect. As a way of addressing the abandonment of infants many states have passed "safe-haven" laws that allow the surrender of a newborn infant up to a certain age under specific conditions where the parents are exempt from charges of abandonment or abuse (CWIG, 2019; ACF, 2017).

Consequences

Effects of child abuse and neglect are both immediate and long term. Cuts, bruises, and broken bones, along with emotional or psychological problems such as impaired development and anxiety may be easily apparent, but left untreated or experienced chronically this maltreatment can lead to increased risk of injury, future violence victimization and perpetration, substance abuse, sexually transmitted infections, delayed brain development, reproductive health problems, involvement in sex trafficking, non-communicable diseases, lower educational attainment, and limited employment opportunities (CDC, 2019; CWIG, 2019, 2019a).



Source: CDC, 2019.

These physical, psychological, behavioral, and societal consequences affect abused children's present and future lives but can also affect the lives of unborn children. Recent research has found that abused children may experience genetic changes associated with a variety of physical and psychological disorders (CWIG, 2019a).

The monetary costs to society are not inconsequential. Centers for Disease Control and Prevention (CDC) researchers used 2015 data on child maltreatment costs to develop cost estimates that included both tangible costs (eg, child welfare, health care, juvenile justice) and intangible costs (eg, pain, suffering, grief).

The estimated lifetime cost for non-fatal incidents of child maltreatment is $831,000 per child, and for fatal incidents, it is estimated to be $16.6 million per child. Researchers appraised the annual cost of nonfatal child maltreatment in the United States to be $428 billion (based on the number of substantiated cases of nonfatal maltreatment) or $2 trillion (based on the number of investigated instances of nonfatal maltreatment) (CWIG, 2019a).

Obviously, the mistreatment itself is foremost, but government agencies have a duty to assess the costs of public health problems. In the United States the total lifetime economic burden of child abuse and neglect rivals that of other high-profile public health problems, such as stroke and type 2 diabetes (CDC, 2019).

Incidence and Prevalence

Child abuse and neglect are regrettably not uncommon, with approximately 1 in 7 children experiencing them in the last year, and this is believed to be an underestimation. The rates of child abuse and neglect are 5 times higher for children in families with low socioeconomic status as compared with those of higher socio-economic status (CDC, 2019).

Nationally, the 2017 Child Maltreatment Report, published by the Children's Bureau (part of the Administration for Children & Families of the U.S. Department of Health and Human Services, or DHHS), indicates that the(national, rounded) number of children who received a child protective services investigation response or alternative response increased 10% from 2013 to 2017. While the number of victims has varied over the last 5 years, the number increased 2.7% between 2013 and 2107 (CB, 2017).

Of the 2017 victims, 74.9% were neglected, 18.3% were physically abused, and 8.6% were sexually abused. Some victims suffered only one type of maltreatment while others were subjected to two or more. In 2017 an estimated 1,720 children died of abuse and neglect, which is 2.32 per 100,000 children in the national population (CB, 2017).

The most devastating outcome is the death of a child, and 72% of child fatalities involved children under the age of 3. Boys experience a higher fatality rate (2.68 per 100,000) than do girls (2.02); and, among African Americans, white, and Hispanic children, African Americans experience the highest rate (4.86) and Hispanic children the lowest (1.59) (CB, 2017).

Dependent Adult Abuse

Dependent adult abuse includes the abuse of elders (defined by the federal Older Americans Act of 1965 as anyone over 60 years of age), but it also includes maltreatment of anyone over age 18 whose physical and/or mental condition makes them dependent on others for care or protection. The term *vulnerable adult* is often used to encompass both groups (ACL, 2017).

The Elder Justice Act was passed in 2010 and is the first comprehensive legislation at the federal level. to address the abuse, neglect, and exploitation of older adults The law authorized a variety of programs and initiatives to better coordinate federal responses to elder abuse, promote elder justice research and innovation, support Adult Protective Services systems, and provide additional protections for residents of long-term care facilities. The Elder Justice Act established the Elder Justice Coordinating Committee to coordinate activities related to elder abuse, neglect, and exploitation across the federal government (ACL, 2017a).

Types of Adult Abuse

In general, **dependent adult abuse** refers to any knowing, intentional, or negligent act by a caregiver or other trusted person that causes harm or a serious risk of harm to the vulnerable adult. All fifty states have some form of law preventing elder abuse, but these laws and the definitions they employ vary considerably, so it is important to understand the specific laws of your state (ACL, 2019; CDC, 2019a; CDC, 2016; NAPSA, 2019).

Frequently recognized types of elder abuse include:

- **Physical**—illness, pain, or injury caused by the use of physical force such as hitting, kicking, pushing, slapping, and burning
- **Sexual**—forced or unwanted sexual interaction of any kind, contact and non-contact
- **Emotional or psychological**—verbal and non-verbal behaviors that inflict anguish, mental pain, fear, or distress and may include name calling, humiliating, destroying property, and blocking access to family and friends
- **Neglect**—failure to meet basic needs of food, water, shelter, clothing, hygiene, and essential medical care
- **Financial**—illegally or improperly using the vulnerable adult's money, benefits, belongings, property, or assets for someone else's benefit, can include removing money from an account without authority, unauthorized credit card use, or changing a will without permission (CDC, 2016).

Other terms that are sometimes treated as separate types or as components of those above include:

- **Isolation**
- **Exploitation**—the illegal taking, misuse, or concealment of funds, property, or assets of a senior for someone else's benefit
- **Abandonment**—desertion of a vulnerable adult by anyone who has assumed the responsibility for care or custody of that person
- **Self-neglect**—characterized as the failure of a person to perform essential, self-care tasks and that such failure threatens his/her own health or safety (ACL, 2019).

Consequences

[This section taken largely from NCEA, 2019.]

Like child abuse, dependent adult abuse has short- and longer-term impacts. Elder abuse's many negative impacts exist on both micro and macro levels:

Physical

- The most commonly documented physical impacts of elder abuse include: welts, wounds, and injuries (bruises, lacerations, dental problems, head injuries, broken bones, pressure sores); persistent physical pain and soreness; nutrition and hydration issues; sleep disturbances; increased susceptibility to new illnesses (including sexually transmitted diseases); exacerbation of pre-existing health conditions; and increased risks for premature death.
- Elders who experienced abuse, even modest abuse, had a 300% higher risk of death when compared to those who had not been abused.

Psychological

- Established psychological impacts include levels of psychological distress, emotional symptoms, and depression higher than those observed among elders who have not experienced these exposures.
- One study of older women found that verbal abuse only leads to greater declines in mental health than physical abuse only.

Financial

- Financial exploitation causes large economic losses for businesses, families, elders, and government programs, and increases reliance on federal health care programs such as Medicaid.
- Research indicates that those with cognitive incapacities suffer 100% greater economic losses than those without such incapacities.
- Financial abuse by itself costs older Americans over $2.6 billion dollars annually.

Social

- Social consequences may vary from increased social isolation (due to self-withdrawal or perpetrator imposition) to decreased social resources (social identities, supports, roles in key networks) and increased expenditures on services to compensate for resources lost through exploitation and to identify and rehabilitate elder abuse victims.

Hospitalizations and disability

- Victims of elder abuse are three times more likely to be admitted to a hospital.
- Elder abuse is predictive of later disability among persons who initially displayed no disability and is associated with increased rates of emergency department utilization, increased risks for hospitalization, and increased risk for mortality.

Medical costs

- The direct medical costs of injuries are estimated to contribute more than $5.3 billion to the nation's annual health expenditures.
- Most adverse events in nursing homes—due largely to inadequate treatment, care and understaffing—lead to preventable harm and $2.8 billion per year in Medicare hospital costs alone (excluding additional—and substantial—Medicaid costs caused by the same events).

Other impacts

- Other societal costs may include expenses associated with the prosecution, punishment, and rehabilitation of elder abuse perpetrators. Estimates of such expenses are not currently available.
- Elder abuse causes victims to be more dependent on caregivers. As a result of providing care, caregivers experience declines in their own physical and mental health and their financial security suffers (NCEA, 2019).

Incidence and Prevalence

The National Council on Elder Abuse notes that experts have reported that knowledge about elder abuse lags as much as two decades behind the fields of child abuse and domestic violence. The need for more research is urgent and it requires a coordinated, systematic approach that includes policymakers, researchers, and funders (NCEA, 2019).

Research on elder abuse as proven to be especially challenging due to variations in definitions; ethical dilemmas; the unfamiliarity of Institutional Review Boards (IRBs) with elder abuse research; variations in standards and methods; reconciling different conclusions as to which type of abuse is most common; research translation; the lack of definitions of successful outcomes, which is an impediment to developing effective interventions; and finally a severe shortage of researchers (NCEA, 2019).

The NCEA notes that we simply do not know with certainty how many people suffer from elder abuse and neglect. Signs of this abuse may be missed by professionals working with the older population because of poor training and lack of awareness. In addition, elders may be reluctant to report abuse for a variety of reasons (NCEA, 2019).

The NCEA notes a several research findings of importance (2008–2015) while noting that studies use differing methodologies and definitions and may reflect regional differences:

- A comprehensive review article found the prevalence of elder abuse to be approximately 10% including physical abuse, psychological or verbal abuse, sexual abuse, financial exploitation, and neglect.

- In a study on elder abuse by family members in which data was collected by elder abuse type, researchers found that respondents most frequently reported verbal mistreatment (9%), followed by financial mistreatment (3.5%) and lastly physical mistreatment (less than 1%).

- A groundbreaking study based in New York estimated that 260,000 (1 in 13) older adults in the state of New York had been victims of at least one form of elder abuse in the preceding year. This study found that major financial exploitation was self-reported at a rate of 41 per 1,000 surveyed, which was higher than self-reported rates of emotional, physical, and sexual abuse or neglect.

- Available data from state Adult Protective Services (APS) agencies show an increasing trend in the reporting of elder abuse.

- Elder abuse is also underreported. The New York State Elder Abuse Prevalence Study found that for every case known to programs and agencies, 24 were unknown (NCEA, 2019).

Financial exploitation is a fast-growing form of abuse of vulnerable adults. In recent research, 1 in 20 elders reported recent incidents of perceived financial mistreatment, and 90% of abusers are family members or trusted others, such as caretakers, neighbors, friends, and professionals (attorneys, doctors and nurses, pastors, bank employees). Elder abuse in all forms is seriously underreported and only 1 in 44 cases of financial abuse is ever reported (NAPSA, 2019).

2. Risk and Protective Factors in Abuse

In Child Abuse

A combination of individual, relational, community, and societal factors contribute to the risk of child maltreatment. Although children are not responsible for the harm inflicted upon them, certain characteristics have been found to increase their risk of being abused or neglected. **Risk factors** are those characteristics associated with child maltreatment—they may or may not be direct causes (CDC, 2019b).

Risk Factors for Victimization

Individual risk factors

- Children younger than 4 years of age

Special needs that may increase caregiver burden (e.g., disabilities, mental health issues, chronic physical illnesses) (CDC, 2019b).

Additional child factors that can increase the risk of abuse include a baby that is sickly, colicky, unwanted, or a product of an abusive relationship; a lack of attachment between child and parent can also be a risk factor (Child Matters, n.d.).

Age can be a factor in the type of abuse children experience. Babies are small and in need of constant care, and are more likely to experience abuse such as shaking by a frustrated or overwhelmed caregiver, while teenagers are at greater risk for sexual abuse (APA, 2019).

Children with aggression, attention deficits, difficult temperaments, or behavior problems have an increased risk of maltreatment, especially if their parents are not well equipped to cope with the behavior. Abuse can then exacerbate the original problem, or a physically abused child may develop aggressive behaviors; in either case a vicious cycle ensues (APA, 2019).

Risk Factors for Perpetration

Individual risk factors

- Parents' lack of understanding of children's needs, child development and parenting skills
- Parents' history of child maltreatment in family of origin
- Substance abuse and/or mental health issues including depression in the family
- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income
- Non-biological, transient caregivers in the home (eg, mother’s male partner)
- Parental thoughts and emotions that tend to support or justify maltreatment behaviors (CDC, 2019b).
- Parent has already abused a child (Child Matters, n.d.).

Family risk factors

- Social isolation
- Family disorganization, dissolution, and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships, and negative interactions (CDC, 2019b).

Community risk factors

- Community violence
- Concentrated neighborhood disadvantage (eg, high poverty and residential instability, high unemployment rates, high density of alcohol outlets), and poor social connections (CDC, 2019b).

It is important to remember that the vast majority of parents and caregivers dealing with the stresses noted above do not abuse the children in their care. However, being aware of these factors and alert to a situation can allow a bystander, family member, or other adult to be supportive, offer assistance or, if necessary, take appropriate action to protect a child's health and safety (APA, 2019; Child Matters, n.d.).

Protective Factors for Child Maltreatment

Protective factors may reduce the likelihood of children's being abused or neglected. However, protective factors have not been studied as extensively or rigorously as risk factors and additional work to identify and understanding protective factors is just as important (CDC, 2019b).

Family protective factors

- Supportive family environment and social networks
- Concrete support for basic needs
- Nurturing parenting skills
- Stable family relationships
- Household rules and child monitoring
- Parental employment
- Parental education
- Adequate housing
- Access to healthcare and social services
- Caring adults outside the family who can serve as role models or mentors
- Community protective factors
- Communities that support parents and take responsibility for preventing abuse (CDC, 2019b).

Factors of a child's personality and experience can also act as protective factors. These include:

- Optimism, high self-esteem, intelligence, creativity, humor, and independence, which improve coping skills when dealing with adversity
- Acceptance from peers
- Experience of love, acceptance, positive guidance, and protection from a caring adult (APA, 2019).

Protective Factors for Children with Disabilities

Children with disabilities are more vulnerable to maltreatment, but different forms of disability carry different levels of risk and not all children diagnosed with the same type of disability will have the same experience with abuse or neglect. Children with conduct-related disabilities may face a higher risk of physical abuse because of the inability of parents/caregivers to deal with the frustration engendered by their behavior (CWIG, 2018).

Children whose disability makes them entirely dependent on a caregiver, who experience hearing impairment, or are non-verbal, are at increased risk of neglect or sexual abuse. Welfare and healthcare providers will be better able to assist a child and family if they understand the nuances of the disability and of the child's personal, family, and social situations (CWIG, 2018).

Children with disabilities may feel isolated and powerless. They may have a limited ability to protect themselves or even to understand if they are being mistreated. The lack of independence and privacy that come with a need for total reliance on a caregiver may make it difficult for a child to identify inappropriate behavior (CWIG, 2018).

While most maltreatment is perpetrated by family members, children with disabilities face additional risks with other caregivers. In cases of substantiated abuse, they are more likely than children without disabilities to be placed in out-of-home care; also, they may face higher risks of sexual abuse with placements in isolating environments such as group homes or long-term care facilities, and it is important that foster care parents receive specific training in disability-related issues (CWIG, 2018).

Despite a common misperception that having a disability is a protective factor for a person, there are still some protective possibilities. One potential protective factor is willingness of parents to engage with a variety of service professionals regarding care for a disabled child. In addition, programs and services that are deliberately developed to emphasize a child's strengths and/or the individual strengths of caregivers can improve confidence and self-esteem and help a child feel more supported (CWIG, 2018).

In Dependent Adult Abuse

As with child abuse, a combination of individual, relational, community, and societal factors contribute to the risk of dependent adult maltreatment. They are contributing factors and may or may not be direct causes, but understanding them may facilitate opportunities for prevention (CDC, 2019c).

Risk Factors for Perpetration

Individual Level

- Current diagnosis of mental illness
- Current abuse of alcohol
- High levels of hostility
- Poor or inadequate preparation or training for caregiving responsibilities
- Assumption of caregiving responsibilities at an early age
- Inadequate coping skills
- Exposure to abuse as a child

Relationship Level

- High financial and emotional dependence upon a vulnerable elder
- Past experience of disruptive behavior
- Lack of social support
- Lack of formal support

Community Level

- Formal services—such as respite care for those providing care to elders—are limited, inaccessible, or unavailable

Societal Level

A culture where:

- There is high tolerance and acceptance of aggressive behavior
- Healthcare personnel, guardians, and other agents are given greater freedom in routine care and decision making
- Family members are expected to care for elders without seeking help from others
- Persons are encouraged to endure suffering or remain silent regarding their pain
- There are negative beliefs about aging and elders (CDC, 2019c).

In addition to the above factors, there are also specific characteristics of institutional settings that can increase the risk for perpetration of abuse of vulnerable elders, including:

- Unsympathetic or negative attitudes toward residents
- Chronic staffing problems
- Lack of administrative oversight, staff burnout, and stressful working conditions (CDC, 2019c).

Protective Factors for Elder Abuse

As with child abuse, protective factors may help reduce risk for perpetrating abuse and neglect of vulnerable adults, but protective factors have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective factors are important as a means to determine whether they are effective as buffers against abuse of elders and other vulnerable adults (CDC, 2019c).

Protective Factors for Perpetration

Relationship Level

- Having numerous, strong relationships with people of varying social status

Community Level

- Coordination of resources and services among community agencies and organizations that serve the elder population and their caregivers
- Higher levels of community cohesion and a strong sense of community or community identity
- Higher levels of community functionality and greater collective efficacy

Institutional settings

- Effective monitoring systems
- Solid institutional policies and procedures regarding patient care
- Regular training on elder abuse and neglect for employees
- Education and clear guidance on durable power of attorney and how it is to be used
- Regular visits by family members, volunteers, and social workers (CDC, 2019c).

For Adults with Dementia

Elders with dementia are thought to be at greater risk of abuse and neglect than those of the general population of elders. Reasons for the added vulnerability include the fact that dementia can prevent a person from reporting or even recognizing that they are being maltreated, and they may be more easily taken advantage of by strangers (Alzheimer's Association, 2019).

The elder population is growing and the number of people with dementias, especially Alzheimer's disease, is also increasing, so this is a growing public health problem (NCEA, 2011; Alzheimer's Association, 2019).

While 1 in 10 elders is believed to have been subject to abuse or neglect, recent studies show that **nearly 50% of those with dementia have been subject to maltreatment** (NCOA, n.d.).

In one U.S. study, 20% of caregivers indicated concern that they might become violent with people in their care. Three studies done in other countries found overall rates of caregiver abuse of people with dementia in the range from 34% to 62%, while a U.S. study found abuse and neglect of people with dementia in 47.3% of the caregivers studied (NCEA, 2011).

In one study published in the *Journal of the American Geriatrics Society,* caregivers of those with dementia were surveyed about the types of abuse they had committed, and 60% reported verbal abuse, 5% to 10% physical abuse, and 14% neglect. Caregiver characteristics that are associated with mistreatment of people with dementia include anxiety, depressive symptoms, lack of social contacts, perceived burden, emotional status, and role limitations due to emotional problems. However, care recipients' psychological aggression and physical assault behaviors were deemed to be the best indicators for elder mistreatment in this study (NCEA, 2011). This is one of many areas surrounding elders and elder abuse that are in critical need of additional research.

For Adults with Disabilities

Based on figures from the 2010 U.S. Census, approximately 14 million, or 1 in 3, adults age 65 or older had a disability (NCEA, 2012). In 2014 estimates indicate that just over 16 million (35.9%) of non-institutionalized adults 65 and older have a disability (NCEA, 2019). A growing elder population and increasing levels of certain diseases associated with disability pointed toward a continuing rise in numbers.

While much more research needs to be done, what is available points to a significant increase in the risk for abuse of dependent adults with disabilities when compared with the risk for those adults without disabilities. Both women and men, institutionalized and non-institutionalized, are subject to this increased risk. A recent meta-analysis of research concludes that "over the course of their lives, IPV [interpersonal violence] occurs at disproportionate and elevated rates among men and women with disabilities" (NCEA, 2019; Hughes et al, 2012; APA, 2019a; WHO, 2019).

Millions of American adults utilize Personal Assistance Service (PAS), which refers to aid in performing activities of well-being, comfort, safety, appearance, and community interaction. Most PAS users are community dwellers and are older than 65 years of age. The majority of them (79%) utilize PAS provided by volunteer/unpaid persons, often a family member or friend. About 11% use a combination of volunteer and paid services, while 10% use only paid (NCEA, 2012).

Thirty percent of adults with disabilities who use PAS for aid with activities of daily living reported one or more types of maltreatment by their primary provider. Adults with lower incomes were most likely to experience mistreatment. Available studies also show increased risk of abuse for institutionalized men and women with disabilities (NCEA, 2012).

Abuse can be particularly hard to recognize with dependent adults and also hard for them to report. Increased awareness and inquiry are critical to helping to reduce this form of abuse.

3. Perpetrators

> What we know about ourselves and our behavior tells us that any of us might abuse or neglect our children. Many of us have felt at times that life is more than we can handle. What stops us from giving up or lashing out are skills and mechanisms we have learned to control or divert our anger, accept and assume adult responsibility, recognize realistic boundaries of acceptable behavior and expectation, and seek and accept help and support. When adults are faced with a situation that requires the use of coping skills that have not been developed, child abuse or neglect often results.
>
> Clermont County Ohio CPS, 2019

Child Abuse

The cogent statement above hints at the complexity of reasons why child abuse occurs. There is no simple answer because there is almost never one specific clear cause. The many risk and protective factors discussed in the previous module hint at the wide variety of personal, family, and community variables that can affect the occurrence of child abuse and neglect.

Some factors we know help predict increased risk, but there is no guaranteed effect because the straw that breaks the camel's back for one parent or caregiver may be an addressable challenge for another. In the end the why may be better turned into "what contributed to this situation and how can understanding those factors direct our efforts to bring the abuse or neglect to an end?"

Generally speaking, a perpetrator of child abuse must be someone responsible for the care of a child, and individual state laws define specific terminology. Perpetrators frequently include:

- Parent, guardian, foster parent
- Relative or any other person the child lives with who assumes responsibility for care and/or supervision
- Employee or agent of a public or private facility that provides care to the child and may include:
    - Hospitals
    - Health care facilities
    - Group homes
    - Mental health facilities
    - Residential treatment centers
    - Shelter care facilities
    - Detention centers
    - Childcare facilities
- Any person providing care for the child

Perpetrators of child abuse come from all walks of life, races, religions, and nationalities. They come from all professions and represent all levels of intelligence and standards of living. There is no single social stratum free from incidents of child abuse.

Abusive parents may show disregard for the child's own needs, limited abilities, and feelings. Many abusive parents believe that children exist to satisfy parental needs and that the child's needs are unimportant. Children who don't satisfy the parent's needs may become victims of child abuse.

Sexual abusers may have deviant personality traits and behaviors that can result in sexual contact with a child. Sexual abuse perpetrators sometimes use threats, bribery, coercion, or force to engage a child in sexual activity. They violate the trust that a child inherently places in them for care and protection and exploit the power and authority of their position as a trusted caretaker in order to misuse a child sexually. Often the child is threatened or warned "not to tell," creating a conspiracy of silence about the abuse.

State laws vary as to whether educators are caretakers and, if so, under what circumstances. Additionally, other children are sometimes cast in the role of caretakers, although an adult who delegated responsibility to them may still be considered responsible. Individuals who are not responsible for the child's care yet expose them to maltreatment are generally subject to a state's criminal statutes. Any questions should be verified in your state's legislation and usually links to that information will be available from your state or local department of health or child protective services department.

Dependent Adult Abuse

As with child abuse and neglect, dependent adult abuse has no single simple explanation, but the two categories of abuse have a somewhat different mix of factors. Among other things, when considering elder abuse, the many years in which a family dynamic has evolved can play a role in the abusive behaviors.

The literature on family and behavior offers several theories about possible factors that contribute to dependent adult abuse. These include the following:

- **Retaliation**. Someone who was abused as a child may harbor anger and resentment toward the abusive parent. When roles are reversed, the once-abused child sees an opportunity for retaliation.
- **Violence as a way of life**. We live in a violent society. The media are filled with violence, both real and imagined. Violence saturates TV, movies, and video games. Domestic violence is increasingly common, particularly in tough economic times. Family violence often creates generational patterns.
- **Unresolved conflict**. Conflict from childhood, from marital or other relationships, creates patterns of abuse that continue without resolution.
- **Lack of close family ties**. Lack of closeness in the relationship between adult children and their parents can create stress and frustration when the parent suddenly or gradually becomes dependent. This can lead to abuse.
- **Lack of financial resources**. Families who must juggle work and caregiving responsibilities may resent the addition of a dependent adult to the household. Increasing costs for medical care and other services can add to financial stress. Public assistance programs such as SSI and Medicaid may also decrease the dependent person's stipend if he or she is living with family members.
- **Resentment of dependency**. Caring for a frail older person who requires attention and assistance can be physically and emotionally exhausting. Stress and frustration can occur even when there is a close family tie.
- **Increased life expectancy**. The dependency period of old age has expanded, leaving caretakers to provide extensive home care for a longer period of time. Smaller families mean fewer children to care for elderly parents and grandparents.
- **History of mental or emotional problems**. Someone who is mentally or emotionally unstable may be unable to cope with the demands of caregiving. This can threaten the well-being of both caretaker and dependent adult.
- Unemployment. Financial and emotional stress raises the level of frustration and weakens self-control.
- **History of alcohol and drug abuse**. Substance abuse is often a factor in family violence. Alcohol suppresses inhibitions, making aggressive behavior more likely. This can be a factor for the caretaker as well as for the dependent adult.
- **Long distance caregiver**. Today's mobile population increases the likelihood that adult children may be living far from their parents, increasing the risk of neglect and additional stress.

Abusers of older adults are both men and women, and almost 60% of elder abuse and neglect is perpetrated by a family member, with two-thirds of perpetrators being adult children or spouses (NCOA, n.d.). After family members, the most frequent perpetrators are friends and neighbors (17%) and home care aides (15%) (NCEA, 2019).

Perpetrators are more likely to be male, have a history of past or current substance abuse, have mental or physical health problems, have a history of trouble with law enforcement, be socially isolated, be unemployed or have financial problems, and be experiencing major stress (NCEA, 2019).

Types of Perpetrators

Abusers can be categorized across a spectrum of types from well-intentioned to sadistic. The categories include:

- Well-intentioned but overwhelmed, stressed by the demands of caregiving and lashes out at the victim (means well but tries to do too much)
- Well-intentioned but ignorant and incompetent, doesn't understand how to take care of someone (leaves an Alzheimer's patient tied to a chair and goes grocery shopping)
- Lacks interest and concern, just needs a job (takes no pride in work, just wants an easy paycheck)
- Abusive, motivated by self-interest, power, and control (gains trust of dependent person, manipulates into signing over money or property)
- Sadistic, enjoys hurting, extreme power and control (looks for jobs with position and authority to gain control for the purpose of hurting others)

A recent study based on data collected from victims breaks perpetrators down in a slightly different way with four profiles—caregiver, temperamental, dependent caregiver, and dangerous—each presenting different risk factors (USC, 2017).

The first group made up 37% of the sample and provided high levels of both functional and emotional support, with about 90% of them assisting elders with personal care tasks. The smallest category at 7% was "dependent caregivers," who provided emotional support but were generally irresponsible, couldn't keep a job, and were financially dependent on the victim (USC, 2017).

Temperamental abusers were described as emotionally draining with volatile tempers. And dangerous abusers, who were nearly 25% of the sample, reflected a group of perpetrators the majority of whom had a history of trouble with the law and drinking problems. Victims described virtually all of them as emotionally draining (USC, 2017).

This study found that dangerous abusers were the most likely to inflict physical and emotional abuse, while those who did provide some emotional support were mainly perpetrating financial exploitation and neglect. Researchers hope that information from this study will be used to design more nuanced interventions that distinguish between types of abuser. When an abuser is providing help and is not likely to physically harm the victim, more training in appropriate care and personal support may address the problem. Situations involving dangerous abusers likely need an entirely different response (USC, 2017).

Expected Responses from Perpetrators

Depending on the type of perpetrator involved, responses to being confronted about the abuse vary among the following:

- Admission of guilt, embarrassment, desire to do better
- Admission, but believes abusive action was justified
- Varies with intelligence and sophistication
- Denial, outrage, rationalizations, attempts to "turn the tables" on the victim, reporter and/or investigator

4. Indicators of Abuse

Child Abuse

The following lists of physical and behavioral indicators suggest signs of possible child abuse for you to consider in evaluating a situation, especially if you need to decide whether to file an official report of child abuse or neglect. Indicators need to be evaluated in the context of the child's environment because the presence of one or more of these symptoms does not necessarily prove abuse. These lists are examples and are not all-inclusive; it is also important to become familiar with the definitions and requirements contained in your state's applicable laws.

Physical and Behavioral Indicators

Physical indicators

- Bruises and welts on the face, lips, mouth, torso, back, buttocks, or thighs in various stages of healing
- Bruises and welts in unusual patterns reflecting the shape of the article used (eg, electric cord, belt buckle) or in clusters indicating repeated contact
- Bruises on infant, especially facial bruises
- Subdural hematomas, retinal hemorrhages, internal injuries
- Cigarette burns, especially on the soles, palms, back, or buttocks
- Immersion burns (sock-like, glove-like, doughnut-shaped) on buttocks or genitalia
- Burns patterned like an electric element, iron, or utensil
- Rope burns on arms, legs, neck, or torso
- Fractures of the skull, nose, ribs, or facial structure in various stages of healing
- Multiple or spiral fractures
- Unexplained (or multiple history for) bruises, burns, or fractures
- Lacerations or abrasions to the mouth, frenulum, lips, gums, eyes, or external genitalia
- Bite marks or loss of hair
- Speech disorders, lags in physical development, ulcers
- Asthma, severe allergies, or failure to thrive
- Consistent hunger, poor hygiene, inappropriate dress
- Consistent lack of supervision, abandonment
- Unattended physical or emotional problems or medical needs
- Difficulty in walking or sitting
- Pain or itching in the genital area
- Bruises, bleeding or infection in the external genitalia, vaginal, or anal areas
- Torn, stained, or bloody underclothing
- Frequent urinary or yeast infections
- Venereal disease, especially in pre-teens
- Pregnancy
- Substance abuse—alcohol or drugs
- Positive test for presence of illegal drugs in the child's body

Behavioral indicators

- Afraid to go home; frightened of parents
- Alcohol or drug abuse
- Apprehensive when children cry, overly concerned for siblings
- Begging, stealing, or hoarding food
- Behavioral extremes, such as aggressiveness or withdrawal
- Complaints of soreness, uncomfortable movement
- Constant fatigue, listlessness, or falling asleep in class
- Delay in securing or failure to secure medical care

- Delinquent, runaway, or truant behaviors
- Destructive, antisocial, or neurotic traits, habit disorders
- Developmental or language delays
- Excessive seductiveness or promiscuity
- Extended stays at school (early arrival and late departure)
- Extreme aggression, rage, or hyperactivity
- Fear of a person or an intense dislike of being left with someone
- Frequently absent or tardy from school or drops out of school or sudden school difficulties
- History of abuse or neglect provided by the child
- Inappropriate clothing for the weather
- Massive weight change
- Indirect allusions to problems at home such as “I want to live with you”
- Lack of emotional control, withdrawal, chronic depression, hysteria, fantasy, or infantile behavior
- Lags in growth or development
- Multiple or inconsistent histories for a given injury
- Overly compliant, passive, undemanding behavior; apathy
- Poor peer relationships; shunned by peers
- Poor self-esteem, self-devaluation, lack of confidence, or self-destructive behavior
- Role-reversal behavior or overly dependent behavior; states there is no caretaker
- Suicide attempts
- Unusual interest in or knowledge of sexual matters, expressing affection in inappropriate ways
- Wary of adult contacts, lack of trust, uncomfortable with or threatened by physical contact or closeness

Perpetrator Behaviors with Children

Indicative actions by an abusive adult can take many forms and the lists below are only a sample. Sometimes the abuser’s behavior will be a clue as to what type of abuse they are engaged in.

Where **physical abuse** is happening, the adult abuser may:

- Have unrealistically high standards and expectations for self and children
- Have an undue fear of spoiling the child
- Consistently react to the child with impatience or annoyance
- Be overly critical of the child and seldom discuss the child in positive terms
- Lack understanding of the child’s physical and emotional needs, or their developmental capabilities
- Be incapable of child rearing
- Believe in the necessity of harsh physical discipline
- Be rigid or compulsive; hostile and aggressive; or impulsive with poor emotional control
- Be authoritative and demanding, or fear or resent authority
- Lack control or fear losing control
- Be cruel or sadistic
- Be irrational
- Accept violence as a viable means of problem resolution
- Be reluctant or unable to explain the child’s injuries or condition or give explanations which are farfetched or inconsistent with the injury
- Over or under react to the child’s injury
- Not consent to diagnostic studies of the child
- Have the child treated by a different hospital or physician each time the child needs medical attention
- Fail to keep appointments
- Trust no one; feel alone, without friends or support; or view seeking or accepting help as a weakness
- Be under pressure
- Have an emotionally dependent spouse; be engaged in a dominant-passive marital relationship; or have other marital problems

- Have been physically abused himself/herself

Where **sexual abuse** is happening, the adult abuser may:

- Be overly protective of the child
- Refuse to allow the child to participate in social activities
- Be jealous of the child's friends or activities
- Accuse the child of promiscuity
- Distrust the child
- Have marital problems
- Need to be in control or fear losing control
- Be domineering, rigid, or authoritarian
- Favor a "special" child in the family
- Have been sexually abused himself/herself

Where **emotional maltreatment** is happening, the adult abuser may:

- Act irrationally or appear to be out of touch with reality
- Be deeply depressed
- Exhibit extreme mood swings
- Constantly belittle the child or describe the child in terms such as "bad," "different," or "stupid"
- Be cruel or sadistic
- Be ambivalent towards the child
- Expect behavior that is inappropriate to the child's age or developmental capabilities
- Consistently shame the child
- Threaten the child with the withdrawal of love, food, shelter, or clothing
- Consistently threaten the child's health or safety
- Reject the child or discriminate among children in the family
- Be involved in criminal activities
- Use bizarre or extreme methods of punishment
- Avoid contact with the child, seldom touching, holding, or caressing him/her
- Avoid looking or smiling at the child
- Be overly strict or rigid
- Torture the child
- Physically abuse or neglect the child
- Have been abused or neglected himself/herself

Where **neglect** is happening, the neglecting adult may:

- Be apathetic
- Have a constant craving for excitement and change
- Express dissatisfaction with his/her life
- Express desire to be free of the demands of the child
- Lack interest in the child's activities
- Have a low acceptance of the child's dependency needs
- Be generally unskilled as a parent
- Have little planning or organizational skills
- Frequently appear unkempt
- Perceive the child as a burden or bother
- Be occupied more with his/her problems than with the child's
- Be overly critical of the child and seldom discuss him/her in positive terms
- Have unrealistic expectations of the child, expecting or demanding behavior beyond the child's years or ability
- Seldom touch or look at the child
- Ignore the child's crying or react with impatience
- Keep the child confined, perhaps in a crib or playpen, for long periods of time

- Be hard to locate
- Lack understanding of the child's physical or emotional needs
- Be sad or moody
- Fit the clinical description "passive and dependent"
- Lack understanding of the child's developmental capabilities
- Fail to keep appointments and return telephone calls
- Have been neglected himself/herself (Clermont County Ohio CPS, 2019).

Dependent Adult Abuse

When evaluating a situation for potential abuse, be alert to behaviors of both the victim and the abuser that signal possible abuse or other serious problems. These behaviors may occur in the absence of abuse, but their presence warrants consideration of the possibility of abuse.

Abuser Behaviors

- Victim not allowed to speak for himself or herself
- Obvious absence of assistance
- Indifference or anger toward victim
- Blames the victim
- Aggressive behavior
- Previous history of abuse to others
- Problems with alcohol or drugs
- Flirtations, coyness, etc.
- Conflicting accounts of incidents by the family, supporters, victim
- Noncompliance with service providers in planning for care and implementation
- Withholding of security and affection

Perpetrators frequently groom their targets before assault, gaining trust, testing the waters to see how the person will react. Indicators of grooming include showing special interest in the person, gifts, touching, massage, setting up time to be alone (bathing in the late evening, providing transportation).

Dependent Adult Behaviors

- Fear or reluctance to openly talk with others
- Withdrawal or quiet/subdued, depressed mood
- Depression, either acute or situational, that is uncharacteristic of the person's past behavior
- Helplessness or resignation, an "I don't care" attitude, too accepting of their perceived fate/future
- Hesitation to talk openly, reluctant to discuss their well-being, change the subject to non-threatening issues
- Implausible stories (not related to dementia), explanations that don't match up with facts or visible circumstances
- Confusion or disorientation (not related to dementia), difficulty in expressing thoughts, appears distracted
- Ambivalence/contradictory statements, fails to show concern about personal events, unable to repeat the same explanation of events or circumstances
- Anger, displayed toward you, family/friends, or toward everyone and everything
- Non-responsiveness, refuses to answer questions appropriately
- Agitation/anxiety, becomes increasingly agitated or anxious when you are there

Indicators of Physical Abuse

The presence of a single indicator may not raise suspicion of abuse, but a combination of indicators may reveal a serious situation. The concerned observer may want to question further, document the situation for future use, or make a report.

Examples of physical abuse in society

- Injury that has not been properly cared for
- Any injury incompatible with history
- Pain on touching
- Cuts, lacerations, or puncture wounds
- Dehydration and/or malnourishment
- Pallor
- Sunken eyes, cheeks
- Evidence of inadequate care
- Eye problems, retinal detachment
- Poor skin hygiene
- Absence of hair or hemorrhaging below scalp
- Soiled clothing or bed
- Burns
- Locked in a room
- Evidence of unset bones
- Heavy or excessive medication

Examples of physical abuse by staff

- Unauthorized use of physical or chemical restraints
- Administration of medications or enforced isolation as punishment or simply for convenience
- Use of substitute treatment in conflict with a physician's order

Dating of bruises

Physicians and law enforcement disagree about the validity of dating of bruises. However, they do agree that bruises change color as the injury ages and the simultaneous presence of bruises of various colors on the same person indicates separate injuries.

Indicators of Sexual Abuse

Some of these indicators include the following:

- Person's behavior changes drastically, e.g., acting out, angry, lashing out, inappropriate affect.
- Person is depressed or shows symptoms of other mental health issues.
- Person acts afraid in the presence of the caretaker.
- Person does not want to be left alone with the caretaker.
- Genital or anal bruises
- Vaginal or anal bleeding
- Swelling or redness of genital area
- Venereal disease

Elders and people with disabilities may be targeted by sexual predators due to their vulnerability. Most people with developmental disabilities have had no sex education. More than 80% of women and more than 30% of men with developmental disabilities have experienced sexual assault. Nearly three-quarters of women with disabilities have been violently victimized sexually at some point in their lives.

Sexual assault is not spontaneous or accidental, but communities tend to blame the survivors. It is often treated as a scandal, an internal personnel matter, or a public relations problem. Although most of the victims are female, there are also male victims.

Frail elders too often lack a strong support system, which makes them more vulnerable to abuse. Their beliefs about sexual abuse increase feelings of shame and guilt.

Sexual abuse differs with age or frailty

- May complicate an existing illness
- Involves a longer recovery time to deal with abuse
- Increases the chance of sustaining serious injury
- May cause genital tearing and bruising
- May fracture pelvis or hip bones
- Increases the risk of infections

Indicators of Financial Exploitation

The act or process of taking unfair advantage of a dependent adult or a dependent adult's physical or financial resources for one's own personal or pecuniary profit, without the informed consent of the dependent adult—including theft, by the use of undue influence, harassment, duress, deception, false representation, or false pretenses as a result of the willful or negligent acts or omissions of a caretaker.

Indicators

- Dependent adult is inaccurate, confused, or has no knowledge of finances
- Disparity between income/assets and lifestyle or living arrangement
- Caretaker expresses unusual interest in the amount of money spent for care of the dependent adult
- Unpaid bills when resources should be adequate
- Caretaker is evasive about financial arrangements
- Signatures on checks don't match dependent adult's signature
- Unusual activity in bank accounts
- Dependent adult turns over financial affairs to someone in exchange for lifelong care, but does not appear to have basic necessities such as food and shelter
- Caretaker begins to handle the dependent adult's financial affairs without his or her presence or without consultation

Examples

- Misuse of power of attorney or conservatorship
- Identity theft
- Scams
- Coercion into signing or changing legal documents
- Taking or misusing a dependent adult's property, money, social security or pension check, food stamps, medication, or others

Indicators of Denial of Critical Care (Neglect)

Denial of critical care (neglect) is defined as the deprivation of the essential minimum food, shelter, clothing, supervision, physical or mental health care, and other care necessary to maintain a dependent adult's life or health, as a result of the willful acts or negligent acts or omissions of a caretaker.

Indicators

- Pattern of failure to provide adequate food; malnourishment; or contaminated or spoiled food in home
- Lack of adequate clothing to provide protection from the weather
- Lack of heat in winter or lack of air conditioning or fans in summer; unsanitary or hazardous conditions
- Refusal to provide medical evaluation for condition detected by medical personnel
- Failure to follow through with medical treatment plan recommended by health professional
- Unable to manage affairs because of confusion and deterioration
- Leaving dependent adult who is incapable of self-supervision without a responsible caretaker
- Knowingly selecting an inappropriate caretaker
- Abandonment

Examples

- Withholding of care, medication, food, liquids, assistance with hygiene, etc.
- Failure to provide physical aids such as eyeglasses, hearing aids, false teeth
- Failure to provide safety precautions and access to care

Indicators of Denial of Critical Care (Self)

Note: Not all states define separate neglect/denial of care in exactly the same way but it is important to understand the general distinctions.

Denial of Critical Care (Self) is the deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or health, as a result of the acts or omissions of the dependent adult.

Indicators

- Failure to provide adequate food, shelter or clothing
- Intentional physical self-abuse
- Suicidal statements
- Refusal of medical treatment or medication (refusal not based on religious grounds)
- Refusal of services that might alleviate the situation, when once would have accepted
- Refusal of visitors
- Denial of obvious problems

Examples

- Unable to prepare food or obtain groceries
- Unable to care for self
- Confused and unable to understand living conditions
- Holes in the floors and walls of home
- Home is cluttered with garbage (health hazard)

What Is Not Abuse

There are situations that may appear to be dependent adult abuse but may not be according to individual state statutes. Some of these situations include:

- Refusal or deprivation of medical treatment based on religious beliefs. The practices and beliefs of some religions call for reliance on spiritual means for healing rather than medical treatment.
- Withholding, withdrawing, or refusing medical treatment based on terminal illness. State laws will specify from whom requests can come and may include: the dependent adult, their next-of-kin, attorney-in-fact (power of attorney), or guardian.
- Domestic abuse situations where the victim is not dependent as defined in law.
- People incarcerated in a penal setting.
- Lack of means or access to means for providing care.

5. Communicating with Victims and Families

Effective communication is based first of all on the principle of respect. Both the sender and the receiver of the message have unique physical, emotional, mental, social, and spiritual characteristics. Effective communication shows acceptance of a person's individual worth and involves good listening skills.

Talking with Children

Do

- Find a private place, not in front of the person who might be causing harm.
- Remain calm—a casual and non-threatening tone will help put the child at ease.
- Be honest, open, upfront, supportive.
- Be an advocate, reassure children that they are not in trouble.
- Listen to the children—allow them to talk. When they pause you can follow up, if necessary, using their vocabulary.
- Report the situation immediately.

Don't

- Overreact
- Make judgments/promises or lay blame
- Interrogate or investigate

Most of the time suspicions of child abuse and maltreatment develop from things that you observe about a child's physical condition or behavior or in the behavior of the child's parent or other legally responsible person. However, sometimes a child will say something to reveal that he or she is possibly being abused or maltreated and you want to be prepared to act in a supportive way without frightening the child or promising something you can't follow through on. Stress that the child is not at fault for the situation or for others' actions (NYSOCFS, 2019, 2011; RAINN, 2019).

Many healthcare and social services professionals receive training in talking to children, and that knowledge can be applied when dealing with children who are possible victims of abuse or maltreatment. However, always keep in mind that your responsibility is to assess for reasonable cause to suspect and make the necessary report (or whatever your state's process is), not to investigate or interrogate (NYSOCFS, 2019, 2011; RAINN, 2019).

Normally there are specific guidelines for cases where sexual abuse is suspected, and once a child reveals information that makes you suspect such abuse you need to avoid talking in detail with the child about the incident. Specially trained CPS and law enforcement professionals will often work together to interview a child at the same time and it will be a traumatic experience for the child to relive (NYSOCFS, 2019, 2011; RAINN, 2019).

You are not legally required to inform the parents or other person legally responsible for the child that you are making a report to your state's mandated agency. Do **not** assume the parent will be supportive of the child. It is always possible that informing the parent will further jeopardize the child's situation and risk more harm. If you have questions or concerns about informing the parents, contact your local or state child protective services office.

Talking with Dependent Adults

When talking with a dependent adult, the following principles will facilitate communication.

Overcoming communication barriers

- Use clear, simple language.
- Ask open-ended, one-part questions.
- Be an attentive listener and allow for periods of silence.
- Allow sufficient time so there is no pressure to hurry.
- Use explanations that progress from simple to complex.
- Allow eye contact, but do not force it.
- Allow plenty of space to move around; medications may cause restlessness.
- Keep background noise to a minimum.
- Sit facing the person to help them identify visual cues.

Ways to Ask About Abuse

First, be **direct**. Ask non-threatening questions and respond empathetically. Second, **universalize the question** rather than personalizing it. For example, "Many people are hurt physically or in other ways by someone they know. Is this happening to you?"

Make your questions **gradual and exploratory**, such as:

- How are things going for you?
- What kinds of stresses do you have in your everyday life?
- Is there anyone in your life who is pretty strict, or hard to please?
- Do you get blamed a lot?
- Can you disagree? What happens when you don't agree?
- Have there been situations in which you felt afraid?
- How often are you called names? How often are your feelings hurt?
- Are you ever threatened with forced sex, been pushed or shoved, had your hair pulled or been slapped?
- Have you had things thrown at you?
- Have any of your precious possessions been deliberately broken?
- Have your pets, children, grandchildren, or other people close to you been intentionally hurt?
- Are you ever prevented from leave the house, or from seeing friends or family?
- Do you feel safe in your home?
- Should I be concerned for your safety?

Supportive Ways to Respond

When talking with victims of abuse:

- Allow time for the person to speak.
- Listen.
- Believe what the person says.
- Empathize: validate the person's feelings.
- Make it clear that the abuse was wrong and it was not the victim's fault.
- Speak directly about the violence.
- Ask in what ways you can be helpful.
- Respect the person's right to self-determination.
- Assure the person there are resources to help and that he or she is not alone.
- Discuss a safety plan and offer followup contacts.

Communication Don'ts

When talking with victims of abuse:

- **DON'T** talk to the victim while others are present. Confidentiality and privacy are essential and the presence of others may interfere with information the victim wants to provide, particularly if the perpetrator is present.
- **DON'T** blame the victim. Societal attitudes often blame the victim for the abusive situation. This is extremely harmful to the victim and may result in an inability to trust.
- **DON'T** tell the victim it is not that bad or minimize the pain. The shame and fear he or she feels is natural.
- **DON'T** check out the story with the abuser. Talking with abusers may tip them off to a possible evaluation. This not only hinders the evaluation but may also endanger the victim.
- **DON'T** demand that the victim take a certain course of action. You may offer suggestions, but it is necessary for him or her to be comfortable with the plan of recourse.
- **DON'T** think you have failed if you did not fix the situation. Many abusive situations indicate long-entrenched patterns of behavior. To assume that you can always alleviate the situation by reporting the abuse or other action is unrealistic.

Try to establish whether the victim is competent and does or does not want help, or whether he or she is incompetent to make decisions. If he or she is not competent, someone else is needed to make decisions for that person. In some cases, the victim is competent to make decisions but there are barriers to that person's being able to ask for or accept help.

6. Reporting Suspected Abuse

Certain categories of professionals are required to make reports to their state's designated agency when they suspect abuse of a child or dependent adults. These people are known as **mandated** or **mandatory reporters**. Any person who believes that a child or dependent adult has suffered abuse may also make a report of the suspected abuse to their state agency. People who report suspected abuse even though they are not legally required to do so are called **permissive reporters**.

Child Abuse

All fifty states, the District of Columbia, and U.S. Territories have laws mandating certain professionals and institutions to report suspected child abuse and neglect to a child protective services (CPS) agency (ACF, 2017).

In most states, a wide variety of healthcare professionals are mandatory reporters, including doctors, nurses, chiropractors, dentists, occupational and physical therapists, psychologists and counselors, most staff and employees of healthcare facilities, assisted living, and day services programs, and many others. Check with your state or your licensing board to determine if you are a mandatory reporter.

State statutes generally establish an agency to receive and process reports under a specific set of criteria and procedures, although some states have more than one place to report depending on the type abuse. Many also establish central abuse registries that perform a number of functions. Requirements and procedures vary for mandated and permissive reporters, and laws require training for mandated reporters, usually tied to professional licensing.

Most states' laws address certain legal issues: immunity from liability, confidentiality, responsibilities and rights of reporters, and sanctions for failure to comply with the law or for filing false reports.

Dependent Adult Abuse

Many older adults are ashamed to report abuse or are afraid a report will get back to the caregiver and the abuse will get worse. If you think someone is being abused—physically, emotionally, or financially—talk to the person alone and offer to get help from adult protective services.

The National Center on Elder Abuse (NCEA) has detailed listings and links for every state for hotlines for abuse reporting, appropriate state agencies, and relevant state laws. Go to ncea.acl.gov for more information or call the Eldercare Locator weekdays at 800 677 1116.

Many local, state, and national social service agencies can help with emotional, legal, and financial problems. Most states require doctors, nurses, and other healthcare professionals to report mistreatment of older adults; (mandatory reporting). You do not have to verify that abuse is occurring, only alert others of your suspicions. Family and friends can also report suspected abuse:

- If an older adult is in urgent danger, call 911 or the local police.
- If the danger is not immediate, report the suspected abuse to the Adult Protective Services agency in the state where the person resides

If nursing home care abuse is suspected, call the Long-Term Care Ombudsman at 202 332 2275.

The Report Process

Child Abuse

In most states, reports are made over the phone and followed up with a physical filing. Instruction is available to guide a potential reporter in collecting information and preparing to make the report. Once a report is made it will be evaluated by the agency and a determination is made as to whether there is sufficient grounds for further investigation. States use different terms at this stage. Some say a report is "registered" or "not registered," while others simply say "accepted" or "rejected." At this stage a rejected report may often happen because the victim is not a child, the alleged perpetrator is not a caregiver, or the alleged abuse does not fall within the state's legal definition of abuse. Most agencies will still evaluate to determine if a child is in danger and law enforcement needs to be contacted.

If a report is accepted, an investigation is begun. Some states have only one process that is followed for all reports, while other states utilize what is called a **differential response system** where reports are evaluated against specific criteria and then assigned to one of two pathways. Generally, one pathway is for reports that are suggestive of a more serious child abuse problem while the other is for reports where some type of family assessment and assistance may be more appropriate.

After investigation, regardless of the system used, a determination is made as to whether or not child abuse or neglect has occurred. Again, states use varying terminology. Some may use “not confirmed/confirmed/founded” while others may use “unfounded/indicated.” Inquire with your state’s agency for specific terminology, procedures, and requirements.

Dependent Adult Abuse

States have been passing legislation and setting up programs to address dependent adult abuse and they observe a variety of processes for accepting and processing these reports. Over half of the states now maintain abuser registries, but they can differ significantly in the information they retain and not all feel that a registry is the best use of their resources (Quinn, 2019). For example, in California ”employees of financial institutions are mandated reporters for suspicious activity involving the senior population and dependent adults” (Miller, 2019).

The NCEA website maintains a state resources page with links to each state’s critical information. As an example, in Nevada (where new legislation just became effective on July 1, 2019) an investigation is begun within 3 working days of the report, there is an evaluation, and then arrangements and referrals are made for other services. The agency website notes that “Protective services are provided if the individual is willing to accept these services” and the agency’s mission is to provide or arrange for services “while safeguarding [the adult’s] civil liberties.” Because dependent adults are still adults they usually cannot be forced to accept services, so the resolution of cases may be complex (NVAPS, 2019, 2019a).

Many other factors may come in to play, including legal actions if a person appears to be unable to protect self. Other states, for example New York with an older program, have policies regarding pursuing both avenues—protecting an adult’s right to choose not to have services and what they do in cases of diminished capacity of the victim (NYSOCFS, 2019a).

Interventions and preventions that take advantage of a combination of personal and community resources may be the most effective at helping dependent adults (see section on Intervention and Prevention Strategies).

Attitudes Toward Reporting Abuse

Why Victims of Abuse Do Not Report

There are many reasons why victims do not report the abuse, including lack of confidence, a history of abuse, fear of retaliation by the abuser, cultural beliefs, embarrassment, and shame. For example, people who have never been self-confident are not likely to ask for help when they become dependent. Those who have been abused or neglected their entire lives expect maltreatment will continue, would never think someone would want to help, and often reject help when it is offered.

Abused dependent adults may have sought help from law enforcement or other agencies in the past, only to experience worse abuse, neglect, or exploitation when representatives of those agencies were not present.

Some cultures believe that whatever happens within a family is no one else’s business. The dependent adult may be ashamed or embarrassed to be neglected, abused, or financially exploited by a trusted family member. The victim may promise to keep the abuse secret so the abuser will not further abuse them or other loved ones, including pets. Abusers may threaten to withhold care or food or other necessities, or to send the dependent adult to a nursing home if the victim tells anyone about the abuse.

Why Mandatory Reporters Do Not Report

Those who are required by law to report suspected abuse of elders or dependent adults share some of the same fears as the abused individuals: that reporting will hurt the relationship with the victim or the abuser or will cause retaliation by the perpetrator. Other stated reasons for reluctance to report include:

- Fear of losing a job
- Court time—with loss of work time
- Nothing will change, and everyone involved will get upset
- Cannot get state agency to accept a report
- Do not want to get involved (“none of my business”)

7. Intervention and Prevention Strategies

All health and human service professionals have a role in preventing abuse, but particularly those who provide care to children or dependent adults in facilities, agencies, and programs. Criminal background checks are usually an important first step in hiring new employees, along with checks of child abuse and sex offender registries when applicable.

The general public also needs greater awareness of the prevalence of child and dependent adult abuse, how to recognize the signs of abuse, and what to do when they suspect abuse. Professionals can help increase public awareness of this often-hidden crime.

Children

Child maltreatment is a serious problem that can have lasting harmful effects on victims. The goal for child maltreatment prevention is clear—to stop child abuse and neglect from happening in the first place. Child abuse is a complex problem rooted in unhealthy relationships and environments. Safe, stable, and nurturing relationships and environments for all children and families can prevent child abuse. Preventing child abuse and neglect requires addressing factors at all levels of the social ecology—individual, relational, community, and societal levels (CDC, 2019d).

Effective prevention strategies focus on modifying policies, practices, and societal norms to create safe, stable, nurturing relationships and environments. The strategies and their corresponding approaches are presented in the table below.

Preventing Child Abuse and Neglect

Strategy	Approach
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Change social norms to support parents and positive parenting	• Public engagement and education campaigns • Legislative approaches to reduce corporal punishment
Provide quality care and education early in life	• Preschool enrichment with family engagement • Improved quality of childcare through licensing and accreditation
Enhance parenting skills to promote healthy child development	• Early childhood home visitation • Parenting skill and family relationship approaches
Intervene to lessen harms and prevent future risk	• Enhanced primary care • Behavioral parent training programs • Treatment to lessen harms of abuse and neglect exposure • Treatment to prevent problem behavior and later involvement in violence

Child abuse and neglect is preventable. Much progress has been made in understanding how to prevent child abuse and neglect. Child abuse and neglect is the result of the interaction of a number of individual, family, and environmental factors. Consequently, there is strong reason to believe that the prevention of child abuse and neglect requires a comprehensive focus that crosscuts key sectors of society (eg, public health, government, education, social services, justice). In addition, there is an urgent need to increase the capacity of state and local governments to implement and scale up effective interventions that can reduce child abuse and neglect.

Preventing child abuse and neglect can also prevent other forms of violence. Each of the various forms of violence are interrelated and share many risk and protective factors, consequences, and effective approaches to prevention. Given the overlap of the risk and protective factors for child abuse and neglect and other forms of violence, it stands to reason that the primary prevention of child abuse and neglect can prevent other forms of violence and abuse. Moreover, strategies that support the development of safe, stable, and nurturing relationships between parents or caregivers and their children could be key in preventing the early development of violent behavior in children.

Emerging evidence suggests that by stemming the early development of violent behavior, such relationships can also reduce many types of violence (eg, youth violence, intimate partner and dating violence, sexual violence, self-directed violence) from occurring in adolescence and early adulthood.

The Centers for Disease Control and Prevention (CDC) offers extensive information and links on child abuse prevention techniques and programs at its website. A number of studies and programs are particularly relevant to health care providers who may be involved with child abuse situations.

Infant Safe-haven Laws

> The focus of these laws is protecting newborns from endangerment by providing parents an alternative to criminal abandonment, and therefore the laws are generally limited to very young children.
>
> Child Welfare Information Gateway (CWIG, 2016)

Texas was the first state, in 1999, to enact infant safe-haven legislation and today all fifty states, the District of Columbia, and Puerto Rico have enacted such legislation. State laws are not identical and vary as to the maximum allowable age of the infant, who can relinquish an infant, where an infant can be left, and whether the parent (or person leaving the infant) can retain confidentiality and immunity from prosecution for child abandonment, abuse, or neglect (CWIG, 2016).

Safe-haven legislation also specifies what a safe-haven location must do with any infant left with them. Locations are agreeing to accept emergency protective custody and to provide any immediate medical care the infant needs. Locations are generally limited to hospitals, emergency medical services providers, or healthcare facilities. Fire stations are also acceptable locations in 27 states and 5 states allow emergency providers responding to a 911 call to accept infants. Churches are also acceptable locations in 5 states, provided the person leaving the baby has verified that personnel are present at the time (CWIG, 2016).

Individual states determine who can leave a baby, what information they are supposed to provide, and any legal actions required. A safe-haven provider is required to notify the local child welfare entity that a baby has been left with them and that entity will retrieve the child and assume custody. The agency then has responsibility for placing the child, usually in a pre-adoptive home, and petitioning the court for termination of the parents' parental rights. Some states may require the agency to make certain inquiries into parental rights and whether the child has been reported missing (CWIG, 2016).

Relinquishing a child under safe-haven laws thus has important consequences for the parents but is an undeniably better outcome for the infant than being left in a trash dumpster or suffering a childhood of abuse or neglect.

Dependent Adults

Interventions with Survivors of Abuse

After an assessment and evaluation, services may be recommended for the victim of abuse, that person's family, or a caretaker. Professionals, relatives, and others seeking to help the dependent adult need to consider whether the person will accept these services, and whether the person is of sound mind to give consent.

As discussed earlier, research on the maltreatment of elders and other dependent adults has tended to lag behind but promising studies on interventions are beginning to point toward the efficacy of multidimensional and multidisciplinary approaches that include social supports and education for both victims and perpetrators (NCEA, 2019).

Some experts have suggested that issue-specific interventions are more effective than generalized "elder abuse prevention" programs. Looking at the three dimensions of risk: victim or at-risk person, caregiver, and their specific context or setting, can help identify specific risk factors that can then be modified, thus suggesting intervention strategies that might address one factor or multiple factors depending on the situation (OBSSR, 2016).

Of course, older adults can accept or refuse services offered to them and they may make decisions that are not in their own best interest, which interveners can do nothing about. Additional challenges for professionals operating within a medical or social-service setting include the need to adapt interventions to institutional governing regulations as well as their own available time and skills (OBSSR, 2016).

It is useful to remember that the intervener's role is to help stop the abuse, not to change anyone's lifestyle or personality. Solutions may be imperfect but if everyone does the best they can, the results will certainly be better than the alternative. If your agency has established protocols for responding to dependent adult abuse, be sure to follow them when developing a response in an individual case of dependent adult abuse.

While **intervention** is about preventing re-occurrence and **prevention** is about preventing occurrence, they have things in common and may both be at play in the same situation. The emphases on multi-dimensionality and multi-disciplinarity are important across the board. The Administration for Community Living (ACL) even uses the term *elder abuse prevention intervention*. Some demonstration projects the ACL is currently funding include partnerships among community, healthcare, legal, and financial organizations ,and address diverse issues including financial exploitation, improving medication adherence, education in Alzheimer's care, preventing abuse of dementia patients, and evaluating new model care protocols for use by APS and police departments (ACL, 2017c).

Determining Possible Interventions

Regarding interventions, there are generally three possible scenarios: the dependent adult accepts services, lacks the decision-making capacity to give consent, or refuses services. Each of these requires different actions to protect the welfare of the dependent adult and will need to conform to the laws of the state where the person resides. The following are general guidelines for each scenario**. Not all are options in every state or municipality**. Be sure to follow the laws of your location and the protocols of the applicable institution or agency.

Adult accepts services

1. Implement a safety plan such as relocation, a protective order, or admission to a hospital.
2. Alleviate causes of mistreatment through "voluntary services."
3. Provide written information on emergency numbers and make appropriate referrals.
4. Get assistance in legal/financial matters.
5. If abuse is determined to have taken place, the local city or county attorney may bring criminal charges against the perpetrator.

Adult lacks capacity to give consent

1. Power of attorney, which must be pre-existing because once a person lacks capacity, they cannot sign such an agreement
2. Conservatorship
3. Guardianship
4. Involuntary commitment of abuser or victim
5. Special court order—injunctions, restraining orders
6. Family member/guardian/case worker may want to consider social services, legal, or financial management assistance for the dependent adult
7. If abuse is determined to have taken place, the perpetrator may be prosecuted.

Adult refuses services

1. Provide written information on emergency numbers and make appropriate referrals.
2. Develop contingency safety plan.
3. If there is immediate danger, consider involuntary relocation of the victim or perpetrator, or protective order, or commitment, if that is within the purview of your state's laws and your agency's mission.
4. Do not enforce your decision without first taking the proper legal steps.
5. If abuse is determined to have taken place, the perpetrator may be prosecuted.

Effective Post Trauma Responses

The following responses are designed to aid the victim in coping with abuse or neglect:

- Assess the victim's psychological response to the abuse/neglect and his or her ability to cope with the situation.
- Tell the victim about services immediately available, such as hotlines, protective services, police, and legal actions.
- The victim should be encouraged to make his or her own decisions. Maintain a nonjudgmental attitude throughout the discussion.
- Depending on the type of abuse, counseling may be available through a geriatric program, a rape counseling program, a domestic violence center, or an adult abuse program.
- Inform the person about appropriate advocacy groups such as legal services programs, protection and advocacy programs, the local area agencies on aging, or other relevant programs.

Public Awareness

Anyone can help raise public awareness about dependent adult abuse. Resources include:

- Work with local area agencies on aging and related government departments on their public awareness campaigns. Put up flyers or notices around your workplace, talk to friends and colleagues, or encourage local radio and TV stations to broadcast public service announcements.
- Publicize hotlines for information on elder abuse and for reporting dependent adult abuse whether it occurs in the community or in facilities or programs, or when it involves Medicaid fraud.
- Encourage people to volunteer in healthcare facilities, at domestic violence shelters, and as respite caretakers.
- Invite a speaker with professional experience with dependent adults to speak to an organization to which you belong.
- Encourage people to identify dependent or older adults in the community who may be at risk of abuse.

Ten Tips for Preventing Abuse

The following list suggests actions that are designed to prevent abuse and to help the family and caretaker develop effective coping mechanisms and support systems:

1. Assess the person for signs of abuse/neglect. Early identification is essential to break a pattern of abuse or neglect.
2. Assess the family at risk for abuse or neglect and intervene as necessary before abuse occurs. Identifying high-risk families can stop abuse before it starts.
3. Develop a trusting relationship with the dependent adult and their relatives. This promotes open discussion of difficulties.
4. Offer guidance in caregiving. The caretaker may lack information on how to properly care for the person.
5. Provide information about community resources and alternative living arrangements before an older person moves in with an adult child. Knowledge of options and services can help avoid situations that may lead to abuse.
6. Encourage the caretaker to join a self-help group and/or to use respite services. Discussion groups provide education and support. They also help relieve frustration.
7. Emphasize the importance of social involvement. Using multiple support sources lessens the caretaker's responsibilities and increases the older adult's sense of independence.
8. Report suspected abuse accurately. Use direct quotes and give specific descriptions of physical findings. Sketches and photographs of injuries may be extremely helpful. Accurate and comprehensive documentation is essential for diagnosis and intervention by legal or social services.
9. Consult a social worker about referring the person to community agencies or providing alternative living arrangements. This encourages her/him to choose formal support services that maximize independence and enhance well-being.
10. Discuss the possibility of alternative living arrangements to prevent abuse or neglect. If appropriate, the dependent adult may need to relocate to live with relatives, friends, or in a boarding home, retirement community, or healthcare facility.

Legal and Other Responses to Abuse

Child Abuse

State legislation relevant to child abuse will often appear in multiple sections of the legal code. Not every state organizes their statutes in the same way and relevant laws often do not appear all together in one section.

Criminal code usually defines specific crimes and provides for the prosecution of alleged perpetrators of a criminal act. Here you are likely to find laws defining all the details of child abuse as a crime.

Another body of laws will be concerned with the reporting of child abuse: designating a central authority, defining reporting requirements and mandatory reporters, providing for a central registry for reports and incidents, and defining penalties for infractions of those reporting laws.

Additional code will define the process for investigation of abuse reports and all the possible actions that may be taken if abuse is discovered. Others govern the operation of state government departments, including health and welfare departments, while others define the operation of professional licensing boards. Juvenile justice laws may be the means by which protective actions or custody are provided to at-risk children. And safe-haven laws many be found in yet another section.

A complete compilation of state laws is usually available online, often as part of a state legislature's website. While one can search these compilations for such terms as "child abuse," it may be more direct to check the websites of health departments, legal aid resources, professional licensing boards, professional associations, and advocacy organizations, many of which provide listings of or direct links to the relevant body of statutes.

Dependent Adult Abuse

Keep in mind that everything said above about state statutes relevant to child abuse applies to those governing dependent adult abuse.

Legal Interventions

Conservatorship, Guardianship, Power of Attorney

Under a conservatorship or guardianship, another person has court-ordered authority and responsibility to manage financial or healthcare decisions for another person who is no longer able to make them for themselves. Each state has legislation regarding the availability and functioning of these powers (NOLO, 2019).

Planning ahead and preparing powers of attorney prior to becoming incapacitated can help a person avoid a conservatorship or guardianship and allow them to choose the representative who will manage their affairs. A power of attorney is a legal document by which one person (the principal) gives to another person (the attorney in fact) the authority to act on the principal's behalf in one or more matters. The principal, who is giving the power to the attorney in fact, must be able to understand the agreement into which they are entering. There are several types, including:

- General powers—financial
- Limited powers or temporary
- Durable
- Health care

Legal Orders

Protective, restraining, and injunctive orders are intended to protect an abuse victim from physical harm and to prevent further abuse. These orders may evict the perpetrator from the victim's home, bar the perpetrator from any contact with the victim, require the perpetrator to provide an accounting of the victim's assets, prevent the perpetrator from transferring the victim's property, or prohibit any violation under the dependent adult abuse statute. When victims lack decision-making capacity or are in an emergency situation, they may be able to receive help from adult protective services programs. Check with your state and local adult protective and legal resource agencies for information.

Substance Abuse/Mental Health Commitment

In some states both perpetrators of dependent adult abuse and victims of self-neglect may be involuntarily committed to a facility or hospital. Check with your state and local adult protective and legal resource agencies for information.

Long-Term Care Ombudsman's Office

The national long-term care ombudsman serves as an advocate for the residents of long-term care facilities or assisted-living programs. The ombudsman is charged with the duty of investigation and resolving complaints in long-term care facilities that may adversely affect the health, safety, welfare, or rights of residents. The national office maintains a resource center supporting state programs, many of which support local programs (see Resources).

Voluntary Services

In most states these services may be offered regardless of whether a report is made or abuse is determined to have taken place. Voluntary services are social services needed to protect the dependent adult or assist the adult toward independence. People with the capacity to consent have the right to refuse such services. These services might include homemaker service, personal care assistance, adult day care, transportation, legal assistance (restraining orders, restitution), financial management assistance (bill paying, insurance counseling, representative payee), admission to hospital, and assistance with applying for Medicare or Medicaid.

Other Remedies

Other remedies might include direct deposit of Social Security and pension checks directly into the person's bank account to help prevent theft of a dependent adult's income; some states and localities have a representative payee program to provide a financial protective service to assist older or disabled low-income people unable to manage their bills and other financial obligations.

Further investigation and action may be indicated by the Medicaid Fraud Control Unit; crime victim assistance programs; domestic abuse hotlines; Medicare Fraud Hotline; professional licensing boards; Social Security Administration; or Veterans' Benefits (see Resources).

In some situations, civil actions may be appropriate to address charges for such things as conversion, replevin, or breach of contract, and to recover property or damages. Check with your state and local adult protective and legal resource agencies for information.

8. Resources

Administration on Aging (USDHHS)
Comprehensive resources including the Office of Supportive and Caregiver Services, Office of Nutrition and Health Promotion Programs, Office of Elder Justice and Adult Protective Services, Office for American Indian, Alaska Natives and Native Hawaiian Programs, Office of Long-term Care Ombudsman Programs, and Older Americans Act and Aging Network https://acl.gov/about-acl/administration-aging

Annie E. Casey Foundation
The Annie E. Casey Foundation is a private charitable organization that uses its resources to partner with and forge collaborations among institutions, agencies, decision makers, and community leaders so they can work together to transform tough places to raise families. We fund research, technical assistance, and multi-site demonstrations that help service and support systems like public schools, juvenile justice agencies, and child welfare systems get better results for kids and families. We directly deliver exemplary services, identify and measure what works, and share lessons learned to demonstrate the potential of reforming public policies and services on behalf of children and their families. 410 547 6600 410 547 6624 (fax) webmail@aecy.org http://www.aecf.org/

Centers for Disease Control and Prevention
Child Abuse and Neglect Prevention
https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html
Elder Abuse
https://www.cdc.gov/violenceprevention/elderabuse/index.html

Center for Law and Social Policy
Develops and advocates for federal, state, and local policies to strengthen families and create pathways to education and work. 202 906 8000 http://www.clasp.org/

Child Welfare Information Gateway / U.S. Department of Health Human Services
Resources on child abuse prevention, protecting children from risk of abuse, and strengthening families. Includes information on supporting families, protective factors, public awareness, community activities, positive parenting, prevention programs, and more. https://www.childwelfare.gov/

Child Welfare League of America
A coalition of hundreds of private and public agencies serving vulnerable children and families since 1920. Provides expertise, leadership and innovation on policies, programs, and practices help improve the lives of millions of children in all fifty states. 202 688 4200 http://www.cwla.org/

Department of Justice (US DOJ)
Elder Justice Initiative https://www.justice.gov/elderjustice

National Adult Protective Services Association
1612 K Street NW, #200
Washington, DC 20006 202 370 6292 http://www.napsa-now.org/resource-center/main/

National Center on Elder Abuse
c/o University of Southern California Keck School of Medicine
Department of Family Medicine and Geriatrics
1000 South Fremont Avenue, Unit 22, Building A-6
Alhambra, CA 91803
855 500 3537 (855 500 ELDR) 626 457 4090 (fax) https://ncea.acl.gov/
The NCEA provides the latest information regarding research, training, best practices, news and resources on elder abuse, neglect and exploitation to professionals and the public.

National Long-Term Care Ombudsman Resource Center
1001 Connecticut Avenue, NW, Suite 632
Washington, DC 20036 (phone) 202 332 2275 (fax) 202 332 2949 (fax) ombudcenter@theconsumervoice.org
https://ltcombudsman.org/about/about-ombudsman

National Institute on Aging
https://www.nia.nih.gov/

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Post Test

1. The four main types of child abuse are:

a. Physical, sexual, emotional, and neglect.

b. Physical, social, emotional, and neglect.

c. Parental, sexual, emotional, and physical.

d. Physical, sexual, emotional, and stranger.

2. The term dependent adult encompasses:

a. Only those over 85 whose physical and/or mental condition makes them dependent on others for care or protection.

b. Anyone over 18 whose physical and/or mental condition makes them dependent on others for care or protection.

c. Anyone under 18 whose physical and/or mental condition makes them dependent on others for care or protection.

d. Only those over 65 whose physical and/or mental condition makes them dependent on others for care or protection.

3. The impacts of dependent adult abuse are:

a. Mainly felt as medical costs.

b. Only felt by the specific victim of an act of abuse.

c. Felt in multiple areas including physical and financial.

d. Only physical.

4. Risk factors for child maltreatment:

a. Are things children do to encourage abuse.

b. Can generally be traced to one person or factor.

c. Are excuses given for engaging in child abuse.

d. May be both direct and indirect.

5. Protective factors for child maltreatment:

a. Include personal, family, and community factors.

b. Are entirely under the child's control.

c. Are entirely under the parent's control.

d. Have nothing to do with the family.

6. Children with disabilities have no higher risk of abuse than any other children.

a. True

b. False

7. Risk factors for perpetration of dependent adult maltreatment:

a. Are things vulnerable adults do to encourage abuse.

b. Can reflect individual, relationship, community and social factors.

c. Are just excuses given by lazy caregivers.

d. Only concern the personal relationship between the dependent adult and caregiver.

8. Adults with dementia are the easiest to care for and therefore have a lower risk of being abused.

a. True

b. False

9. Typical perpetrators of child abuse are:

a. Men in relationships with single mothers.

b. Women of child-bearing age.

c. People from all walks of life.

d. Young parents with little education.

10. Reasons for dependent adult abuse include all but one of the following:

a. Violence as a way of life.

b. Resentment of dependency.

c. History of alcohol and drug abuse.

d. Close family ties.

11. The majority of perpetrators of dependent adult abuse are:

a. Partners, spouses, children, or other relatives.

b. Home intruders, muggers, or other criminals.

c. Caretakers and healthcare personnel.

d. Accountants, financial advisors, and bankers.

12. Indicators of child abuse can:

a. Only be physical signs.

b. Include physical and behavioral signs.

c. Must be things the child tells you directly.

d. Never come from a perpetrator's behavior.

13. When perpetrators “groom” their targets, it means they:

a. Gain trust by being meticulous about caretaker duties.

b. Take care of the person’s physical needs.

c. Show special interest through gifts, touching, or setting up time to be alone.

d. Pay attention to hairdressing.

14. Victim behaviors in dependent adults that may suggest abuse include:

a. Fear, withdrawal, talkativeness.

b. Ambivalence, confusion, talkativeness.

c. Withdrawal, ambivalence, talkativeness.

d. Fear, ambivalence, helplessness.

15. Indicators of financial exploitation of dependent adults include:

a. Lifestyle is not reflective of income or assets.

b. Person claims to be the “black sheep” of the family.

c. Unexplained weight gain is noted.

d. Person’s checkbook has not been balanced for more than 3 months.

16. Denial of critical care includes all but:

a. Withholding food or medications.

b. Withholding TV privileges.

c. Failure to provide physical aids such as hearing aids.

d. Failure to provide safety precautions.

17. One supportive way to respond to victims of abuse is to:

a. Take the lead in conversation about the abuse.

b. Try to lighten the mood with humor.

c. Make sure they understand that it was not their fault.

d. Urge them to share their experience with other residents.

18. Certain persons required to make reports of either child or dependent adult abuse are known as:

a. Permitted reporters.

b. Guaranteed reporters.

c. Permissive reporters.

d. Mandated or mandatory reporters.

19. Reasons that victims of abuse do not report include all but one of the following:

A. They have a history of complaining.

B. They fear retaliation by the abuser.

c. They have a history of abuse.

d. They lack confidence that someone will care.

20. Which of the following is not true about child abuse?

a. Child abuse is preventable.

b. The effects of child abuse are not long lasting.

c. Strategies that support family relationships aid in preventing abuse.

d. Preventing child abuse can help prevent other kinds of violence.

21. Infant Safe-haven Laws vary from state to state:

a. True

b. False

22. Interventions with dependent adults:

a. Are easy to set up and accomplish.

b. Only involve providing names and phone numbers of resources.

c. Must accommodate the adult's right to choose or refuse services.

d. Can be forced upon an abuse victim anytime it is in their best interests.

23. One effective post trauma response you could offer would be to:

a. Offer several suggestions that you think would be best for the person.

b. Take a firm hand in planning for the person, who is probably traumatized.

c. Tell the individual about appropriate advocacy groups.

d. Think of the person as needy and vulnerable.

Answer Sheet

Passing score is 80%

Name (Please print)_____

Date_____

1. _____	13. _____
2. _____	14. _____
3. _____	15. _____
4. _____	16. _____
5. _____	17. _____
6. _____	18. _____
7. _____	19. _____
8. _____	20. _____
9. _____	21. _____
10. _____	22. _____
11. _____	23. _____
12. _____	

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Course Evaluation

Please use this scale for your course evaluation. Items with asterisks * are required.

5 = Strongly agree 4 = Agree 3 = Neutral 2 = Disagree 1 = Strongly disagree

*Upon completion of the course, I was able to:

1. Describe abuse in 3 ways: type, consequences, and incidence and prevalence.	5 4 3 2 1
2. Identify at least 3 risk and 3 protective factors for victims and perpetrators of abuse.	5 4 3 2 1
3. State 4 categories of perpetrators.	5 4 3 2 1
4. List at least 4 physical and 4 behavioral indicators of possible abuse.	5 4 3 2 1
5. Relate 6 ways to ask about abuse.	5 4 3 2 1
6. Explain the obligation to report abuse if you are a mandated reporter.	5 4 3 2 1
7. Name 1 intervention and prevention strategy for addressing abuse.	5 4 3 2 1

*The author(s) are knowledgeable about the subject matter. 5 4 3 2 1

*The author(s) cited evidence that supported the material presented. 5 4 3 2 1

*Did this course contain discriminatory or prejudicial language? Yes No

*Was this course free of commercial bias and product promotion? Yes No

*As a result of what you have learned, will make any changes in your practice? Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

*Do you intend to return to ATrain for your ongoing CE needs?

_____Yes, within the next 30 days. _____Yes, during my next renewal cycle.

_____Maybe, not sure. _____No, I only needed this one course.

*Would you recommend ATrain Education to a friend, co-worker, or colleague?

_____Yes, definitely. _____Possibly. _____No, not at this time.

*What is your overall satisfaction with this learning activity? 5 4 3 2 1

*Navigating the ATrain Education website was:

_____Easy. _____Somewhat easy. _____Not at all easy.

*How long did it take you to complete this course, posttest, and course evaluation?

_____60 minutes (or more) per contact hour _____59 minutes per contact hour

_____40-49 minutes per contact hour _____30-39 minutes per contact hour

_____Less than 30 minutes per contact hour

I heard about ATrain Education from:

_____Government or Department of Health website. _____State board or professional association.

_____Searching the Internet. _____A friend.

_____An advertisement. _____I am a returning customer.

_____My employer. _____Social Media

_____Other _____

Please let us know your age group to help us meet your professional needs:

_____18 to 30 _____31 to 45 _____46+

I completed this course on:

_____My own or a friend's computer. _____A computer at work.

_____A library computer. _____A tablet.

_____A cellphone. _____A paper copy of the course.

Please enter your comments or suggestions here:

Registration and Payment Form

Please answer all of the following questions (* required).

*Name: _____

*Email: _____

*Address: _____

*City and State: _____

*Zip: _____

*Country: _____

*Phone: _____

*Professional Credentials/Designations:

_____

*License Number and State: _____

*Name and credentials as you want them to appear on your certificate.

_____

Payment Options

You may pay by credit card, check or money order.

Fill out this section only if you are paying by credit card.

4 contact hours: $29

Credit card information

*Name: _____

Address (if different from above):

*City and State: _____

*Zip: _____

*Card type: Visa Master Card American Express Discover

*Card number: _____

*CVS#: _____ *Expiration date: _____