Problems in Family Practice

Child Abuse and Neglect

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Family physicians annually see a large number of children at risk for child abuse and neglect. Because of the family physician's orientation toward a vision of the family constellation as a whole rather than a grouping of individual members, and because of trained sensitivity and gravitation toward a generally humanistic approach to clinical problems, the family physician is well equipped to identify child abuse and neglect. An appropriate assessment and management scheme includes a well-documented history, a complete physical examination, clinical laboratory evaluation, utilization of consultation services, selection of a diagnostic category, and choice of disposition. The family physician's primary function rests in his ability to coordinate and facilitate the process of problem resolution while simultaneously supporting the family as an intact unit.

Child Abuse and Neglect as a Continuum

This year, family physicians will see a major proportion of the children at risk for child abuse and neglect and will treat many children who in fact are the targets of abusive and neglectful behavior. Before embarking on a general or specific plan of identification and evaluation of abuse and neglect, a physician must have a firm grasp of the concept of abuse and neglect—what it is and how it can best be viewed for the optimal benefit of the patient and family. Without a clear and thorough understanding of this concept, the physician will be less able to treat the syndrome and to cope with the personal feelings that are a function of the role of the primary helper. Further, the physician is likely to deliver treatment in specialized rather than general or global terms or to lose sight of the

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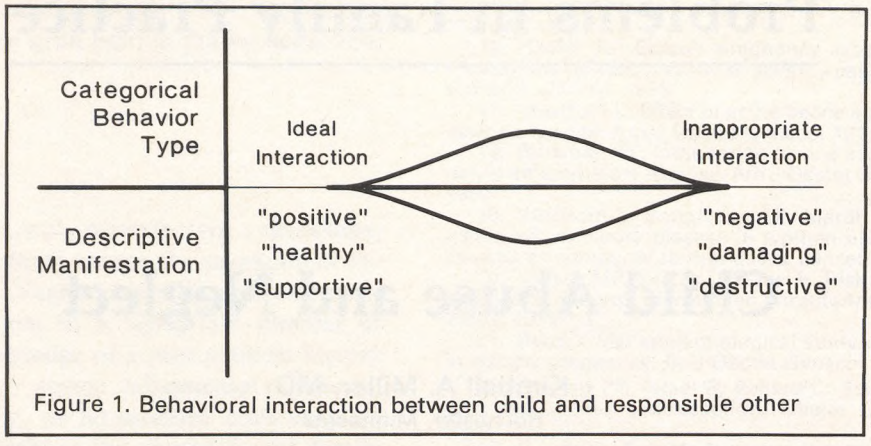

Figure 1. Behavioral interaction between child and responsible other

focal point of treatment, that is, the family as the identified patient rather than the individual.

Like many issues in American society, the concept of abuse and neglect is often discussed, diagnosed, and treated as a dichotomy: the child is abused, or the child is not abused; the child is neglected, or the child is not neglected. This characterization of the abuse and neglect phenomenon can be seen as a false dichotomy. In fact, with the exception of gender, there are few or no true dichotomies in society. In behavioral terms, the abuse and neglect syndrome must be viewed as being continuous with other types of human behavior, physical and psychologic. It is not a separate and distinct category of behavior, but rather one of many behavioral frames on a continuum of potential behaviors, a spectrum of behavioral interaction between parent and child or between child and some other responsible person. Figure 1 displays the abuse and neglect syndrome as one which rests on a continuum. The closer the progression to inappropriate behavior, the more the type of behavioral interaction may be classified as abusive or neglectful. If a particular family behavioral interaction is viewed as ideal, that interaction can be generally described by such adjectives as "positive," "healthy," "supportive," and "growth promoting." In contrast, family behavioral interactions that are inappropriate may well be characterized by such words as "destructive," "counterproductive," "damaging," and "negative," to list only a few. The transitional phase is of great importance, since the family physician is often involved in clinical cases that are in this category. The degree to which the physician views the family interactions as leaning to the left or right of the continuum necessarily influences the plan of treatment or lack of it.

Because the family physician views the family as a whole rather than as a grouping of individual members, has a trained sensitivity and a generally humanistic approach to clinical situations, and possesses a basic awareness common to all caring human beings of appropriate and inappropriate behavior, this physician will not find it difficult to identify and distinguish the extremes of behavioral interaction. Rather, it is the transitional phase of the behavioral continuum—the gray area—that will challenge the physician to produce a diagnosis and to develop a plan of treatment that will reduce the abusive and neglectful tendencies and at the same time keep the family intact.

As a professional, the family physician appears to be ideally suited to identify abuse and neglect, to coordinate treatment, and to resolve the problem with the help of other members of the child protection team, including other mental health care professionals. With this perhaps greater suitability for involvement in abusive cases comes an additional responsibility which is related to individual vested interest. The physician must never forget that he is an advocate for the entire family,

not for any one member. The physician who is clearly and closely aligned with the mother or the father will find it difficult to remain objective in his advocacy role. Therefore, when such an alignment between family physician and individual family member is observed, it is important that other members of the child protection team (mental health professionals and psychoeducational consultants, such as counselors, priests, ministers, and teachers) and other necessary community professionals become directly involved. It is important that the family physician systematically coordinate the process of evaluation and resolution of problems. However, if other professionals are not consulted, the risk of exacerbating the abusive tendencies in the family is greatly increased.

Prevalence of Abuse

The abuse and neglect syndrome occurs in all socioeconomic classes and is not specific to any one professional, religious, ethnic, or cultural group.[1-4] In addition, although a greater proportion of racial minorities and the poor are represented in national statistics on abuse and neglect (in 1968, 6.7 per 100,000 white children compared with 21 per 100,000 nonwhite children),[5] this difference might be related to intrinsic problems in reporting. Minority group members and the poor have greater visibility in social and community service programs and local health care agencies. In contrast, upper and middle class persons tend to use private agencies and facilities and are thereby less vulnerable to professional scrutiny.

Certain myths and falsehoods surround the issue of prevalence of abuse and neglect, and the family physician must avoid them. One such myth involves the psychologic state, an intrapsychic process of the designated abusers. Not all abusers are psychotic, and not all simply "misjudge their strength."[6] Violent behavior toward children is prevalent in this country. Statistical research data generated by a random, national probability sample in the United States show that in 1975, 6.3 percent of respondents who had children between the ages of 3 and 17 years cited at least one violent episode during the course of rearing a child.[7] Research by Gelles revealed a diverse range of physical and violent behavior between parent and child.[7] Of the respondents, 71 percent indicated that they had slapped or spanked their children at some point in rearing them, 46.4 percent said they had pushed, shoved, or grabbed their children, and 20 percent reported that they had thrown objects at their children. Data were also collected for behavior of increased severity. It was noted that at least once, 9.6 percent of the respondents kicked or bit their children or hit them with a fist. Furthermore, 2.8 percent of the respondents indicated that they had threatened their children with a gun or knife.

Classification of Abuse and Neglect

A review of the literature reveals that abuse and neglect can be classified into eight categories of maltreatment.[1,2,4,5,8]

1. *Physical Abuse*—Injuries inflicted on the child by a parent or guardian. Examples of this type of abuse range from minor scratches and bruises to large burns, multiple fractures, and death secondary to trauma.

2. *Sexual Abuse*—Sexual exploitation of any person younger than 18 years by an adult. Exploitation ranges from indecent exposure by an adult to oral-genital and genital-genital contact between an adult and the child.

3. *Psychologic Abuse*—A broad range of maladapted parent-child interactions, ranging from intermittent or chronic scapegoating of the child by the parent to severe psychopathology in parents or guardian that is manifested through interactions with the child.

4. *Physical Neglect*—Failure of the parents or guardian to provide the child with minimum standards of food, shelter, and clothing.

5. *Medical Care Neglect*—Treatable acute or chronic illnesses that, because the parents refuse to adhere to reasonable medical recommendations, result in deterioration of the child's health or in death.

6. *Intentional Drugging*—Use of sedatives or tranquilizers by parents or guardian to modify the behavior of the child. A typical example of this

abuse is drugging with sedatives to achieve a "quiet child."

7. *Educational Deprivation*—Intentional parental induced truancy of the child for the ultimate purposes of the parent. Examples often given by parents as reasons for withholding education are parental need for daytime companionship and family need for housekeeping and babysitting services not met by the parents.

8. *Abandonment or Lack of Supervision*—Intermittent or permanent nonsupervision of a minor by the responsible adult.

Guidelines and Assessment Techniques

History

In making a clinical evaluation of suspected abuse or neglect, the family physician should be particularly careful during the history taking phase. The history should include a verbatim account of the child's and the parent or guardian's descriptions of how the injury, abuse, or neglect occurred. Care should be taken to obtain the date, time, and location of the incident and the names of the persons present. The state of the child's health maintenance and factors bearing on safety in the home should be evaluated. In addition, the history should include any pediatric medical and surgical difficulties. A thorough and effective history must reveal the parents' child rearing beliefs and practices in juxtaposition with observation of the parent-child interaction.

Physical Examination

It is always important, especially so in instances of suspected sexual abuse, to do a complete examination. Anything less than a complete examination, for example, a pelvic examination alone, serves only to psychologically assault the child and heighten attendant fears, anxieties, and verbal reluctance.[9,10] This careful and complete examination must be well documented for legal purposes and must emphasize the following aspects. The size, tenderness, shape, color, and pattern of all visible injuries, old and new, should be recorded on a skin map.[11] Funduscopic findings should be carefully reported, especially retinal hemorrhages in infants, and height and weight should be documented on growth charts. Finally, there should be some statement of general language, personal-social, and motor development.

Clinical Laboratory Evaluation

The clinical laboratory evaluation should include a radiologic trauma screening examination (especially in children younger than two years), bleeding disorder screening, and in suspected sexual abuse, the state mandated forensic specimens. In addition, high-quality color photographs should be obtained of the injury site on the abused child. For legal purposes, extreme care should be exercised in the identification of laboratory and photographic evidence.

Consultation Services

As noted earlier, the family physician should be aware of the support services and functions of the consulting agencies available. During the clinical evaluation of the injury or abuse, mental health professionals and social service agencies should be consulted for additional background information and for such things as methods of achieving therapeutic outcomes.

Diagnosis and Disposition

By using the outlined classification schedule and data obtained through a complete evaluation and examination, the family physician must arrive at a diagnostic category or categories for the type of abuse or neglect under scrutiny. Once the phy-

sician has completed the evaluation and made the diagnosis, the suspected abuse or neglect must be legally reported and the disposition considered.

Most states have child protection laws requiring the physician who suspects child abuse and neglect to notify the child protective service division of the Department of Human Services immediately and to file a written report within a certain time period. These laws also give immunity from civil and criminal liability to the physician who reports in good faith as an advocate for the child and the family. Generally speaking, there are four main options:

1. Release of the patient to the responsible person (identified in the medical records) and further evaluation planned through the child protective service division of the Department of Human Services
2. Release of the patient to the responsible person (identified in the medical records) and supervision by the child protective service division of the Department of Human Services
3. Temporary foster care placement of the child by the child protective service division of the Department of Human Services
4. Hospitalization of the patient for further evaluation and determination of an interdisciplinary management plan

During the disposition phase the family physician must realize his two most important functions: (1) to protect the child at risk for abuse from further harm or injury while, if possible, rehabilitating the family so that the family may ultimately remain intact, and (2) to avoid lashing out at anyone who harmed or injured a defenseless child (the physician must guard against any display of emotional value judgments). The family physician must keep firmly in mind the purpose of his/her role and the productive impact a positive reaction can have on the family.[12]

Effective delivery of health care in an instance of abuse and neglect requires a combination of commitment, competence, and love. Without this basic yet complex mixture of professional ingredients, achievement of the optimal result may be in doubt. The long-term goals for the victims to heal their wounds and to grow into whole persons, including the ability to experience normal sexuality, depend not only on the kind of abuse, the relationship with the abuser, and the existing environmental support system but also on how their maltreatment is managed by the mental health, social service, medical, legal, and educational professionals.

Conclusions

Today's family physician has the opportunity to be forcefully active in the identification, assessment, and treatment of behavioral interactions of parents and children. The child abuse and neglect syndrome is not an isolated disease entity, but rather is a range of parent-child interactions that begins with diminished fulfillment of parent-child needs and progresses toward physical and emotional maltreatment of the child. Every year 3 to 4 million children are abused or neglected, and thousands die. The pediatric health challenges of the future lie in the identification of parenting difficulties, coordination of multidisciplinary evaluations, and intervention, with the goal that every child should be wanted, loved, fed, protected, and educated.

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