Scientific Research Publishing

Health, 2023, 15, 1003-1012
https://www.scirp.org/journal/health
ISSN Online: 1949-5005
ISSN Print: 1949-4998

Child Abuse during the Pandemic and Trauma-Informed Care: A Review of Evidence-Based Literature

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How to cite this paper: DiPlacido, A.J., Leitzel, L., Kameg, B., Braxter, B.J. and Constantino, R. (2023) Child Abuse during the Pandemic and Trauma-Informed Care: A Review of Evidence-Based Literature. *Health*, **15**, 1003-1012.
https://doi.org/10.4236/health.2023.159068

Received: November 11, 2022
Accepted: September 25, 2023
Published: September 28, 2023

Abstract

Abuse of infants and children is a public health problem that warrants immediate attention. It is estimated that over 7 million children are affected by child abuse yearly, with the highest rate of abuse in those less than one year of age. Approximately 60% of child abuse victims are children under the age of three years, making infants and young children a particularly vulnerable population. Interventions targeting the perinatal period can be effective in mitigating child abuse, including parent education programs and trauma-informed care services. This paper provides an overview of the current evidence base related to child abuse following the COVID-19 pandemic, with a focus on prevention and intervention strategies that can be utilized to increase caregiver support and reduce child abuse rates during the perinatal period.

Keywords

Neonates, Newborn, Infant Child Abuse, Perinatal Trauma-Informed Care

1. Introduction

Abuse of infants and children is a public health problem that warrants immediate attention. It is estimated that over 7 million children are affected by child abuse yearly, with the highest rate of abuse in those less than one year of age [1]. Approximately 60% of child abuse victims are children under the age of three years, making infants and young children a particularly vulnerable population [2]. In 2020, it was estimated that 1750 children died from abuse or neglect. Of these children, 46.4% of them were under one year of age [2]. Quite disturbing is data that shows that of the 7.2 million children involved in child abuse reports in 2021, only 3.1 million received prevention and post-response services [2]. Without adequate prevention and post-response services, the effects of abuse can begin in

infancy and last a lifetime.

Abuse experienced during infancy and childhood has been linked to negative effects on early neurological development [3] [4]. These negative effects on neurological development have been associated with health problems throughout the lifespan such as major depression, attachment problems, and physical disorders [5] [6] [7]. Infants and children exposed to abuse are also more susceptible to the development of acute physical problems, such as fractures or abusive head trauma (AHT) [8] [9] [10], and chronic conditions, such as cancer, diabetes, or obesity during childhood [11]-[16]. Lifelong sequelae can also be a result of abuse, specifically from AHT, more frequently referred to as "shaken baby syndrome". AHT has a greater than 20% mortality rate and a vast range of symptoms including lethargy, seizures, or coma. Clinical findings suggestive of AHT include retinal hemorrhages, diffuse axonal injury, and subdural hematomas, all of which warrant emergency evaluation and treatment. AHT may also contribute to lifelong problems such as cerebral palsy, developmental delays, and neurological deficits [17].

Individuals exposed to child abuse or neglect can experience long-lasting mental health, physical health, and psychosocial impacts across the lifespan. About one-third of child abuse survivors are at risk of becoming a perpetrator in adulthood. Additionally, of those ages 21 years and older who were abused, 80% of them meet the criteria for one or more psychological disorders (*e.g.*, depression, anxiety disorders, PTSD) [2]. Subsequently, child abuse exposure can lead to both cumulative and intergenerational trauma.

Evidence drawn from the review of the literature confirms that infants have increased morbidity and mortality because of abuse. Multiple factors contribute to the risk of abuse, including childhood disabilities, lack of recreational facilities in the family's community, having multiple siblings at home, and parental depression [17]. Key interventions to prevent child abuse include increasing family social support and providing parental education about normative growth and development [17].

Finally, the effects of the COVID-19 pandemic have contributed to changes in child abuse epidemiology. Although the COVID-19 pandemic and its mitigation efforts may have successfully decreased viral transmission, social isolation, financial strain, and other stressors led to an increase in family violence. Rates of AHT have increased since the onset of the pandemic [17], as has the incidence of other types of physical child abuse [18] [19] [20]. Given that the COVID-19 pandemic exacerbated child abuse as a public health problem, coupled with the fact that there are effective intervention strategies available, this paper provides an overview of the current evidence base related to child abuse post-pandemic, with a focus on prevention and intervention strategies that can be utilized to increase caregiver support and reduce child abuse rates during the perinatal period.

2. Review of Literature

At the onset of the COVID-19 pandemic, shelter-in-place mandates resulted in

most Americans being isolated at home and only leaving their homes for essential activities or life-threatening emergencies. Approximately 91% of U.S. adults stated that their lives changed since the onset of the pandemic, and about half of these individuals reported that their lives changed in significant ways [21]. Additionally, 35% of U.S. adults admitted to struggling with childcare and the responsibility of their children, increasing the level of stress at home, and leading to parental burnout [22]. Parental burnout has been linked to a higher incidence of child abuse and neglect, but interventions can be implemented to reduce the incidence of parental burnout, thus reducing child abuse. Screening tools such as the Parental Burnout Inventory and Parental Burnout Assessment may be used to help identify parents at risk for or experiencing parental burnout so they can be provided with appropriate resources [22]. It has been noted that parenting is influenced by social support and that parenting programs are effective in reducing the risks of child abuse and maltreatment [23]. Parenting programs can offer a wide range of services such as support to parents, skill-building activities, and parent-educational interventions, which in turn have positive effects on parenting behavior, such as improved problem-solving abilities and child-parent interactions [23]. The respective studies by Griffith, and Chen and Chan highlight the contributions of well-developed measures targeting risk factors (e.g., parental burnout) associated with child abuse, as well as the positive impact of supportive parental programs. The studies provide insight into factors to consider when developing parent support interventions that incorporate a trauma-informed conceptual framework. Other studies targeting risk factors associated with infant and child abuse, as well as descriptions of parental programs/interventions are presented in subsequent paragraphs.

In a recent study, pediatric patients were placed into a trauma registry if they were confirmed or suspected victims of assault, if a trauma consultation was performed during their hospital visit, or if they met trauma activation criteria. The study included subjects less than 15 years of age and was conducted for one month following Maryland's statewide closures of childcare facilities, specifically between the dates March 28, 2020-April 27, 2020. Exclusion criteria included a history of intentional trauma (*e.g.*, a fight or intentional firearm injury) and a history of sexual abuse or child neglect without an inflicted injury [19]. Fisher's exact tests were used to examine the ratio of patients with physical abuse injuries during the COVID-19 period in comparison to the preceding two years. A total of 257 patients were included in this study with 15 of them being identified as physically abused. A total of eight patients equating to 13% of the trauma patients were victims of physical abuse during this study ($p = 0.029$), which was more than double the rate pre-COVID. Significant injuries were caused by blunt force trauma and included intracranial hemorrhage, skull fractures, and long bone fractures [19]. Another 2021 study in line with Kolver and colleagues' identified multiple risk factors associated with an increase in abuse during the pandemic. The factors cited included the inability to escape the abuser, quarantines and social isolation,

reduced access to first responders, and poverty-related stress [24]. Martinkevich and colleagues reported a 33% increase in domestic violence during the COVID-19 pandemic, which also increased the risk for nonaccidental injuries in children.

Regarding interventions, a mixed-methods feasibility study used an 8-week in-home education program for families who had children 0 - 4 years of age, to prevent child abuse and maltreatment [25]. This study included families who were at risk for maltreatment, and qualitative interviews were conducted with the parents. Risk factors for child abuse included child-parent relationship difficulties, social isolation, and developmental concerns. The authors reported that mothers engaged in the intervention demonstrated increased knowledge of parenting, improved mental health, stronger relationships with their children, and a feeling of increased community support. With the positive impact of in-home parenting education, many children were able to be reunified with their families [25].

Authors of the Promoting Attachment through Healing (PATH) study employed a different programmatic approach using cognitive behavioral therapy (CBT) and trauma-and-violence-informed care during the perinatal time [26]. CBT is an evidence-based psychological intervention to treat mood and anxiety disorders by promoting positive coping skills. Trauma-and-violence-informed CBT (TVICBT) is an approach that is grounded in trauma-informed care. A retrospective chart review of 69 medical charts among patients with depression, anxiety, or posttraumatic stress disorder, between 2014 and 2019 was utilized to compare maternal mental health, maternal coping, and maternal-fetal bonding among women who received TVICBT to those receiving usual care. A total of 37 women received TVICBT throughout their pregnancy and 32 women received standard care. The women who received standard care were only given referrals to psychiatrists, social workers, or family therapists for further treatment. The TVICBT intervention involved an initial assessment, two to three therapeutic relationship-building sessions, and up to eight TVICBT-focused sessions, with the addition of homework to be completed in between sessions. Women in the TVICBT group could identify triggers and advocate for their health by proactively expressing their concerns. As an example, more women in the TVICBT group indicated that they "prefer no males" before receiving care. During the intrapartum period, researchers reported that 94.6% of TVICBT (35/37) women coped successfully compared to 78.1% (25/32) of women who received standard care [26].

The two aforementioned studies [25] [26] underscore score the breadth of intervention strategies ranging from education to CBT resulting in positive parent-child outcomes. Mantler and colleagues' findings have implications for perinatal practitioners because the study was conducted with birthing persons during the perinatal period, and also added to the literature related to trauma-informed services to reduce the risk of child abuse.

Racine and colleagues conducted a study focusing on trauma-informed care and maternal-child health outcomes. The medical charts of 601 women receiving prenatal care at a low-risk maternity clinic in western Canada were included for

review. A total of 263 women between May 2016 and May 2017 received standard care, and 338 women between June 2017 and December 2018 received trauma-informed care [27]. Trauma-informed care included healthcare provider training and an adverse childhood experience (ACE) screening. In the training, healthcare providers learned how to communicate empathetically, use a non-judgmental stance, and verbalize what they are doing before they do it. Racine and colleagues reported that 32% of 601 women reported at least one ACE. Approximately 70% of infants of women who received trauma-informed care had no adverse birth outcome while 63.5% of infants of women in the standard care group had no adverse birth outcomes. Maternal pregnancy health outcomes were not significantly different with TIC as compared to standard care [27].

Much work has been done in the prevention of infant and childhood abuse as noted by the breadth of the cited studies. However, less has been done related to the incorporation of a trauma-informed framework into child abuse prevention and intervention strategies [27]. To minimize this gap in practice, healthcare providers will need to become knowledgeable about trauma-informed care conceptually as well as operationally to design and implement effective interventions. The next several paragraphs provide a conceptual overview of trauma-informed care, in addition to specific programs targeting families.

3. Trauma-Informed Care

Trauma-informed care is influenced by the understanding of the impact of violence and trauma on an individual [28]. Trauma-informed care services actively avoid re-traumatization and promote healing in individuals exposed to trauma. The role that trauma plays in an individual is explored in trauma-informed care. Physicians, nurses, and therapists are healthcare providers who can use trauma-informed care to care for patients more effectively. There are six guiding principles in trauma-informed care. The first principle is safety. Patients should feel physically and emotionally safe within the healthcare environment and when interacting with staff. The second guiding principle is trustworthiness and transparency. It is important to build and maintain trust with the patient. Maintaining trust creates a better environment for the patient to heal. The third guiding principle is collaboration and mutuality. Sharing power and decision-making allows for equity between the provider and the patient, allowing the patient greater dignity in their healthcare. The fourth guiding principle is empowerment and choice. Providers and nurses should strive to recognize, validate, and build the strengths of the patient. The fifth guiding principle is recognizing cultural, gender, and historical issues. This principle involves practices that are responsive to racial, ethical, and cultural needs. The last guiding principle is peer support. Trauma-informed care strives to encourage collaboration by sharing experiences to promote healing and recovery [28]. Very few trauma-informed care models for the perinatal period have been developed. Implementation of these models could better treat perinatal persons and could reduce early childhood trauma.

3.1. Trauma-Informed Perinatal Care

Gokhale and colleagues described trauma-informed perinatal care for urban prenatal care patients with multiple lifetime traumatic exposures, summarizing the desires of women in healthcare after they are faced with trauma using a qualitative approach [29]. A convenience sample of 30 women who were pregnant or less than two months postpartum were recruited from a healthcare system in Chicago, Illinois to participate in an interview. There were three components to the interview: a patient history questionnaire that screened for depression, a trauma history questionnaire, and a positive and negative experiences with perinatal care providers component [29]. Four common themes emerged. The first theme was that trauma was a normalized experience in the population. Women experienced trauma at high rates. The second theme was that disclosure of traumatic experiences to perinatal care providers could be either beneficial or retraumatizing, often depending on how such disclosure was received. The third theme was that women may not link their past traumatic experiences to symptoms within their current pregnancy. The fourth finding was that a therapeutic relationship is critical prior to any trauma inquiry. Women are more inclined to talk to a healthcare provider when they feel comfortable, but this may be difficult with rotating staff and short appointment windows. The study concluded that women desired resources for coping methods such as referrals, support groups, transportation, and financial assistance [29].

3.2. Trauma-Informed Care in Medical Homes for Adolescent Mothers

Adolescent mothers face higher rates of trauma and abuse with an increased risk for mental health disorders. A history of childhood sexual abuse doubles the risk of becoming pregnant in adolescence, and when coupled with physical abuse, the risk quadruples [30]. A history of childhood abuse increases the risk of miscarriage, cervical insufficiency, preterm contractions, and preterm delivery, and data suggests that women with PTSD or a history of trauma attend fewer appointments and feel less supported. The Colorado Adolescent Maternity Program (CAMP) is an obstetric and pediatric medical home for pregnant and parenting adolescents up to age 22 years [30]. Ashby and colleagues conducted a retrospective chart review inclusive of 429 patients from 2007 to 2008 and 415 patients from 2012 to 2013. A trauma-informed care practice model was introduced between the two groups. The practice model included trauma-informed training facilitated by behavioral health providers and integrated behavioral health staff within the clinic. Before the implementation of this practice model, patients could be turned away if they did not report to their scheduled appointment on time. Following the change in practice, patients were not terminated after not reporting for an appointment (*i.e.*, no show), and efforts were made to see patients who were late to appointments. All staff were also trained in motivational interviewing, building trust, and gender-responsive care. The authors of this study ana-

lyzed age, number of pregnancies, rates of trauma, preterm birth, and low birth weight. The authors reported that 30% of CAMP patients reported histories of trauma. There were significant differences in the rate of infants born with low birthweight in the pre-intervention group (11.4%) compared to the post-intervention group (6.6%; p = 0.02) [30].

4. Implications

Nurses encountering patients who have experienced violence, intentional injuries, or trauma play an important role in the healthcare system when caring for survivors of violence [31]. In the perinatal period, women are especially vulnerable. Antenatal nurses, labor and delivery nurses, and postpartum nurses should implement trauma-informed care in their daily practice. There are limited studies on the direct effect of trauma-informed care in the perinatal period. It is essential to be able to care for women who have complex needs from trauma, pregnancy, and stress. Women who have experienced trauma can feel hopeless, unheard, and re-traumatized when engaging in healthcare services that are disempowering and not grounded in trauma-informed care. Women should feel empowered and in control of their healthcare during this vulnerable time. Trauma-informed care such as screening, empathetic communication, explaining procedures, and active listening should be implemented in all maternal health facilities.

Addressing child abuse and nonaccidental trauma requires a multidisciplinary approach that is aimed at the three levels of prevention, including primary, secondary, and tertiary [32]. Primary prevention strategies include health teaching, such as parent education programs. Primary prevention strategies should be grounded in a trauma-informed approach, utilizing a patient-centered, evidence-based model. Further, appropriate trauma screening should be implemented universally across settings, with a focus on perinatal individuals and children or adolescents. Screening is in line with secondary prevention strategies that improve early identification of risk factors for child abuse or child abuse exposure, allowing for timely referral and intervention. Finally, tertiary prevention strategies include treatment for acute and chronic sequelae of child abuse. The goal of tertiary prevention is to restore the functions of the child, parents, and other family members. The pandemic and other socioeconomic crises increase the risk of physical abuse, and thus healthcare providers should be familiar with prevention and intervention strategies to address the growing number of individuals impacted by abuse and violence.

5. Conclusion

Child abuse includes physical abuse, sexual abuse, and neglect, among other types of child abuse. The COVID-19 pandemic resulted in an increase in child abuse rates, and the effects of this will be seen for years to come. Healthcare workers, including nurses, are key agents in the prevention and identification of child abuse and should be able to offer parental education and utilize trauma-informed

care practices. Additional policies and future work should continue to prioritize reducing child abuse risk factors and the incidence of child abuse, while also focusing on support for survivors of child abuse. The development of policies that reduce the stigma of needing help for parenting skills, substance use, depression, or suicidal ideation; the adoption of evidence-based strategies to strengthen economic support for families; and the development of partnerships in the community that support programs that provide safe and healthy conditions for all children and families are examples of ways to mitigate child abuse and its consequences [33].

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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