CHILD MEDICAL EVALUATION PROGRAM NEWSLETTER AUGUST, 2010

SEXUAL DEVELOPMENT IN CHILDREN AGES 2-12

Continuing our discussion from last month on sexual development in children ages 2-12,we are including more information from The National Center on Sexual Behavior of Youth.

Research on sexual behavior of children ages 2-12 has documented that:

- sexual responses are present from birth
- a wide range of sexual behaviors for this age range are normal and non-problematic
- increasing numbers of school age children are being identified with inappropriate or aggressive sexual behavior; it is not clear if this increase reflects an increase in the actual number of cases or an increase in identification and reporting
- several treatment interventions have been found to be effective in reducing problematic sexual behavior in children, such as cognitive behavioral group treatment
- sexual development and behavior are influenced by social, familial, and cultural factors, as well as genetics and biology

Typical sexual knowledge of children age 2 to 6 years old:

- understand that boys and girls have different private parts
- know labels for sexual body parts, but use slang words such as weenie for penis
- have limited information about pregnancy and childbirth

Typical sexual knowledge of children ages 7 to 12 years old:

- learn the correct names for the genitals but use slang terms
- have increased knowledge about masturbation, intercourse, and pregnancy
- understand the physical aspects of puberty by age 10

Sexual play vs. problematic sexual behavior

Sexual Play

- is exploratory and spontaneous
- occurs intermittently and by mutual agreement
- occurs with children of similar age, size, or developmental level, such as siblings, cousins, or peers

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Sexual Play cont'd

- is not associated with high levels of fear, anger, or anxiety
- decreases when told by caregivers to stop, and
- can be controlled by increased supervision

Problematic sexual behavior

- is a frequent, repeated behavior, such as compulsive masturbation
- occurs between children who do not know each other well
- occurs with high frequency and interferes with normal childhood activities
- is between children of different ages, size, and developmental level
- is aggressive, forced, or coerced
- does not decrease after the child is told to stop the behavior
- causes harm to the child or others.

Suggestions for professionals and parents

- Do not overreact as most sexual behaviors in children are within the typical or expected range.
- Inappropriate or problematic sexual behavior in children is not a clear indicator that a child has been sexually abused.
- Most children will stop the behavior if they are told the rules, mildly restricted, well supervised, and praised for appropriate behavior.
- If the sexual behavior is problematic as defined above, referral for mental health services is recommended.
- It is important to remember that children with problematic sexual behavior are significantly different from adolescent and adult sex offenders.

Additional information about adolescent sex offenders and children with sexual behavior problems is available from the National Center o Sexual Behavior of Youth, www.ncsby.org.

ELAINE CABINUM FOELLER, MD, FAAP WRITES FOR THE N.C. MEDICAL BOARD

Elaine is a provider for the CMEP and works in Greenville. She recently wrote the following article on reporting for the N.C. Board of Medicine's Board Forum publication.

Recognizing and reporting suspected child abuse: A clinician's guide

Author: Elaine Cabinum Foeller, MD, FAAP
Newsletter: 2010 No. 1
Categories: Special Features
1 comment

RP is an eight-month-old who died of blunt head trauma. On exam, he had bruises on his face and trunk that were patterned. His skeletal survey also documented a healing right transverse humerus fracture and numerous healing rib fractures. Medical record review revealed that at five months of age he had been seen at his local ED for "not moving his right arm." History obtained at that time related the injury to a fall from the couch to the floor. At that visit, small bruises were observed on his left cheek, which were also said to be from the fall. He was splinted in the ED and told to follow up with orthopedics and his primary care physician. No one called Child Protective Services or mentioned concerns about possible abuse in the medical record.

The case above is only illustrative, but it is only too typical of the findings in our state when these cases are reviewed. As the pediatrician appointed to the state Child Fatality Task Force and state Child Fatality Prevention Team, I help review cases similar to RP's on an almost monthly basis. Whether or not we see children in a professional capacity, we are all responsible for helping the children of our state have a healthy and safe childhood. Outside of our professional roles we are mothers, fathers, uncles, aunts, grandparents or godparents to many children throughout our lives. We interact with children through church and service organiza-

tions. We should care about all children and help to ensure that all children grow up free from abuse and fear of injury or death.

Nonetheless, child abuse is widely understood to be underrecognized and underreported. Even physicians, who might seem more able to spot possible signs of abuse due to specialized training and experience with objectively evaluating injury and illness, miss or overlook possible danger signs for a variety of reasons. We may be hesitant to report a suspicion for fear of wrongly accusing or implicating parents or other caregivers. We may not understand what signs represent reasonable evidence to suspect abuse. Or, we may not know how to report suspicions, or who to report them to.

This article will provide an overview of child abuse and neglect, as well as child deaths due to injury or neglect. It will also provide physicians, physician assistants and other clinicians with the basic knowledge to make a report of suspected child abuse to the proper authorities.

Child abuse and neglect is epidemic in our society with an estimated 794,000 child victims in 2007 in the United States.(1) Of those, approximately 1,760 children died due to abuse and neglect.(1) In North Carolina during fiscal year 2008-2009, 122,672 children were reported as possibly abused and neglected. (2) Of those reports, 23,781 cases were either substantiated or found "in need of services" after investigation by social services. (2) Many cases involved multiple children. In 2008, 33 children in North Carolina were killed by their parent or caregiver. This number typically fluctuates between 20 and 35. Each of these deaths is tragic and should be considered preventable. Box 3 is a summary of North Carolina child homicides by parent or caregiver each year since 2000.

An important step in preventing child abuse and especially the related deaths is recognition and reporting suspected child abuse or neglect. The American Medical Association recently adopted Report 2 of the Council on Science and Public Health regarding identifying and reporting suspected child abuse. Among other things, this report calls for the AMA to: recognize that physicians underreport suspected child abuse, affi rm that all physicians have a responsibility to protect children when abuse is suspected, support studies on why physicians fail to recognize and report suspected child abuse, encourage state protective agencies to have a medical director or liaison for communicating with health care providers, and reaffi rm strong support for mandatory reporting of suspected child altreatment. (3)

Child abuse happens all the time and all around us. We have a responsibility to help prevent child abuse and neglect in North Carolina, both as health care professionals and citizens. As physicians and physician assistants, we must recognize the signs, both physical and behavioral, that may signal abuse. We must also understand our duty to report suspected abuse.

North Carolina state law (G.S. 7B-301) mandates that all residents with cause to suspect that a child is abused, neglected, or dependent must report their suspicions to the Child Protective Service Division (CPS) of the local Department of Social Services. This report may be made anonymously. However, CPS must contact reporters who provide their name and contact information to let them know
whether the case was accepted for investigation.

When making a report of suspected child abuse, the person reporting should share with DSS the child's name, address, parent or caretaker's name and address, any other children living in home, and why the reporter suspects that the child is abused or neglected. It is important to note that the medical professional does not have to make a determination of abuse. Rather, the findings (physical, behavioral or disclosure) should rise to the level of suspicion of abuse. CPS is charged with investigating reports, with making a determination of abuse or neglect and with formulating a plan to protect the child, when appropriate. Another state law (G.S. 7B-309) expressly protects the person reporting suspected abuse from any civil or criminal liability, provided the report was made in good faith.

The North Carolina legislature recently clarified a state law (G.S. 90-21.20) that requires the reporting of wounds, injuries and illnesses possibly resulting from criminal acts. For many years, the law required reporting by physicians and hospitals of certain wounds, injuries, and illnesses (e.g., injuries often seen in emergency departments such as gunshot wounds and stabbings) to law enforcement.

Recently the law was expanded to include the duty of reporting to law enforcement any cases of recurrent illness or serious physical injury in a patient under the age of 18 where the illness or injury appears to be the result of non-accidental trauma. The expanded law went into effect December 1, 2008.

The obligation to report to law enforcement does not replace the obligation to report to the Department of Social Services as described above; Rather, the treating physician, physician assistant or other clinician would be required to make two reports. This change was made to ensure that law enforcement is involved early in investigations of serious abuse. Law enforcement investigates allegations of child abuse or neglect if it appears that a crime may have been committed. Many times, law enforcement officers and DSS investigators work collaboratively on a case.

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North Carolina is blessed to have many resources in the fight against child abuse (see Box 1). For example, we are in the midst of implementing a statewide child abuse prevention campaign, the Period of PURPLE Crying. This program is aimed at educating caregivers about infant crying and ways to handle the stresses of parenthood. Infant crying is often the proximate trigger of infant shaking, so education about normal infant crying and avoiding shaking of an infant may decrease the related morbidity and mortality.

Through newborn nurseries and health care provider offices, this program is being shared with the parents of every newborn in our state. Under the leadership of Dr. Desmond Runyan, a pediatrician in the Department of Social Medicine at the UNC School of Medicine at the University of North Carolina, Chapel Hill, data are being collected to assess the effectiveness of this intervention in the prevention of child abuse statewide.

If we look at the case in the introduction, at least one real opportunity was missed to intervene with this hypothetical family. An intervention based on that emergency room visit might have saved RP's life. Were there other missed opportunities? Had RP come in for regular medical care and immunizations? Were there clues at those visits? Did any neighbors or relatives have concerns about RP's care? Did RP attend daycare where staff there may have noticed bruises or other injuries? It is our duty, both legally and morally, not to miss these opportunities to protect children.

As members of the medical profession and as members of society, we should value our children. Let us all work together to ensure their health and safety. Let us prevent child abuse when possible, report suspicions when appropriate and protect our next generation.

References:

1 U.S. Department of Health and Human services, Administration on Children, Youth and Families. Child Maltreatment 2007 (Washington, DC: U.S. Government Printing Office, 2009)
2 Prevent Child Abuse North Carolina, statistics on Child Abuse and Neglect in North Carolina for state fiscal year 2008-2009. www.preventchildabusenc.org/resources (Accessed February 21, 2010).
3 American Medical Association, Action of the AMA House of Delegates at the 2009 Interim Meeting: Council on Science and Public Health Report 2 Recommendations Adopted as Amended, and Remainder of Report Filed.

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Resources

Prevent Child Abuse North Carolina - www.preventchildabusenc.org
Period of PURPLE Crying project in NC - www.purplecryingnc.info
UNC Child Medical Evaluation Program - www.med.unc.edu/cmep/
Children's Advocacy Centers of NC - www.cacnc.org/home
North Carolina Professional Society on the Abuse of Children (NCPSAC) - www.ncpsac.org
North Carolina Pediatric Society - www.ncpeds.org
Darkness to Light - www.darkness2light.org | Child Sexual Abuse prevention program aimed at adults

How To Make a Child Protective Services CPS Report of Suspected Child Abuse, Neglect, or Dependency

Call the local Department of Social Services, Child Protective Service Division, and ask to speak with a social worker to make a report of suspected abuse or neglect. DSS involvement is based upon the county in which the child lives (which may be different from the county where you work or live). Share any information you have about the child including name, address, parent/caretaker name and address, other children in home; and why you suspect abuse or neglect. Contact information for local DSS offices can be found at the state Department of Social Services website: www.dhhs.state.nc.us/dss/local/index.htm

NC Child Homicides by Parent/Caregiver

Click on the link below:
http://www.ncmedboard.org/images/uploads/article images/Box 3.pdf

LETTERS OF AGREMENT

Deb Flowers and Gina Cochrane

All CMEP and CFEP examiners should have received a Letter of Agreement in early July. Thanks to all of you who have returned them in such a timely manner! If you have not had a chance to return it yet, we ask that you please fax it to us at 919-843-9368 as soon as possible. If you did not receive the letter or need another copy, we will be happy to send you one. Just e-mail us at cmep@med.unc.edu or call us at 919-843-9365 to request an additional copy that you can sign and return. Please keep in mind that we will be unable to make payment for evaluations you have performed if you have not signed and returned this letter. Thanks so much for your cooperation! Please feel free to call us if you have any questions.

UPCOMING CMEP TRAININGS

September 28-30, 2010

16th Annual Symposium on Child Abuse and Neglect
Children's Advocacy Centers of NC Medical Track Training

Lake Junaluska

The medical track training will be extended to 3 days this year. Please click here to see the brochure, which includes the agenda.
The UNC-CH School of Nursing & School of Medicine will provide AANC and CME credit.
Information and registration can be found here.

November 4&5, 2010

Child Advocacy Centers of NC (CACNC) is very excited to announce that Dr. Patrick Besant-Matthews, MD will provide training on Forensic Photography and other child abuse medical topics in High Point, NC.
More details to come in late summer – please refer to www.cacnc.org for updates and registration information.

January 23 - 28, 2011

The 25th Annual San Diego International Conference on Child and Family Maltreatment
Information here