NCLEX 2026 TEST PLAN | PSYCHOSOCIAL INTEGRITY | SAFETY & INFECTION CONTROL | MENTAL HEALTH SERIES

Child Abuse & Maltreatment

A nurse's field guide to recognition, intervention, and mandatory reporting — built for clinical judgment items.

SYSTEM: MENTAL HEALTH · PEDIATRICS · SAFETY

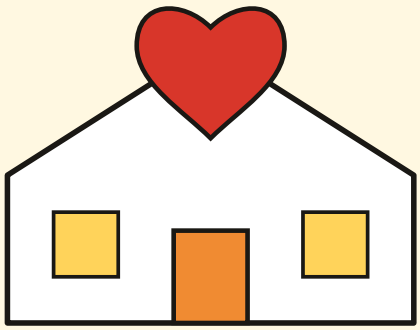
01 What Is Child Abuse?

DEFINITION · OVERVIEW

Child abuse is any **act or failure to act** by a parent or caregiver that results in death, serious physical or emotional harm, sexual abuse, or exploitation of a child under **age 18**.

- **Federal floor:** CAPTA (Child Abuse Prevention & Treatment Act) sets the minimum definition; each state expands on it.
- **Includes acts of commission** (doing harm) **and omission** (neglecting basic needs).
- **Nurses are mandated reporters** in all 50 U.S. states — suspicion is enough; proof is *not* required.

<18	5	100%
AGE DEFINED	MAJOR TYPES	SUSPICION = REPORT



The home should be the safest place.

Physical
Hitting, shaking, burning, biting — non-accidental injury.

Sexual
Any sexual contact, exploitation, or exposure.

Emotional
Belittling, rejection, terrorizing, isolating.

Neglect
Failure to provide food, shelter, hygiene, medical care, supervision, or education.

FDIA / MSBP
Factitious Disorder Imposed on Another — caregiver feigns or induces illness.

02

PATHOPHYSIOLOGY · MECHANISM

How Abuse Hurts the Developing Brain

Repeated trauma activates a chronic stress response in the child's developing nervous system — leading to lasting biological, behavioral, and emotional changes.

STEP 1
Acute Threat
Caregiver violence, neglect, or fear triggers the amygdala.

→

STEP 2
HPA Axis Activation
Cortisol & catecholamines surge; "fight, flight, freeze."

→

STEP 3
Chronic Toxic Stress
Repeated activation = sustained high cortisol levels.

STEP 4
Neuro Remodeling
Hippocampus (memory) shrinks; amygdala (fear) enlarges; prefrontal cortex (judgment) impaired.

→

STEP 5
Disrupted Attachment
Insecure or disorganized attachment; impaired trust & emotional regulation.

→

OUTCOME
Lifelong Sequelae
↑ PTSD, depression, substance use, chronic illness, suicide risk (high ACE score).

ACEs — Adverse Childhood Experiences

Each ACE raises lifelong risk for heart disease, COPD, depression, addiction, and early death. **Score ≥ 4 = high-risk patient** — flag for trauma-informed care.

03

SIGNS & SYMPTOMS · ASSESSMENT

What You'll See on the Floor

Physical Findings

BODY SYSTEM	SUSPICIOUS FINDINGS
Skin	Bruises in **various stages of healing**, patterned marks (belt, cord, hand, cigarette burns, glove/sock burns from immersion).
Skeletal	Spiral, posterior rib, or metaphyseal "bucket handle" fractures; multiple fractures in different stages on x-ray.
Head/Neuro	Retinal hemorrhages, subdural hematoma, bulging fontanelle (Abusive Head Trauma / Shaken Baby Syndrome).
GU/GI	STIs in prepubertal child, pregnancy in adolescent, recurrent UTIs, anal/genital trauma.
Growth	Failure to thrive, poor hygiene, dental caries, untreated chronic conditions (neglect).

Behavioral & Emotional

AGE GROUP	BEHAVIORAL CUES
Infant	Limp/lethargic, excessive crying, poor feeding, no eye contact, lack of stranger anxiety, "frozen watchfulness."
Toddler/Preschool	Regression (bed-wetting, thumb-sucking), aggression, fearful of caregiver, sexualized play, nightmares.
School-age	Declining grades, withdrawal, somatic complaints, role reversal, parentified behavior.
Adolescent	Self-harm, eating disorders, substance use, running away, promiscuity, suicidal ideation.
Caregiver Clues	Inconsistent/changing story, delayed seeking care, blames child, refuses tests, hostility to staff.

DAY 0–2
Red
Fresh

DAY 2–5
Blue–Purple
Bleeding

DAY 5–7
Green
Hemoglobin breakdown

DAY 7–10
Yellow
Bilirubin

DAY 10–14
Brown
Resolving

Red-Flag Patterns — Escalate Immediately

- Story **doesn't match** the injury or developmental ability ("3-month-old rolled off the couch").
- Bruises in **multiple stages** of healing.
- Delay in seeking medical care > 24 hours.
- Retinal hemorrhage + subdural bleed = **Abusive Head Trauma**.
- STI in a prepubertal child = **sexual abuse until proven otherwise**.
- Bruises on non-bony areas: ears, neck, abdomen, genitals, buttocks, inner thighs.
- Patterned marks (belt loops, cord, hand outline, looped extension cord).
- Spiral fracture in a child **not yet walking**.
- Child <4 with any femur or rib fracture (high specificity for abuse).
- Caregiver who is **overly calm, hostile, or rehearsed**.

04

PRIORITY NURSING INTERVENTIONS

What the Nurse Does — In Order

Always sequence by **ABCs → Safety → Reporting → Documentation → Support**. The exam rewards the answer that protects the child ***now***.

1 ABC

Stabilize the child medically

Assess airway, breathing, circulation, neuro status. Treat life-threats first — abusive head trauma, internal bleeding, severe burns.

ASSESS · STABILIZE · TREAT

2 SAFETY

Ensure immediate safety — remove the threat

Place child in a safe environment. **Interview the child alone**, away from the suspected abuser. Do not confront the caregiver.

SEPARATE · PROTECT · OBSERVE

3 REPORT

Mandatory report to CPS / law enforcement

Report **suspicion** — you don't need proof. Confidentiality & HIPAA do *not* apply to suspected abuse. Failure to report = legal and licensure consequences for the nurse.

REPORT · NOTIFY CPS · DOCUMENT

4 DOC

Document objectively & precisely

Use **direct quotes** ("My dad hit me with a belt"). Describe injuries with size, shape, color, location. **Photograph** with consent/protocol. Use body diagrams. Avoid opinions or labels like "abused."

QUOTE · MEASURE · PHOTOGRAPH

5 COLLECT

Preserve forensic evidence

For suspected sexual abuse — **do not bathe, change, or feed** the child until forensic exam is complete. Preserve clothing in paper bags. SANE nurse if available.

PRESERVE · BAG · CHAIN-OF-CUSTODY

6 SUPPORT

Therapeutic communication & support

Believe the child. Use open-ended, non-leading questions. Provide a calm presence. Refer to social work, child-life specialist, mental health, and victim advocacy.

LISTEN · VALIDATE · REFER

RN

Mandatory Reporter Rule

If you **suspect** abuse, you **must** report — even without parental consent, even if a peer disagrees, even if a physician says no. The duty is yours. *Suspicion > Certainty.*

05

PHARMACOLOGY · TRAUMA SEQUELAE

Medications That May Be Used

There is **no drug to "treat" abuse.** Pharmacology targets ***consequences***: trauma, depression, anxiety, nightmares, and acute agitation in the post-exposure phase.

Sertraline (Zoloft)

SSRI · 1ST-LINE FOR PEDIATRIC PTSD & DEPRESSION

- **MOA:** Blocks serotonin reuptake → ↑ synaptic serotonin.
- **Side effects:** GI upset, headache, insomnia, sexual dysfunction; **black-box: ↑ suicidality in <25 y/o**.
- **Nursing:** 4–6 wks for full effect; monitor mood & suicidality weekly first month; serotonin syndrome.
- PEDS FDA-approved for pediatric OCD (≥6); off-label for PTSD/MDD.

Prazosin (Minipress)

ALPHA-1 ANTAGONIST · PTSD NIGHTMARES

- **MOA:** Blocks alpha-1 receptors → ↓ sympathetic CNS arousal during sleep.
- **Side effects: First-dose orthostatic hypotension**, dizziness, syncope.
- **Nursing:** Give at **bedtime**; teach slow position changes; monitor BP.
- USE Reduces trauma nightmares & improves sleep.

Fluoxetine (Prozac)

SSRI · FDA-APPROVED PEDS DEPRESSION (≥8)

- **MOA:** Selective serotonin reuptake inhibition.
- **Side effects:** Activation, insomnia, GI; **black-box: suicidality**.
- **Nursing:** Take in morning; do *not* stop abruptly; assess for serotonin syndrome.
- WATCH Long half-life — drug interactions persist for weeks.

Clonidine (Catapres)

ALPHA-2 AGONIST · HYPERAROUSAL, SLEEP, ADHD COMORBID

- **MOA:** Stimulates central alpha-2 → ↓ sympathetic outflow.
- **Side effects:** Sedation, hypotension, dry mouth; **rebound HTN if stopped abruptly**.
- **Nursing:** Taper — never abrupt discontinuation; check BP/HR; useful for nightmares & aggression.

NCLEX Pearl: Trauma-focused CBT (TF-CBT) is *first-line* for childhood trauma — meds are **adjuncts**, not stand-alones. Benzodiazepines are **avoided** in children (paradoxical agitation, dependence, no efficacy in pediatric PTSD).

06

NCLEX TEST TRAPS

Where Students Lose the Question

Trap 1 — Who do you call *first*?

~~Call the parents to clarify the story.~~ **vs** Notify CPS & the charge nurse.

Why: Confronting the caregiver delays safety and may worsen the child's risk. The nurse's duty is reporting, not investigating.

Trap 2 — Suspected sexual abuse

~~Bathe the child & change clothing for comfort.~~ **vs** Preserve evidence — no bathing, no food, no clothing change until forensic exam.

Why: Bathing destroys DNA/forensic evidence. Comfort comes *after* the SANE/SART exam.

Trap 3 — Interviewing the child

~~"Did your father hit you with a belt?"~~ **vs** "Can you tell me how this happened?"

Why: Leading questions are inadmissible & can re-traumatize. Use open-ended, age-appropriate language and the child's own words.

Trap 4 — Reporting threshold

~~"Wait until I have enough evidence to be sure."~~ **vs** Report on reasonable suspicion.

Why: Mandated reporting is on *suspicion*, not proof. Investigation is CPS's job, not the nurse's.

Trap 5 — Bruise interpretation

~~"A bruise on the shin is suspicious."~~ **vs** Bruises on ears, neck, trunk, buttocks, genitals are suspicious.

Why: Shins/knees/elbows are normal play injuries. *"TEN-4–FACES–P"* areas are high-suspicion.

Trap 6 — Munchausen by proxy (FDIA)

~~Praise the "devoted" parent for medical knowledge.~~ **vs** Document symptoms only when caregiver is absent.

Why: In FDIA the caregiver fabricates/induces illness. Symptoms resolve when the caregiver leaves the bedside — that pattern is the diagnostic clue.

07

PATIENT & FAMILY EDUCATION

Teaching for Prevention & Recovery

C For the Child / Adolescent

- ✓ **"It is not your fault"** — repeat this; abused children almost always blame themselves.
- ✓ Teach **safe-touch / unsafe-touch** using age-appropriate language and visual aids.
- ✓ Identify **trusted adults** (teacher, school nurse, relative) the child can tell.
- ✓ Memorize **911** and the Childhelp Hotline: `1-800-422-4453`.
- ✓ Reinforce that telling someone is *brave*, not "tattling."
- ✓ Promote **self-soothing skills**: grounding (5-4-3-2-1), deep breathing, journaling.

F For the Family / Non-offending Caregiver

- ✓ **Believe the child**. Disclosure is the most important moment in recovery.
- ✓ Maintain routines — predictable meals, bedtime, school provide safety cues.
- ✓ Avoid pressing for details; let the child lead disclosure at their pace.
- ✓ Watch for **red flags**: regression, nightmares, somatic complaints, withdrawal.
- ✓ Engage in **family therapy** & parenting classes; address caregiver substance use, IPV, mental illness.
- ✓ Recognize that healing is **non-linear**; setbacks are normal.

P Community & Prevention

- ✓ **Period of PURPLE Crying** education for new parents — reduces shaken baby syndrome.
- ✓ Home-visitation programs (Nurse-Family Partnership) for at-risk first-time parents.
- ✓ Encourage **never shake a baby** — put the baby down safely and walk away.
- ✓ Screen for IPV at every well-child visit; co-occurring with child abuse in 30-60% of homes.
- ✓ Promote ACEs screening in primary care.

R Resources to Provide at Discharge

- ✓ Childhelp National Hotline: **1-800-422-4453** (24/7, multi-lingual).
- ✓ Local Child Advocacy Center (CAC) for forensic interview & follow-up.
- ✓ Trauma-Focused CBT (TF-CBT) referral — gold standard for childhood trauma.
- ✓ School counselor & IEP/504 plan if learning is affected.
- ✓ Safety plan: code word, neighbor's house, escape route.

08

MEMORY BOOSTERS · MNEMONICS

What to Remember on Test Day

"CHILD ABUSE"

RECOGNITION CHECKLIST

- **C** — **Conflicting** story / cause of injury
- **H** — **Healing** in different stages
- **I** — **Inappropriate** dress / hygiene / behavior
- **L** — **Lethargy** or "frozen watchfulness"
- **D** — **Delayed** care-seeking
- **A** — **Affect** flat / fearful of caregiver
- **B** — **Bruises** in patterns or non-bony areas
- **U** — **Untreated** injuries / chronic neglect
- **S** — **Sexualized** behavior or STI in child
- **E** — **Escalating** ER visits / multiple hospitals

"TEN-4-FACES-P"

HIGH-SPECIFICITY BRUISE LOCATIONS (AGE < 4)

- **T** — **Torso**
- **E** — **Ears**
- **N** — **Neck**
- **4** — Any of above in child ≤ **4 yrs** — or *any* bruise in infant ≤ 4 months
- **F** — **Frenulum**
- **A** — **Auricular** (ear)
- **C** — **Cheek** (fleshy)
- **E** — **Eyelid**
- **S** — **Subconjunctival**
- **P** — **Patterned** bruising

"SAFE"

NURSING PRIORITY SEQUENCE

- **S** — **Stabilize** — ABCs, treat injuries
- **A** — **Assess** — interview child alone, document objectively
- **F** — **File report** — CPS / law enforcement; suspicion is enough
- **E** — **Educate & empower** — refer to TF-CBT, advocacy, support

"4 R's of Abusive Head Trauma"

SHAKEN BABY RED FLAGS

- **R** — **Retinal** hemorrhages
- **R** — **Rib** fractures (posterior)
- **R** — **Reduced** consciousness / lethargy / seizures
- **R** — **Ruptured** bridging veins → subdural hematoma

Pattern Recognition — If you see this on the exam...

- → **Spiral fracture, child not walking** → abuse
- → **Retinal bleed + subdural** → shaken baby
- → **Story changes** → suspect abuse
- → **"Frozen watchfulness"** → chronic trauma
- → **STI in 6-year-old** → sexual abuse
- → **Symptoms only with caregiver** → FDIA
- → **Bruises in stages** → ongoing abuse
- → **Caregiver answers for the child** → assess alone