

Preventing Child Neglect and Physical Abuse: A Role for Pediatricians

Howard Dubowitz, MD,
MS*

Objectives After completing this article, readers should be able to:

1. Describe the importance of preventing child abuse and neglect.
2. Identify key risk and protective factors for child abuse and neglect.
3. Delineate useful principles and practical guidance for pediatricians on screening, brief assessment, and initial management of problems related to child abuse and neglect.

The Importance of Prevention

Preventing child abuse and neglect spares a child pain and suffering, both physical and psychological. This is intuitively and morally preferable to intervening “after the fact.” Further, early intervention or prevention may be more effective than later intervention. For example, the time when a family has a new baby often is described as “a window of opportunity,” and early efforts to support the family and strengthen their parenting abilities may be particularly effective and cost-effective.

Child maltreatment is not a rare phenomenon. Data from the 3rd National Incidence Study of Child Abuse and Neglect revealed that approximately 1% of children were identified as abused and 1.5% as neglected in 1993, and these rates are likely the “tip of the iceberg.” A number of studies have found that as many as one in four girls and one in ten boys has been sexually abused during childhood.

Another reason for preventing child abuse and neglect is its immense morbidity and significant mortality rates. Research has documented the multiple physical, cognitive, behavioral, social, and emotional sequelae of child maltreatment. Brain damage, learning problems, aggression, juvenile delinquency and adult criminal behavior, depression, and parenting difficulties are a few of the potential long-term problems.

The goal of preventing child maltreatment fits well with the goals and scope of pediatrics. “As physicians who assume a responsibility for children’s physical, mental, and emotional progress from conception to maturity, pediatricians must be concerned with social and environmental influences, which have a major impact on the health and well being of children and their families. . . .” (Behrman, see Suggested Reading). The system of “child health supervision” in the United States focuses on the prevention and early detection of problems and occupies approximately 60% of pediatricians’ time. Parents often seek information on psychosocial issues from pediatricians; incorporating family support into pediatric care is an important response.

Perhaps the most compelling argument is that prevention of child maltreatment has at its heart the goal of strengthening families and enhancing childrearing. Effective interventions achieve much more than the narrow goal of preventing abuse and neglect. Olds and Kitzman found that in addition to reducing the incidence of child maltreatment, nurse home visitation led to mothers adopting better health habits prenatally, having fewer perinatal complications, using more constructive forms of discipline, increasing spacing of subsequent pregnancies, and having fewer problems with the justice system.

Roles Pediatricians Can Play

For the most part, pediatric practice has focused on the important issues of identifying abuse and neglect, reporting it to public agencies, and facilitating referrals for assessment and treatment. However, to fulfill their responsibility of ensuring children’s health and well being, pediatricians also should focus on preventing maltreatment. Prevention strategies

*Professor of Pediatrics, University of Maryland School of Medicine, Baltimore, Md.

can be built on the excellent relationships with families that pediatricians enjoy, which facilitates a valuable entrée into their lives. Trust enables sharing of sensitive information. Demonstrated caring, gentle probing, careful listening, and astute observation are the tools.

Given inevitable time constraints, clinicians must identify priorities to maximize the opportunity offered by each encounter. Although the term “the new morbidity” was coined more than 25 years ago, there remains a need to establish these concerns as a priority and to provide pediatricians with the knowledge and skills to address them competently and efficiently.

Defining Child Abuse and Neglect

Physical abuse usually is defined as an act that results in a significant inflicted physical injury or the risk of such injury. Neglect generally is defined as omission in care by caregivers that results in significant harm or the risk of significant harm. A more constructive and child-focused definition is to consider neglect as occurring when a child’s basic needs are not met, including adequate food, clothing, health care, education, supervision, protection from environmental hazards, nurturance, support, affection, and a home.

Types of Prevention

The focus of this article is on primary (ie, universal) and secondary (ie, selected) prevention, before maltreatment occurs. Universal efforts target an entire population, such as all children receiving pediatric primary care. Selected interventions focus on high-risk groups, such as low-income, teenage mothers.

The Etiology of Physical Abuse and Neglect

Empiric data, clinical experience, and sound theory regarding the etiology of the problem should guide prevention. The current understanding is that no one factor explains physical abuse and neglect. Rather, multiple and interacting contributory factors usually are involved; these need to be viewed together with protective factors (eg, a supportive grandmother) that may offset a risk. For example, a single mother who has recently lost her job and health insurance, faces eviction, and has a child who has severe asthma represents a high-risk situation for child abuse and neglect. An involved father who offers financial and emotional support reduces this risk. Examples of risk factors are listed in Table 1.

Screening

Screening involves efforts to determine whether there is a high risk of a problem occurring (ie, prevention oppor-

Table 1. Risk Factors for Child Abuse and Neglect	
Child	
<ul style="list-style-type: none"> • Disability • “Difficult” temperament or behavior 	
Parent	
<ul style="list-style-type: none"> • Substance abuse • Depression • Other mental illness • Poor coping ability • Limited intelligence • Impulsivity • Poor anger control • History of having been maltreated 	
Family	
<ul style="list-style-type: none"> • Domestic violence • Poverty • Single parent • Multiple children • Stress • Lack of health insurance • Inadequate food • Lack of support 	
Community	
<ul style="list-style-type: none"> • Poverty • Crime • Violence • Substance abuse • Social isolation • Lack of supports 	

tunity) or whether the problem already exists (ie, detection). Appropriate intervention requires identification of those at risk. Some risk factors are unlikely to be detected unless specific screening efforts are made. For example, parental depression often is not obvious and may be missed. Domestic violence frequently is kept secret. Food shortages and hunger are seldom part of the medical history; impaired growth is a relatively late development. Parents’ inability to purchase a medication may not be known. One approach to identifying these problems is to screen all families at certain pediatric visits (eg, initially, then annually), using a brief questionnaire that can be completed while the parent is waiting or can be incorporated into the interview. Relying on clinical judgment as to who, for example, appears “high” or intoxicated will result in many problems remaining hidden.

Building on Prior Research and Clinical Experience

Substantial research has been undertaken on screening for some problems, such as depression and alcohol and substance abuse. Some of these screening tools are brief and could be incorporated into practice easily. For example, Whooley and associates found that two questions had a 96% sensitivity and 57% specificity in detecting depression. Brown and colleagues achieved 81% sensitivity and specificity using two items to identify current alcohol or drug problems.

Pediatricians routinely use the review of systems (ROS) to screen for possible problems. Expansion of the ROS or the social history could readily screen family system functioning and identify risk factors for child maltreatment.

Introducing Sensitive Questions

Some of the information being sought is sensitive, and parents may be uncomfortable divulging it, especially if pediatricians are uncomfortable asking. It is essential to introduce such questions carefully (see Appendix 1 in the electronic edition of this article). For example:

“We want to make sure every kid is in a safe environment. There are some problems lots of families have, so I’m asking everyone these questions. If there’s a problem, I’ll try to help. Also, it’s OK if you prefer not to answer some questions.”

It is useful to begin with well-accepted issues, such as bike helmets and smoke alarms. Pediatricians’ longstanding interest in child safety eases the transition into areas such as parental depression, substance abuse, corporal punishment, and domestic violence.

Gathering the Information

There has been considerable experience with questionnaires in pediatric practice. Relevant items could be incorporated into an existing questionnaire or a new one could be developed. The questionnaire could be completed by a parent before the visit and presented to the pediatrician during the visit to save time. Alternatively, the questions could be read or asked as part of the history. Appendix 1 (in the electronic edition of this article), as an example, is a questionnaire we developed focusing on selected risk factors and problems.

Another strategy is to have ancillary staff administer the psychosocial screening, together with questions pertaining to children’s development, behavior, and school performance (McLearn et al). Time constraints are a major challenge, and there is a need to explore innovative models of primary care to address the behavioral, devel-

opmental, and psychosocial issues confronting many families.

In addition to questions directed to parents, valuable information can be obtained directly from children and adolescents. It now is customary to obtain a history independently from adolescents; this approach can be extended to younger children (see Appendix 2 in the electronic edition of this article).

Observation

Astute pediatricians can gather useful information by observing, for example, parents who appear depressed or who are having difficulty coping. The observations of other professionals (eg, nurses, teachers) help provide a more complete portrait.

Confidentiality

When information is gathered on sensitive problems, particularly domestic violence, it is important to assess the problem privately. Children may be coerced later to report on what was said during the visit. There is also an issue of documentation, given that both parents may have access to the child’s medical record. One approach is to place sensitive information in a separate section of the chart.

Assessment

If screening identifies possible risk factors, further assessment is required. It is also important to assess protective factors (Table 2) in considering the overall situation. Pediatricians can conduct brief assessments to guide the initial management (see Appendix 2 in the electronic edition of this article for examples). For example, the initial screen may identify depressive symptoms. A brief assessment could clarify whether suicide is a concern, whether the caregiver is receiving therapy for the problem, and whether he or she is interested in help. It also is important to know what interventions have been tried (including those of the pediatrician) and with what results. This assessment could lead to various recommendations, including: seeking immediate care in an emergency department, referral to a community mental health program, or suggested follow-up with the parent’s primary care provider. The brief assessment could be performed by a pediatrician or by ancillary staff, such as a clinical social worker.

Management

A critical criterion for screening is that the person benefits from having the problem identified. After screening and a brief assessment, there may be a need for additional

Table 2. Examples of Factors That May Protect Against Child Abuse and Neglect

Child

- Healthy
- Intelligent
- Engaging

Parent

- Caring
- Intelligent
- Knowledgeable and experienced with parenting
- Child-focused
- Sound decision-making skills
- Ability to express affection
- Organized
- Religious faith

Family

- Adequate financial resources
- Good support
- Involvement of both parents
- Extended family support

Community

- Safe neighborhood
- Supportive resources
- Access to health care

evaluation and intervention. In some instances, pediatricians can provide education and guidance, such as helping parents manage challenging child behavior; in others, ancillary staff can assume this role. In cases of domestic violence or substance abuse, pediatricians serve primarily as “gatekeepers,” facilitating referrals.

To provide good health care to a child and to prevent abuse or neglect, pediatricians must be familiar with the family’s structure, beliefs regarding health care and discipline, stresses and strengths, and barriers to care. Rooted in a trusting relationship, this understanding requires time and is an ongoing process because circumstances change. The following are general principles to enhance pediatricians’ preventive efforts (see Appendix 2 for specific examples):

◆ **Risk factors** for maltreatment need to be identified and addressed. Families at risk for maltreatment often require social and mental health services, and pediatricians should facilitate referrals.

◆ **Anticipatory guidance** is an integral part of primary care. For example, when pediatricians explain the natural curiosity of toddlers and recommend safety pre-

cautions, they help prevent injuries that may be related to inadequate supervision. Educating parents about normal development will help them understand normal behavior. For children who have health problems (eg, allergies), families should be educated about the condition, what to expect, when to seek help, and what they can do at home.

◆ **The needs of parents, children, and families** should be addressed, following the vision of *Bright Futures* (Green). Parents may require attention to their own emotional needs to nurture their children adequately. Support and guidance regarding child rearing are important, together with general support and encouragement (eg, “You’re doing a terrific job raising _____!”)

◆ **Child and parental goals** should be clarified and incorporated into the plan. For example, a parent’s wish for a child to respect rather than fear him or her helps introduce constructive forms of discipline.

◆ Identification of a **family’s strengths and resources** is key to comprehending the situation and intervening.

◆ Use of **informal supports** (ie, family, friends) can be encouraged. For example, pediatricians can foster a father’s involvement in child rearing by inviting him to office visits.

◆ Support through a **religious affiliation** can be valuable.

◆ The need for **concrete services** (eg, Medical Assistance, Temporary Assistance to Needy Families [TANF], Food Stamps, and WIC) should be addressed.

◆ The pediatrician should be knowledgeable about **community resources** and facilitate referrals. Primary care clinicians are in a good position to encourage reluctant or ambivalent families to accept or try services. Although pediatricians can play valuable roles in helping meet the needs of children and families, wide-ranging community resources are available, and collaboration is essential.

◆ It is important to provide **support and follow-up, review progress, and adjust the plan** if needed.

Advocacy

Advocacy is needed at different levels: the individual child, parent, family, community, and society. Helping parents meet their children’s needs is advocacy for children who are unable to express or meet their own needs. Facilitating help for a depressed parent is advocacy. Efforts to strengthen families and develop community resources, such as a home visiting program, are forms of advocacy. Support for full access to health care represents

advocacy at the broadest level. Each of these levels of advocacy may help prevent child abuse and neglect.

Challenges

1. “There’s not enough time to delve into these problems.” It does take time, but if done efficiently, it is possible to assess and manage these problems briefly. Much can be covered in even a 15- to 20-minute visit. Knowledge, skill, and practice enhance efficiency. Time-saving strategies include use of a questionnaire while parents are waiting. Priorities need to be set. Prevalent problems affecting children deserve attention; other issues may be given less time (eg, listening to the lungs in an asymptomatic child). Pediatricians face an important challenge: How can we respond best to the major needs of many children and families?

2. “I’m not sure how to handle these problems.” Most pediatricians need training on issues such as domestic violence. In addition, identification of local resources for consultation and referral is essential.

3. “These issues are very sensitive. I don’t feel comfortable raising them.” If framed carefully (eg, “Lots of families have these problems, so I’m asking everyone. . .”), most families will not be offended, and some will be grateful. Discomfort also is related to not knowing what to do; knowledge, skill, and experience help.

4. “What if the screening gives a false-positive or false-negative result?” False-positive results are a minor concern because further assessment should clarify the situation. False-negative results are likely, for example, when a parent chooses not to disclose domestic violence. However, probing these issues still is a significant advance over current practice. Admittedly, research evaluations are needed to improve the sensitivity and specificity of screening approaches.

5. “We don’t really know that these approaches work.” This is a fair statement given the paucity of

research. This is also true for many other areas in pediatrics in which the effectiveness of interventions has not been evaluated. Experience, however, suggests that pediatricians can facilitate successful referrals for mental health and social services. The positive relationships that pediatricians usually have with families enable them to be trusted confidants and to offer valuable support and guidance. In the absence of solid evidence, we need to employ strategies that are grounded in theory (eg, educating parents about environmental hazards) and that appear promising. There is also a need to evaluate the effectiveness of different approaches and interventions, including current practice.

ACKNOWLEDGMENTS

The author thanks Cathy Read, LCSW-C, Charles Shubin, MD, Susan Feigelman, MD, Catherine Koverola, PhD, and the reviewers for their helpful input.

Suggested Reading

- Behrman RE. Overview of pediatrics. In: Behrman RE, Kliegman RM, Jenson HB, eds. *Nelson Textbook of Pediatrics*. 16th ed. Philadelphia, Pa: WB Saunders Company; 2000:1–4
- Brown RL, Leonard T, Saunders LA, Papasouliotis O. A two-item screening test for alcohol and other drug problems. *J Fam Pract*. 1997;44:151–160
- Dubowitz H. Prevention of child maltreatment: what is known. *Pediatrics*. 1989;83:570–577
- Green M. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, Va: National Center for Education and Maternal and Child Health; 1994
- McLearn KT, Zuckerman BS, Parker S, Yellowitz M, Kaplan-Sanoff M. Child development and pediatrics for the 21st century: the Healthy Steps approach. *J Urban Health Bull N Y Acad Med*. 1998;75:704–723
- Olds DL, Kitzman H. Review of research on home visiting for pregnant women and parents of young children. *The Future of Children*. 1993;3(3):53–92
- Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instruments for depression. Two questions are as good as many. *J Gen Intern Med*. 1997;12:439–445

PIR Quiz

Quiz also available online at www.pedsinreview.org.

1. Which of the following is a *clear* risk factor for child abuse or neglect?
 - A. An "over-concerned" grandmother.
 - B. Children whose development is advanced.
 - C. Low socioeconomic status.
 - D. Male gender.
 - E. Maternal depression.

2. Which of the following is a *clear* protective factor against child abuse or neglect?
 - A. A child who has language and is capable of describing his or her home situation.
 - B. A child who is not in a child care setting.
 - C. A comprehensive child abuse treatment center.
 - D. Good support for the mother or primary caregiver.
 - E. Multiple agency involvement with the family.

3. A crucial aspect of screening for risk factors for child abuse and neglect is:
 - A. Not to disclose to parents why you are probing certain issues.
 - B. To ask only children and teenagers about possible risk factors.
 - C. To make a report to Child Protective Services if the screening result is positive.
 - D. To rely primarily on clinical appearances and intuition.
 - E. To screen all families routinely.

4. An important aspect of helping prevent child abuse and neglect is to:
 - A. Address the needs of the parent(s), which will ensure that the child's needs are met.
 - B. Advocate for policies and programs that support families.
 - C. Be wary of the family's informal supports.
 - D. Facilitate referrals to appropriate community resources.
 - E. Warn the family of what they should do to avoid your referring them to Child Protective Services.