CONDITION

Child physical abuse

Learn how child physical abuse may present, how clinicians evaluate injuries, and how medical care, safety planning, and follow-up can support a child.

WHAT IT IS
Intentional physical force causing injury or serious risk

BODY SYSTEM
Whole body

MAIN SYMPTOMS
Bruises, burns, pain, vomiting

WHAT CAUSES IT
A person's harmful actions

HOW IT IS DIAGNOSED
History, physical examination, laboratory tests, imaging

MAIN TREATMENT
Injury care, safety planning, trauma-focused support

CAN IT BE CURED?
Sometimes - injuries heal, effects may persist

IS IT AN EMERGENCY?
Sometimes - breathing difficulty or immediate danger

LONG-TERM OUTLOOK
Recovery can improve, but disability or death can occur

Overview

Child physical abuse is the intentional use of physical force against a child that causes injury or creates a serious risk of injury. It may involve hitting, shaking, kicking, burning, biting, choking, poisoning, or another harmful act. Physical punishment may also meet the definition of abuse when it injures a child or places the child at substantial risk.

Abuse can occur in any family or community. The person responsible may be a parent, caregiver, relative, household member, or another person with access to the child. A child is never responsible for being abused.

Many childhood injuries are accidental. A bruise, fracture, or other injury does not by itself prove abuse. Concern rises when the injury does not fit the explanation, the child's developmental abilities, or the expected pattern of an accident. More than one injury, injuries

of different ages, or delays in seeking care can also require further evaluation.

Recognizing possible abuse matters because a child may have hidden injuries or remain at risk of further harm. Medical professionals focus first on treating injuries and keeping the child safe. In many places, healthcare workers must report reasonable concerns to child protection authorities. A report starts a safety assessment; it is not a medical diagnosis or a finding of guilt.

If a child may be in immediate danger, contact local emergency services or child protection authorities. If it is safe to do so, take the child to a medical setting without confronting a person who may become threatening.

Symptoms

Signs vary with the child's age, the type of force used, and the body area affected. Some children have clear injuries. Others have subtle symptoms, especially after injury to the head or abdomen.

Possible physical findings include:

Bruising patterns can help clinicians decide whether a young child needs further assessment. However, a screening rule is not proof of abuse. Skin tone, medical conditions, cultural practices, medications, and ordinary accidents must also be considered.

A child may become fearful of a person or of going home. Other possible changes include withdrawal, aggression, sleep problems, developmental regression, poor school attendance, or a sudden drop in school performance. These behaviors have many possible causes and should be assessed in context.

Call emergency services for a child who has:

Infants with possible head injury may show poor feeding, vomiting, unusual crying, breathing changes, reduced alertness, or seizures. Because these signs can be subtle, urgent medical evaluation is appropriate when head trauma is suspected.

- Bruises in an infant who is not yet independently mobile
- Bruises on the ears, neck, torso, buttocks, cheeks, or other protected areas
- Bruises or burns with a recognizable shape, such as a hand or object
- Burns with sharp borders or a pattern suggesting contact with a hot item
- Mouth injuries, torn tissue under the lip, loose teeth, or unexplained bleeding
- Swelling, pain, reduced movement, or a limb that appears abnormal

- Repeated fractures or fractures that do not fit the reported event
- Hair loss caused by pulling
- Abdominal pain, vomiting, swelling, or tenderness
- Headache, unusual sleepiness, irritability, confusion, or changes in behavior
- Trouble breathing, choking symptoms, or blue or gray skin
- A seizure, loss of consciousness, severe confusion, or difficulty waking
- Weakness, trouble walking, or unequal pupils
- Repeated vomiting after a possible head injury
- Severe abdominal pain, a swollen abdomen, fainting, or signs of shock
- Heavy bleeding, a serious burn, or an obviously deformed limb
- A current threat of serious harm

Causes and risk factors

Physical abuse is caused by a person's harmful actions, not by a child's behavior. Crying, toileting accidents, disability, poor grades, or challenging behavior never justify violence.

No single risk factor predicts who will harm a child. Abuse can occur without any recognized warning factors. Conditions that may increase family stress or reduce a caregiver's ability to cope include substance use, untreated mental health problems, intimate partner violence, social isolation, severe financial strain, and limited knowledge of child development.

Risk may also rise when a caregiver has unrealistic expectations of a child's behavior or responds impulsively to crying and other normal developmental challenges. A personal history of abuse can affect coping and parenting, but most people who experienced abuse do not go on to abuse children.

Some children may be more vulnerable because they are very young, have disabilities or complex medical needs, or depend on several caregivers. These characteristics do not cause abuse. They may increase caregiving demands or make it harder for a child to communicate what happened.

Protective support can include dependable adults, safe childcare, access to healthcare, treatment for substance use or mental health conditions, and practical help with food, housing, or respite care. Prevention services should support families without blaming children or assuming abuse based on social circumstances alone.

Diagnosis

There is no single test that confirms child physical abuse. Clinicians combine the child's history, physical examination, developmental abilities, laboratory tests, and imaging findings. They also consider accidental injuries and medical conditions that can resemble abuse.

The medical team will ask what happened, when symptoms began, who was present, and how the child behaved afterward. Details may be gathered separately from different caregivers. When appropriate, the child may be asked open-ended, non-leading questions in a calm and private setting. Repeated or suggestive questioning is avoided because it can increase distress and affect the accuracy of information.

The clinician performs a complete examination, not only an examination of the visible injury. This may include the skin, mouth, head, eyes, abdomen, bones, joints, and nervous system. Findings may be documented with body diagrams and medical photographs according to local policy.

Tests depend on the child's age, symptoms, and injuries. They may include blood tests for anemia, bleeding disorders, liver or pancreatic injury, and other medical explanations. Urine testing may help detect blood caused by internal injury.

A skeletal survey is a set of X-rays that looks for fractures throughout the body. It is commonly considered for infants and young children when abuse is suspected because some fractures cause few outward symptoms. Follow-up X-rays may sometimes show injuries that were not visible initially.

Brain imaging may be needed when there are neurological symptoms, concerning head findings, or a risk of hidden head trauma. An eye specialist may examine the inside of the eyes in selected cases of suspected abusive head injury. Abdominal imaging may be used when symptoms, examination findings, or laboratory results suggest internal injury.

Clinicians may consult a child abuse pediatrician, who has additional training in evaluating possible maltreatment. Social workers, radiologists, surgeons, mental health professionals, law enforcement, and child protection agencies may also be involved. Their roles differ, but the shared priorities are medical care, careful documentation, and safety.

Treatment and management

Immediate treatment depends on the injury. A child may need wound or burn care, pain relief, treatment for a fracture, surgery for an internal injury, or close monitoring after head trauma. Serious injuries may require hospital admission.

Safety planning begins during the medical assessment. The child may be discharged to a safe caregiver, remain in the hospital while plans are made, or enter temporary protective care. These decisions are generally made with child protection professionals and according to local law. Clinicians do not expect a child to manage their own safety.

If you are worried about a child, write down what you directly observed, including dates and the child's exact words when possible. Do not pressure the child for details or ask the same questions repeatedly. A helpful response is to stay calm, listen, say that the child did the right thing by speaking, and explain that the abuse was not their fault.

Do not confront a suspected person if doing so could place the child or anyone else at risk. Local child protection services, law enforcement, or a healthcare professional can help determine the safest next step. Reporting requirements and available hotlines differ by location.

Emotional care is part of treatment. A child may benefit from a trauma-informed mental health assessment. Trauma-focused therapy can help with fear, sleep problems, intrusive memories, behavior changes, or feelings of guilt. Treatment should match the child's age, development, symptoms, family situation, and culture.

Safe caregivers may also need guidance about responding to trauma, setting nonviolent limits, and helping the child regain a sense of security. Family services can address practical needs such as housing, food, childcare, transportation, mental healthcare, or substance use treatment. Family-based care is appropriate only when it can be provided without compromising the child's safety.

Complications

Physical injuries can range from minor wounds to brain injury, internal bleeding, disability, or death. Young children are especially vulnerable because their bodies and brains are still developing, and they may not be able to describe symptoms.

Some complications are initially hidden. Head injury can affect memory, learning, movement, vision, or behavior. Abdominal injury may cause internal bleeding or damage to organs. Fractures near a growth plate, the area where a child's bone lengthens, may affect future growth.

Abuse can also affect emotional and social development. Possible long-term effects include anxiety, depression, post-traumatic stress symptoms, sleep problems, difficulty trusting others, substance use, and problems at school. Chronic stress may also affect physical health over time.

These outcomes are not inevitable. A stable relationship with a safe adult, prompt medical care, protection from further harm, and appropriate mental health support can improve recovery.

Follow up

Follow-up should be tailored to the child's injuries and safety plan. Routine medical visits may include checking wound or burn healing, fracture alignment, growth, movement, hearing, vision, and neurological function. Repeat imaging or specialist appointments may be arranged when needed.

The child's primary care clinician can monitor sleep, mood, behavior, school progress, and developmental milestones. Mental health follow-up may continue even after physical injuries have healed. Safe caregivers should tell clinicians about new symptoms or changes at home or school.

Seek prompt medical advice for increasing pain, fever, wound redness, repeated vomiting, new limping, reduced use of a limb, worsening headaches, or important changes in behavior or alertness.

Use emergency services for breathing difficulty, seizures, fainting, inability to wake the child normally, severe bleeding, new weakness, or another immediate threat to the child's safety. Routine follow-up appointments are not a substitute for emergency care.

Sources

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