Family Practice Grand Rounds

Evaluation, Treatment, and Follow-Up of Child Abuse

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DR. LOUIS KETTEL *(Dean, College of Medicine)*: Today's discussion will focus on a difficult clinical problem encountered with increasing frequency in primary care: child abuse. Such cases tax the physician's clinical skills and sensibilities. They require multidisciplinary approaches and medical, social, and legal interventions. What role should physicians and concerned citizens in the 1980s play?

DR. RONALD FISCHLER *(Assistant Professor, Family and Community Medicine and Pediatrics)*: Michael, aged 18 months, was admitted to Arizona Health Sciences Center in July 1979 in semicoma with bruises on his face, scalp, ears, and shoulder. X-rays and a computed tomographic (CT) scan showed multiple new skull fractures, brain contusion, and two unexplained rib fractures estimated to be two to four months old. The mother stated that Michael was normal at his 8 PM bedtime but was alone with the mother's fiance, Harold, until midnight. At 7 AM she found Michael with the injuries mentioned and rushed him to the Emergency Room. Harold offered no explanation for what happened.

Michael was the product of a term pregnancy to an unwed mother (gravida 3, para 2, therapeutic abortus 1) whose intrauterine device had failed. Both the pregnancy and the delivery were uncomplicated. Bottle fed, Michael was brought to the clinic three times within the first months of life with feeding difficulties and spitting, but the examinations were normal. The mother was noted to be extremely anxious. Over the next 15 months, eight clinic visits occurred for minor acute illnesses. Significant family stress and inconsistent caretakers were identified as major problems, but no intervention occurred until Michael was admitted with severe injuries.

During Michael's hospitalization, a social evaluation elicited the following: the mother, Fran, is 26 years old and had been adopted. Despite a description of a warm and close childhood relationship with her parents, she relates a history of a turbulent adolescence with hysterical seizures, psychiatric hospitalizations, a period in detention, and a suicide attempt. She was later raped by eleven men and became pregnant and had a child. There were frequent moves and she finally could not care for the child and gave him up for adoption to friends at two and one half years of age. She subsequently had a therapeutic abortion. Fran met her current boyfriend, Harold, at a bar and planned to marry him, had Michael not been admitted to the hospital one day before the scheduled wedding. During the social work interview Fran described Michael as a "brat" who is clinging and dependent, jealous of Harold or anyone else who gets close to her. Michael shared a bedroom with Fran until Harold moved in. Fran admitted to a drinking problem and a violent temper

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but denied ever losing control with Michael.

Harold is 30 years old, was also adopted, and claims to have had a good childhood relationship with his parents. He married the girl next door, she became pregnant, and he went to Vietnam. When he returned two years later, they were divorced. He has had irregular employment since, and he injured his hand at work one month before Michael's hospitalization. Harold admits to a violent temper but denies losing control with Michael.

In the Intensive Care Unit, Michael remained in semicoma for two days and then made a gradual recovery. At the time of discharge, three weeks later, he had a mild left hemiparesis, used two single words (hi, bye), walked unsteadily, fed himself partially, and demonstrated some oppositional behaviors. He appeared friendly to strangers, afraid of Harold, and indifferent to his mother. His mother was observed to be anxious and inconsistent in her interactions with Michael, at times consoling, at other times rejecting. The diagnosis of child abuse was made, and it was decided that Michael could not be safely cared for at home with his mother. He was made a ward of the court and placed in foster care. The treatment plan, agreed to by the attending physician, hospital social worker, and Child Protective Services worker included the following:

1. Foster care was to be provided for Michael with at least twice-weekly visits with the mother, supervised by the Child Protective Services social worker.
2. Help was to be provided for the mother so that she could learn to provide safe and effective parenting and regain custody of Michael. She was referred for individual counseling, to Alcoholics Anonymous, and to a parenting group.

Michael made a poor adjustment in his first foster home. The experienced foster mother, who was under stress caring for five children, was extremely frustrated with his clinging and whining behaviors. At the six-week check-up, both Michael and the foster mother appeared depressed, and it was recommended that another foster placement be found. Michael functioned in the borderline retarded range on developmental testing but had normal hearing and a normal neurologic examination. His mother failed to follow through with any treatment and proceeded to marry Harold.

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Harold was intensively interrogated by the police, failed a lie detector test, and began hallucinating, but continued to deny knowledge of what happened. No charges were filed.

Michael made a satisfactory adjustment in his second foster home, where he remained for a year. Tantrums, nightmares, clinging, and whining disappeared after ten days of placement when he was offered much cuddling and support by the new foster mother. Fran, on threat of losing custody, finally began attending treatment sessions regularly and enrolled in the parents group. Visits with Michael, although initially tense, began to be enjoyable for both. Harold later admitted to causing Michael's injuries, and charges were filed by the police. He was convicted of child abuse and placed on probation, contingent upon his continuing in treatment, avoiding contact with the child, and obtaining gainful employment. He followed through with each condition.

Approximately nine months after placement in the second foster home, Michael's development was normal. He no longer appeared depressed and demonstrated strong attachments both to the foster mother and to his natural mother. Three months later, his foster home placement was disrupted, precipitated by the departure of a nine-year-old foster child, who was returned to her natural family. Michael's whining, crying, clinging, and nightmares reappeared. However, on this occasion the foster mother, who was experiencing considerable grief both at the loss of the first foster child and at the realization that eventually she would lose Michael as well, was unable to comfort him. Instead, she punished him for these behaviors by hitting him with a wooden spoon 10 to 20 times per day. Attempts to provide counseling for the foster family were unsuccessful, as the foster care system has no resources for this type of problem. Since the mother was not yet ready to assume custody, Michael was moved to his third foster home.

Over the next six months, Fran continued to make progress and Harold also continued with work, counseling, and avoiding contact with Michael. Michael was returned to his mother on the condition that Harold move out. Harold moved out, and 18 months following his injuries, Michael was returned to the physical custody of his mother. Contact with Harold was gradually introduced under supervision by Child Protective Services, and approximately six months later the family was reunited. The family continues to see a counselor approximately once per month. Michael attends preschool, and his health and developmental status continue to be normal. His mother continues to work part-time and is completing her general high-school equivalency diploma with hopes of entering college. Harold changed jobs but continues regular employment.

DR. GEORGE COMERCI *(Professor of Pediatrics and Family Medicine)*: It was not until 1962 that Drs. Kempe and Helfer, at the University of Colorado, reported the "battered child syndrome" and called upon health professionals to recognize and report victims.

It is often difficult to convince people who care for children of the magnitude of the problem. Death from physical abuse is a leading cause of death in infants in the first year of life. Of infants under one year of age who present with physical injury to a typical urban emergency room, one out of four will be victims of nonaccidental trauma.

The first responsibility of the health professional is to be aware of the problem and to be appropriately alert to the diagnosis. The criteria for diagnosis of nonaccidental trauma include (1) an injury without adequate explanation, or for which the history is not in keeping with the extent of the injury, (2) multiple fractures in different stages of healing, and (3) abnormal caretaking behavior on the part of parents. Parents who have abused their children often demonstrate highly inappropriate reactions to the injuries. They may act unconcerned about how serious the injuries are or about what is going to happen to their child, or they may rush to ask when they can leave the hospital.

In taking the history, the physician should ask how and when the injury occurred to determine whether the explanation is adequate or inadequate. The emphasis should be on how the injury occurred, not on who perpetrated the injury. Physicians should record in detail the history obtained from each parent, and from the child, if he or she is old enough to give an account. The physician must exclude alternative explanations, such as bleeding disorders or underlying bone diseases or interrupted sudden infant death syndrome, in making the diagnosis of suspected nonaccidental trauma. A careful past history of previous trauma and

open-ended questions to ascertain the parent's perception of the child are helpful. A careful physical examination with attention to the earlobes and mouth, genital areas, and extremities, along with plotting the infant's growth and performing developmental screening, is essential. In a child suspected of nonaccidental trauma, x-ray examination of the skull, ribs, long bones, and spine may disclose unsuspected injuries. It is often helpful to have color photographs taken as soon as possible after admission and carefully labeled. Documentation of location, shape, and color of bruises, using a body diagram, is helpful. Careful attention to legal requirements following the chain of evidence (as in rape, for example) is important.

The next responsibility of the health professional is to protect the child. Such protection usually begins, with infants and young children, with admission to the hospital. Following the necessary emergency medical or surgical care, physicians must report the case to Child Protective Services or to the police. The emergency room or clinic is not the place for confrontation, anger, accusations, or interrogation. Instead, parents should be informed of the physician's legal requirement to report injuries that are not adequately explained.

Always keep the parent informed about what is happening. Abusive parents usually care about their child and want help. Experts in child abuse are generally available, as are consultants in hematology or metabolism, when confusion exists about whether a rare disease is present. Most radiologists can readily distinguish between traumatic bony injuries and underlying bone disease and can date old fractures. Once the child's immediate safety is assured, further social, developmental, and psychiatric consultations and treatment planning can occur.

DR. ALAYNE YATES *(Chief of Child Psychiatry)*: I was initially consulted, following Michael's hospitalization, to perform a family assessment and make recommendations about treatment planning to the court and Child Protective Services. I found that Fran and Harold had formed a dysfunctional relationship characterized by frequent arguments and mutual criticism. Fran expressed her anger through drinking and leaving home. Harold expressed his anger by freeloading and by blaming Fran for not being a good parent to Michael. Although Harold presented himself as a model citizen, in actuality he was exhausting Fran's meager emotional and economic resources. Harold was especially irritated by having to babysit Michael while Fran worked. Her bar-hopping further intensified Harold's rage, which may well have been displaced to Michael. Michael contributed to this pattern through whining, clinging, and jealous behaviors.

As a result of the initial evaluation, I recommended that Michael not be returned home while Harold was in the family, as Harold demonstrated a major personality dysfunction: passive-aggressive personality disorder. This disorder connotes pervasive and longstanding social and occupational ineffectiveness. Such individuals procrastinate and often rationalize or blame others for their inadequacies; they often consult physicians to qualify for disability payments. These people are "takers" rather than "givers" who may become angry and aggressive when under stress.

In spite of her history, I felt that Fran demonstrated the greater potential for change because of her evident and persistent concern for Michael. She was honest in recognizing her inadequacies, expressed a desire for help, and seemed motivated for therapy.

Eight months following the initial evaluation, I was asked to re-evaluate Fran and Harold. In the interim, Harold had confessed to and been convicted of child abuse. Harold and Fran had married, were involved in multiple therapies, and with sentencing at hand, Harold was cooperative with therapy, claiming a miraculous personality metamorphosis. Their relationship had gained stability as both focused on gaining Michael's return home. Fran's self-esteem had improved, and she was better able to mother Michael. In the meantime, Michael had suffered multiple foster placements and further emotional trauma. No one, other than Fran, was firmly committed to Michael. The system had clearly been detrimental to Michael's well-being. I felt that the least harmful alternative for Michael was to be reintegrated in his mother and stepfather's home with continued close supervision by Child Protective Services supervision and the understanding that Harold would remain on probation.

DR. FISCHLER: What is an optimal outcome for child abuse? How can such a story end happily? First, the child's placement should be safe and secure in a family he comes to identify as his

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own, whether this is his natural family or a suitable adoptive family. After all the disruption experienced by the abused child, it is most important that he achieve the sense of security derived from a permanent placement. Second, the child's potential for normal development must be restored. Any developmental delays and behavior problems must be treated, and he should develop strong attachments to his principal caregivers. Third, family function should be restored to at least a level where the likelihood of reabuse is minimized on a long-term basis, where re-entry into the protective service system or the criminal justice system is unlikely.

Child abuse has been found to be unusually common in the early histories of adults with significant maladjustment, including juvenile delinquents, violent criminals, prostitutes, child abusers, institutionalized persons, and teenage runaways.

Child abuse accounts for 5,000 to 10,000 deaths annually in the United States, representing about 0.5 percent of all reported cases. Permanent disability occurs in a similar number. By far the most frequent problems seen in abused children are the emotional and psychological scars from growing up in an abusive environment. Most abused children show significant developmental problems with delays in cognition, language, behavior, and interpersonal relationships, as Michael demonstrated. These problems are amenable to treatment if recognized early and appropriate intervention is begun. Because abused children have been emotionally as well as physically traumatized, their behaviors may be difficult, even provocative, and it may take a long time before they learn how to return affection. Thus, abused children are often difficult in foster care and require close follow-up and often specific treatment. Usually this involves obtaining a stable and appropriate home environment, parent counseling on behavior management, and for some, play therapy. Without treatment, behavior problems tend to recur in subsequent placements, as happened with Michael.

A recent major follow-up study summarizes the current state of child abuse treatment.[1] The study evaluated 2,000 abused children in protective services. Sixteen percent suffered severe injuries, although developmental and behavioral problems occurred in the majority. Treatment was conducted over a 6- to 12-month period. Fifty percent of the

children were considered to have improved, 25 percent showed no change, and 25 percent became worse. Strikingly, 30 percent were reabused severely during treatment. Families fared no better; only 42 percent were considered to have improved and showed a decreased risk of abuse at the end of treatment compared with the beginning.

Treatment of child abuse is also not without harm, especially when it involves removal of a child from the home. In Arizona in 1980, the average foster child spent three years in care and endured more than five placements each (Boyd Dover, personal communication, January 1981). These findings are corroborated elsewhere. After five years, a New York study showed one half of abused children were still in foster care, and one half of these were not visited by their parents.[2] Unstable long-term foster care does not provide enough security for the child's normal development. The treatment of child abuse carries its own risks, and the child must be followed carefully during treatment. The primary care physician, in close communication with consultants from mental health, child development, and Child Protective Services, is in an excellent position to monitor treatment. A happy ending can be achieved, but it depends upon the continuing hard work of many from several fields who share one commitment: to speak for abused children who cannot speak for themselves.

MR. BOYD DOVER *(Director, Child Protective Services, Tucson)*: Child Protective Services is mandated with the legal responsibility to investigate all reports of abuse and neglect. It might seem, from reviewing this case, that numbers of professionals are involved, that it is a very well organized and functioning system, and that all alternatives are developed and evaluated. This is not true. It is totally impossible to do that, a fact I am not happy to report.

One of the frequent charges leveled against Child Protective Services is that we continually do one of two things. Either we leave children in potentially abusive situations too long, and they end up being severely abused, or we remove them too fast and place them in our system without justification.

I do not know of any professional in the human services field who has a more difficult job than a protective service worker, probably the most important point I would like to make today. In this community of nearly one-half million, we receive between three and four hundred telephone calls per month in regard to child abuse, neglect, or abandonment. We have the capability with existing staffing patterns to investigate personally about one half of these calls. By necessity, there must be a priority system that makes a report of a scalding in a bathtub more crucial than an unsupervised child in a dirty home.

Our child care system is in a critical state. We do not have sufficient shelters for children needing temporary care. Sometimes it appears that the system that is developed and defined by law to protect a child may be potentially more abusive than the situation from which that child would be or had been removed. Changes in the new administration have caused social service programs to be cut, and the impact is felt by all protective service units at a time when reports for suspected abuse continue to rise. As concerned citizens in the community, you need to know that right now the system is not working and needs your help.

DR. KETTEL: Dr. Johnson, from the perspective of a pediatrician on the front lines, how would you react to today's presentation?

DR. HELEN JOHNSON *(Assistant Professor of Pediatrics)*: I think we are doing a good job now with recognition and reporting of child abuse. What we do afterward remains the most difficult part of the job and the one yet to be done well. We can no longer assume when we report a case that the system will take over and all will be well. These children need close follow-up by pediatricians and family physicians who are alert to their ongoing health and developmental problems and are in close communication with Child Protective Services.

DR. KETTEL: What is the demography of child abuse? Is there a population that is more susceptible?

DR. JOHNSON: Child abuse cuts across all economic groups and all educational levels. Stress appears to be greater in lower socioeconomic groups and the capacity to cope with stress is also reduced.

DR. FISCHLER: Such factors as family stress, a history of poor coping with stress, poor perception of child care (as occurs when parents themselves were abused), and isolation from a social network have been associated with high risk of

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child abuse. Unwanted pregnancy, poor adjustment to pregnancy, teenage pregnancy, inappropriate maternal-infant interactions, and perception of the child as "difficult" are additional risk factors correlated with abuse. Although these factors are helpful clues, no one has succeeded at developing a reliable instrument to predict child abuse.

DR. KETTEL: Can we prevent child abuse?

DR. FISCHLER: Three levels of prevention have been applied to child abuse. *Primary prevention* implies preparing prospective parents for the tasks of parenting: at home, at school, during prenatal care by offering family-centered perinatal care, and in well-child care. *Secondary prevention* means identifying children and families at risk and intervening to prevent serious complications. In Michael's case, there were numerous red flags that unfortunately went unheeded by the physicians caring for him during his first year of life. Had they been picked up and led to appropriate assessment and treatment, perhaps his battering could have been prevented. *Tertiary prevention* implies that once a child has been abused, further complications such as reabuse or the trauma of unstable or interminable foster care are prevented in the hope of achieving a good long-term outcome. At every level, physicians caring for mothers and children have an opportunity to focus attention on helping families adjust to child rearing. There are now widely available texts on parenting, courses for professionals and parents, parent support groups, and mental health professionals skilled in assessment and treatment of family dysfunctions.

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