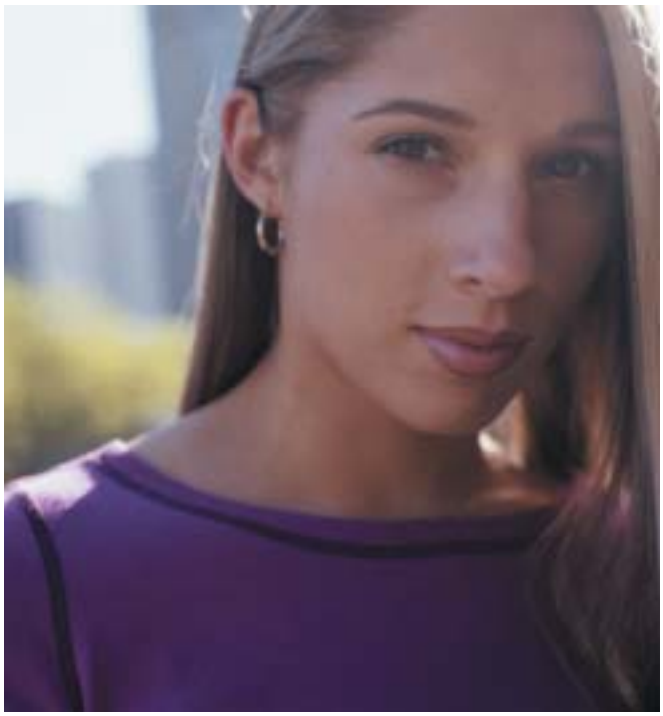
CHILD MALTREATMENT

KEY FACTS

- More than 1.5 million children and adolescents in the United States are abused or neglected annually, as measured by the Harm Standard (Sedlak and Broadhurst, 1996).
- Over 50 percent of reported child maltreatment cases involve neglect, 25 percent involve physical abuse, 13 percent involve sexual abuse, and 6 percent involve psychological abuse or neglect (Sedlak and Broadhurst, 1996; U.S. Department of Health and Human Services, 1999).
- Between 1,000 and 2,000 children and adolescents in the United States die each year as a result of maltreatment (U.S. Department of Health and Human Services, 1999; Wissow, 1995).
- Although adolescents are abused twice as often as children, 80 percent of deaths from child abuse occur in children under age 5 (U.S. Department of Health and Human Services, 1999; Wissow, 1995).
- In over 50 percent of families that have experienced child abuse or neglect there is a parent who abuses drugs or alcohol (Peterson et al., 1996).

Child maltreatment affects children and adolescents of all ages. The degree of maltreatment may range from failure to adequately nurture a child's or adolescent's development to physical neglect or overt abuse. The long-term consequences of child maltreatment are many and include the risk of physical injury and even death, and increased risk for depression, suicide, posttraumatic stress disorder (PTSD), substance abuse, oppositional and aggressive behaviors, eating disorders, medical problems and somatic complaints, lower IQ scores, early pregnancy, and continuation of intergenerational violence and/or neglect (i.e., adults who were maltreated as children or adolescents are more likely to abuse or neglect their own children).



DESCRIPTION OF SYMPTOMS

Quality of Nurture Problem

(Diagnostic code: V61.20)

Adapted from DSM-PC. Selected additional information from DSM-PC is available in the appendix. Refer to DSM-PC for further description.

- Inadequate supervision, cognitive stimulation, or emotional nurturing
- Inflexible rules
- Harsh or highly inconsistent discipline

Child Neglect/Abuse

(Diagnostic code: 995.5x)

Adapted from DSM-PC. Selected additional information from DSM-PC is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for further description.

- Neglect (may be physical or emotional)
  - Failure to provide basic physical or medical care or nurturing
  - Failure to keep child or adolescent safe
- Abuse (may be physical, sexual, or emotional)
  - Adult's actions result in direct harm to child or adolescent
- Factitious illness by proxy (sometimes called Munchausen syndrome by proxy) (See Special Topic: Factitious Illness by Proxy [Munchausen Syndrome by Proxy], p. 221.)
  - A caregiver (usually the mother) pretends an infant or child is ill or causes the infant or child to become ill (Schreier and Libow, 1994)

COMMONLY ASSOCIATED PSYCHOSOCIAL PROBLEMS AND DISORDERS

In Parents

- Parental alcohol/substance abuse
- Parental depression
- Parental personality disorder
- Parental anxiety disorder

In Children and Adolescents

Child maltreatment can be manifested by a range of behavioral and emotional difficulties including symptoms of depression, anxiety, attachment disturbance, irritability, aggression, hypersexual behaviors, and school failure.

INITIAL INTERVENTIONS

Evaluating a family's capacity to care for a child or adolescent is a critical aspect of health supervision. In cases of suspected maltreatment, a comprehensive assessment of both the child or adolescent and the family is essential. Health professionals are legally mandated to report any suspected abuse or neglect and should immediately notify the designated child protective service agency. Any medical, psychiatric, or forensic evaluations must be carefully conducted and appropriately documented. Once maltreatment has been identified and reported as mandated, the primary care health professional needs to work with social service agencies to ensure that timely and appropriate mental health services are provided to the child or adolescent and the family. In cases of maltreatment, referrals to mental health professionals are indicated for both the child or adolescent and the family, and it is frequently up to the primary care health professional to encourage follow-up with referrals.

Treatment approaches that are collaborative, coordinated, and comprehensive, and that involve both the parents and the child or adolescent, are most effective in preventing the negative outcomes associated with child maltreatment. (See *Bright Futures Case Studies for Primary Care Clinicians:* Physical Abuse: The Father's Hand Print [Vandeven and Knight, 2001]; Sexual Abuse: Margaret's Secret [Leder and Vandeven, 2001]; Neglect: The Silent Cry [Wilson and Knight, 2001] at http://www.pedicases.org.)

Child or Adolescent

1. If maltreatment is suspected, try to talk with each parent and the child or adolescent privately when gathering health and family histories.

   Speak sensitively to each family member, as this is an opportunity to establish a therapeutic relationship with the family, which will increase their receptivity to future interventions.

2. If evidence of abuse or neglect is present, immediate steps to protect the child or adolescent must be taken once the child or adolescent has been medically evaluated and stabilized.

   - Health professionals are legally mandated to report any suspected abuse or neglect and should immediately notify the designated child protective service agency.
   - If it appears that the child or adolescent is not safe at home, the primary care health professional should request an emergency out-of-home placement when making the mandated referral to the protective service agency.

3. If evidence of neglect is present, the severity of neglect must be assessed. Severity of neglect can range from less severe (e.g., exercising poor judgment about supervision) to more severe (e.g., perpetuating life-threatening neglect).

   - If it appears that the child or adolescent is at significant risk, the primary care health professional should notify child protective services even as she continues to work with the family.

4. Primary care health professionals need to consider safety issues in the medical setting.

   - In addition to asking other staff members to stand by, consider asking your health center's security force or the local police to be present if you anticipate that a parent may become upset or agitated when he or she is told that the child or adolescent cannot go home or that a protective agency referral has been made.

- If maltreatment by a parent is suspected, do not leave the parent and the child or adolescent alone together in the exam room or the waiting room.

5. When discussing a protective services referral with a parent, the following approaches may be helpful:
   - Calmly review the objective indications for the referral without ascribing blame (e.g., "I am legally required to report this type of fracture, because this injury is sometimes seen in children who have been abused").
   - Highlight your concern for the child or adolescent and the family as the main reason for the referral (e.g., "We want to make sure that everyone in your family is safe").
   - Explain that you will continue to work as an advocate for both the child or adolescent and the family.
6. After the primary care health professional has made a referral to a protective service agency, ongoing involvement of the primary care health professional is extremely important. Because the consequences of child maltreatment may extend throughout the child's or adolescent's life and may affect her behavioral, social, emotional, cognitive, and medical needs, comprehensive treatment and collaboration among all health professionals involved is crucial.
   - Provide the child's or adolescent's medical, developmental, and social history to protective agency staff
   - Provide continuity of care when possible
   - Become familiar with mental health professionals in your community who treat children, adolescents, and families who have suffered abuse or neglect so that you can make referrals for the following services, as appropriate:
     - Mental health referrals for the child or adolescent and the family
     - Individual and/or family treatment
     - Parent education/support groups
     - Assessment of the child's or adolescent's school needs
   - Maintain ongoing collaboration with mental health professionals:
     - After making a referral for mental health and protective services and obtaining releases for the exchange of information, remain in close contact with all parties involved in the child's or adolescent's care.
     - Encourage follow-up with mental health treatment.
     - Follow guidelines for confidentiality whenever communicating with other professionals, agencies, and schools.
   - Maintain ongoing collaboration with the child's or adolescent's school:
     - Closely monitor any decline in the child's or adolescent's school functioning.
     - With appropriate permission, work with school personnel to meet the child's or adolescent's needs, and supportively address concerns that may arise (e.g., for a child or adolescent with frequent somatic complaints without evidence of illness, develop a plan with the school nurse to gently reassure the child or adolescent and to minimize the class time he misses).

- Consider making a referral for neuropsychological testing for a child or adolescent who experiences persistent school difficulties.

7. Perpetrators of child or adolescent sexual abuse can make the child or adolescent extremely afraid to disclose the abuse. The child or adolescent may be able to talk about the abuse only after a significant effort has been made to help her feel safe. It is also possible that a child or adolescent will recant her disclosure. (See Tool for Families: Preventing Child Sexual Abuse, *Mental Health Tool Kit,* p. 140.)
   - The child or adolescent who discloses sexual abuse should have a timely and comprehensive medical and psychological assessment by health professionals with expertise and experience in treating sexual abuse.
   - Prompt evaluation and treatment of the child or adolescent and the family is the best way to avoid or minimize the serious problems that can result from sexual abuse.
   - If a child or adolescent says that she has been sexually abused, parents or other caregivers and the primary care health professional should help the child or adolescent understand that what happened was not her fault.
8. For any child or adolescent who has not had adequate nurturing (including children and adolescents who have not suffered overt abuse or neglect), primary care health professionals should consider the following interventions:
   - During office visits, provide opportunities for the child or adolescent to talk openly about his feelings and experiences in the family.
   - Look for difficulties in the following important areas:
     - General mood and behavior, including
       -- Inhibition, withdrawal
       -- Aggression or anger
       -- Overt passivity, compliance, or dependency
       -- Attachment difficulties
       -- Demanding behavior and oppositionality
       -- Role reversal (child or adolescent takes on adult responsibilities)
     - Relationships with family members
     - Relationships with peers
     - School functioning
     - Development
   - Screening instruments and questionnaires that may help primary care health professionals assess a child's or adolescent's functioning in these areas include the following:
     - The Child Behavior Checklist (Achenbach, 1991) to assess internalizing and externalizing behavioral and mood concerns
     - The Pediatric Emotional Distress Scale (Saylor et al., 1999)
     - The Pediatric Symptom Checklist (Jellinek et al., 1988; Jellinek et al., 1999) (See Tool for Health Professionals: Pediatric Symptom Checklist, *Mental Health Tool Kit,* p. 16.)
     - The Trauma Symptom Checklist for Children (TSCC) (ages 8–16) (Briere, 1996a) and the Trauma Symptom Checklist for Young Children (TSCYC) (ages 3–12) (Briere, in press) to assess trauma-specific sequelae
   - For impairment in functioning that persists despite support, guidance, and the child's or adolescent's efforts to change, consider a referral to a mental health professional.

- Encourage relationships between the child or adolescent and other positive adult role models in the community (e.g., teachers, coaches, grandparents, aunts and uncles, neighbors).
- Help the child or adolescent access sources of support (e.g., after-school programs, clubs, sports, faith-based youth groups).
- Tell the child or adolescent how to contact you between visits.

Family

1. Primary care health professionals should implement prevention measures to increase awareness of and communication about maltreatment issues early, since many child maltreatment cases involve infants and young children. Stress with families that adults are responsible for protecting children. Emphasize that a child or adolescent is never to blame for an adult's harmful actions.
   - As part of the initial health supervision visit, preferably the prenatal visit, ask parents if they were ever exposed to maltreatment during their childhoods. Ask about history of or current mental health problems and specifically about substance use problems (Wilson and Knight, 2001).
   - Discuss with new parents the dangers of shaken baby syndrome.
     - Explain that shaking an infant can lead to blindness or eye damage, brain damage, seizures, spinal cord damage, and death.
   - Discuss the following strategies that can help parents cope when they feel overwhelmed or are about to lose their tempers:
     - Take a deep breath and count to 10
     - Take time out and let your child cry alone, in a safe place
     - Call someone close to you for emotional support
     - Call your primary care health professional's office to see if there may be a medical explanation for why your child is crying
     - Remember that it is never OK to shake, throw, or hit a child
   - Train office staff to be responsive to any telephone calls from distressed parents.
   - Assist parents in finding ways to talk to their child or adolescent about interpersonal safety. Children and adolescents should know how to get help (e.g., how to contact parents or a trusted adult) if they are ever afraid of or uncomfortable with another person. Parents

need to be aware of their child's or adolescent's subtle clues of discomfort with other adults. They may need to gather more information to determine whether their child's or adolescent's safety is in jeopardy.

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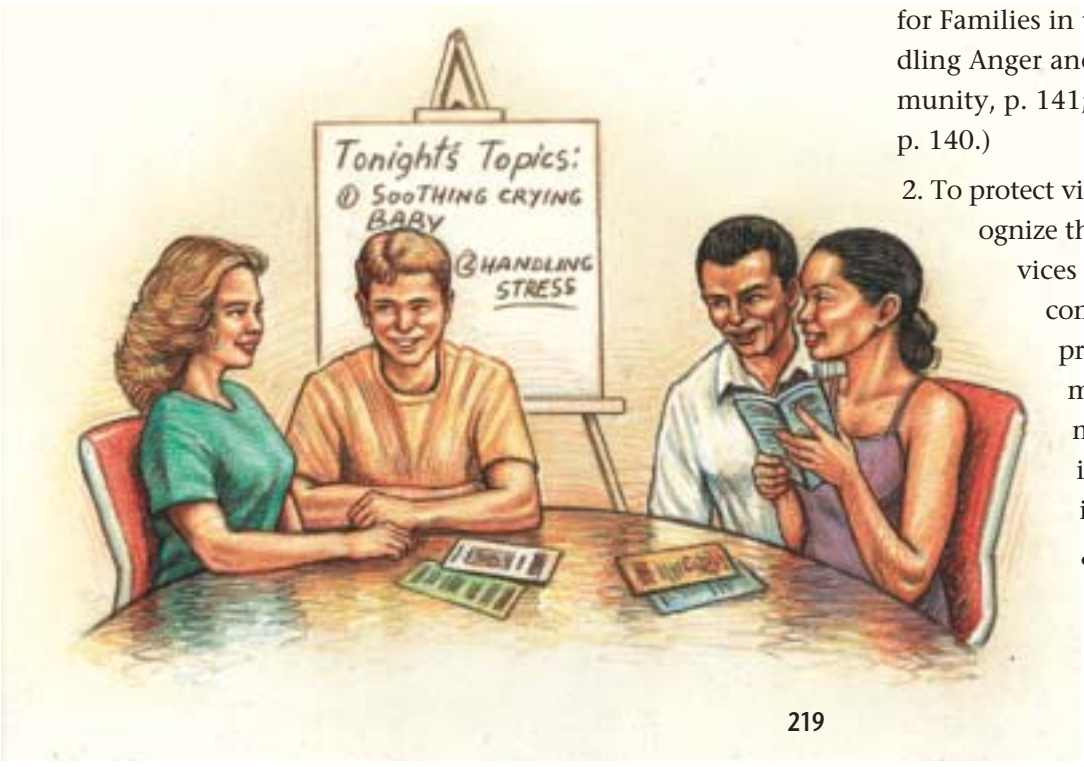

- Provide parents with guidelines for preventing child maltreatment. (See the following Tools for Families in the *Mental Health Tool Kit:* Handling Anger and Countering Abuse in the Community, p. 141; Preventing Child Sexual Abuse, p. 140.)

2. To protect victims of child maltreatment, recognize the need for comprehensive services for all family members. Many communities have comprehensive programs that can address child maltreatment issues. Engage community supports and resources as indicated to address the following stressors:

- Parental substance abuse; parental mood, anxiety, or personality disorders

- Refer parent to mental health services (e.g., substance abuse treatment, individual or family treatment).

• Marital discord, domestic violence

- The estimated overlap between domestic violence and child abuse ranges from 30 to 50 percent (Prevent Child Abuse America, 1996).
- If the home is unsafe, help family members access shelter services and seek police and legal protection. (See bridge topic: Domestic Violence, p. 227.)
- For ongoing marital discord without violence, refer parents for couples counseling.

• Poverty, inadequate housing

- Engage social work services for referrals to housing and financial services, job training, and educational opportunities.

• Physical illness or disability in parent or child or adolescent

- Engage social work services to help family access adequate medical care for all family members.
- Refer for respite care or home visiting services.

• Poor social supports

- Refer to community support groups (e.g., faith-based groups, Parents Without Partners).
- Help parents learn to engage relatives, friends, or neighbors to provide respite child care, to model parenting practices, and to provide social opportunities.
- Provide numbers for crisis hotlines.

3. Discuss with parents the impact of stressors and risk factors on parenting practices. Strengthen family and community support. Screening tools such as the Parenting Stress Index (PSI) (Abidin, 1990) can help primary care health professionals identify families for further evaluation or possible referral.
4. Discuss basic concepts of child development to help parents form reasonable expectations of their child (e.g., when toddlers can begin toilet learning; when adolescents can baby-sit a sibling). For parents at risk for child maltreatment, discuss the benefits of learning about child development, strengthening parenting skills, and learning to manage stress and anger. Help parents access programs in the community that provide services in these areas, and, if necessary, work with the designated child protective services agency to ensure successful completion of the referral and continuation of the program.

Community

1. Communitywide prevention efforts can help reduce the incidence of child maltreatment. These efforts benefit from the participation of primary care health professionals.
2. Social disorganization within a community is one of the key characteristics correlated with child maltreatment. Primary care health professionals are powerful advocates on behalf of children, adolescents, and families at risk for family violence. Consider suggesting to members of the practice team that they become involved in community-based initiatives (e.g., domestic violence shelters, public housing units, neighborhood centers).
3. Inform parents about their community's 24-hour support services and telephone hotlines. Develop a list, and give every family a copy.