BACKGROUND INFORMATION ON SELECTED SENSITIVE TOPICS

parental substance abuse

child abuse and neglect

child witness to domestic violence

child and adolescent substance abuse

Parental Substance Abuse

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Dynamics in Substance Abusing Families

Substance abuse is a major stressor on individual family members as well as the family as a whole (Kaufman and Pattison, 1982). It can drain a family's financial resources, threaten job security, and lead to excessive hostility, verbal, physical, and sexual abuse and constant conflict. Children, in particular, intensely feel the confusion, conflict, unpredictability, and anxiety that characterize substance abusing families. Because every member of the family system is affected, substance abuse can be understood as a family problem.

The substance abusing family is characterized by inconsistency and unpredictability (Throwe, 1986). With the progression of the substance abuser's problem, there is a marked decline in the amount of clear, honest communication in the family. Silence and secrets are used to try to control the family's tension level, since the honest sharing of thoughts may provoke hostility, rejection, ridicule or overprotectiveness. When communication occurs, it often alternates between silence and angry outbursts, especially between spouses.

In the substance abusing family, children and adults learn they cannot count on the substance abuser to carry out family responsibilities. Members of the family adapt by reassigning roles and responsibilities to other members. As nondrinking/non-drug using spouses become progressively stressed by their additional responsibilities and lack of support, they may find nurturing their children increasingly difficult. Children may begin to take on some of the family responsibilities and tasks. For example, older children often become caretakers of younger children and the house, whether or not they are able to do this successfully.

When parental substance abuse is present, children and adults may be emotionally neglected and verbally abused. In some substance abusing families, the abuse may alternate with extremely loving behavior, gift-giving, promises of improved behavior and displays of charm. Often these behaviors disappear as the substance abuser becomes increasingly unable to meet the family's needs. Children may be neglected by both parents, as one parent continues to drink or use other drugs and the other becomes more and more preoccupied with the substance abuser. Physical violence and sexual abuse may also occur, resulting in physical and emotional trauma, which may bring the child to the attention of the health care provider.

Because of the ongoing crises in substance abusing families, common feelings include hopelessness and helplessness (Bluhm, 1987). Trust and intimacy give way to fear, suspicion, threats, and power struggles. Family life includes a series of broken promises, unexpressed anger and resentment, continual hurt, and feelings of abandonment. The family withdraws from interaction with others, so that no one can see its problems. When anyone gets close enough to ask questions, problems are minimized or denied, or even blamed on something other than the substance abuse. Feelings of shame and guilt increase the need for isolation, family secrecy and denial. All the family's energies are focused on the needs of the substance abuser and maintaining peace.

Family members understand and believe in the proscription against discussing the alcohol or other drug problem. There is a deep sense of shame about the "family secret." Children learn to say "Dad isn't feeling well," or "Mom has a headache," instead of openly discussing the problem. When talking with outsiders, family members make excuses for the substance abusing parent, and know how to "keep their family's business to themselves."

One of the ways denial and stigma about substance abuse are manifested is by rules being made against discussing the substance abuse

problem with anyone inside or outside the family; this serves to protect members of the family from consciously experiencing emotional pain. Three of the most common rules are: don't feel; don't trust; and don't talk. For example, a six-year-old boy may be told by his mother that his alcoholic father is not angry, despite his father's clearly hostile and destructive behavior. However, the child remains afraid because of the father's behavior and is bewildered by the paradox of what he sees versus what he is told.

drugs other than alcohol

While research on children from families where only illegal drugs are being abused is limited, the existing literature does highlight some special risks. Because drugs other than alcohol and prescription medications are not legal, youngsters growing up in these families are expected to be even more secretive. Disclosure of the drug problem might result in parental incarceration and other legal reprisals, foster care, and community rejection. This means that the support mechanisms traditionally available - police, fire department, emergency services - are not within reach for these children in emergency situations (Austin and Prendergast, 1991).

In addition to the dynamics of secrecy, children growing up with drug addicted parents are also at risk for being orphaned by AIDS or street violence, being left with other caregivers during periods of parental incarceration, and being exposed to prostitution and other forms of illegal activity for financial gain. Moreover, research shows that these families are significantly more dysfunctional than other families (Austin and Prendergast, 1991).

Because of the secrecy surrounding the drug problem, drug-addicted families are considerably isolated and lacking in support. Drug addicted parents, studies have found, spend half as much time with their children as parents who are not substance abusers (Kumpfer and DeMarsh, 1986). And many researchers have cast doubt on the ability of heroin abusing mothers to adequately care for their children. Data have shown the inability of heroin addicts to accommodate a new child or to act in the best interests of a child (Austin and Prendergast, 1991).

Effects of Parental Substance Abuse on Children

Children from substance abusing families are at risk for a wide range of psychological, developmental and physical health problems. Children from substance abusing families are also at risk for developing their own alcoholism and other drug addiction, in part because of their inherited predisposition. There is strong research evidence that alcoholism has an inherited component (Niven, 1984). Inheritable factors may influence susceptibility to the disease, as well as enhance an individual's reaction to alcohol and other drugs when consumed. Research has also demonstrated that, in many cases, environmental factors and social learning interact with inherited characteristics to produce alcoholism. Because these factors are interrelated, interventions can be directed toward those identified at higher risk for developing substance abuse, which in turn can affect the multigenerational progression of the problem.

However, most of the health problems experienced by children of substance abusers are due to the extreme family and personal stress they feel when growing up with an alcoholic or other drug addicted parent. Children of substance abusers have been reported to have more cognitive, academic and emotional problems than children of non-substance abusers. They also have a higher incidence of depression, anxiety, generalized stress, low self-esteem, and Attention Deficit/Hyperactivity Disorder (ADHD). In addition, they exhibit more behavioral problems such as fighting, truancy, and conduct disorders, and are more likely to have parents who are separated or divorced (National Institute on Alcohol Abuse and Alcoholism, 1990; Kolar et al., 1994).

Children may believe that they are to blame for a parent's drinking or other drug use. In fact, parents may tell their children that the substance use is their fault. For example, a mother might say to her daughter, "If you got better grades, I wouldn't drink so much," or "If you didn't get on my nerves so much, I wouldn't need my pills - they're just to relieve stress." In addition, to avoid conflict and tension, the non-substance abusing parent might ask the child to be quiet, stay out of the way, take on more responsibility,

ask for fewer things or expect less. In the child's mind, if the substance abusing parent continues to drink or use, it may be because the child failed to be good enough. Children want to make things better, and believe that if they work harder and behave better, the problems will go away. When they find they cannot stop the substance use, they may feel like failures.

Young children, especially, do not understand that the inconsistencies and unpredictability are caused by the level of alcohol or other drugs in the parent's blood. Children may see a responsible parent who is loving and attentive while sober become frightening, uncaring, self-centered or hostile while intoxicated. Rules may change frequently - television watching is allowed one night, not the next. Studies have found that children who have the most difficulty coping with family substance abuse come from homes where the rules change most frequently (Throwe, 1986). Because of the stress and added responsibilities of the non-substance abusing spouse, frequently the inconsistency comes from both the substance abusing and the non-substance abusing adult family members.

Children internalize this inconsistency as a message that they lack worth and value within the family. Their self-esteem may be regularly challenged. They may stop trusting their parents and begin to feel that no matter how good they are, they will never get what they want or need. Constant disappointment leads to minimal expectations for the future, a lack of pleasure and joy in life, an inability to have fun and the building of emotional walls to protect against future disappointments.

Frequent family crises force children to develop coping strategies. Some children cope by numbing themselves to their feelings, both positive and negative. Other children stop trusting people, since they feel they cannot count on their own family to love and nurture them. Sometimes children take over adult responsibilities, attempting to control family chaos. These adaptive behaviors are a reflection of efforts to create some normalcy in life, and the focus is generally on survival. For these youngsters, family life may mean denial, rejection, increased responsibility and seriousness. The message is clear - do not talk about problems because they aren't really what they seem, and no one can be trusted to understand.

Research suggests that children's individual responses to family substance abuse problems are as varied as the children themselves (Baird, 1992). It is appropriate, therefore, to be sensitive to a child's individual behavior that signals problems at home rather than try to fit the child's behavior into predetermined roles.

Many children from substance abusing families also must deal with their anger and ambivalence about their parents. For example, while a child may love his cocaine addicted father, he may also be angry with him for losing his job and being unable to provide for his family. Children also often feel afraid, for their own safety if the parent becomes abusive, or for the well-being of the parent who might get into a fight or an accident.

Children from substance abusing families may manifest their stress through physical illness. For example, studies show that children from alcoholic families are more likely than their peers to seek medical attention for a variety of health problems. Child health care providers may anticipate seeing a broad range of physical manifestations of problems among children of substance abusers, such as:

- sleep disturbance, including fatigue and inability to sleep soundly
- frequent, multiple complaints about gastrointestinal problems, for instance, vague epigastric pain, irritable bowel symptoms, stomach aches and nausea
- frequent complaints of musculoskeletal pain, especially back and leg pain, which could be caused by either stress or physical abuse
- vascular or migraine headaches
- undifferentiated symptoms, such as chronic fatigue and weakness, lethargy, dizziness and lack of appetite
- enuresis (Baird, 1992).

The limited research available on children from non-alcohol drug abusing families again portrays a picture of significant disarray and risk. One study of children of opiate addicts found that many of these youngsters required treatment for emotional disorders and nearly half had repeated a grade in school. Behavior problems in school had resulted in suspensions for 30% of the children, and 20% of the parents reported that their children had themselves been involved with

the law. And perhaps most meaningful, children were frequently separated from their parents due to incarceration, hospitalization, and substance abuse treatment. In many cases, during their parents absence, children were left with substitute caregivers who themselves had alcohol or other drug problems (Kolar, 1994).

The Role of the Health Care Provider

Recent findings have pointed to the impaired functioning of the family rather than the substance abuse that places a child at risk. The implication of these findings is that child health care providers can play an active role in strengthening resiliency and providing critical information, support, and referrals to children and their families.

Child health care providers sometimes learn of parental substance abuse when children choose to disclose this information because the provider has established him or herself as a trustworthy, caring adult. More typically, however, the child is unable or unwilling to discuss the substance abuse openly, but provides other clues. Sometimes, a non-substance abusing parent will disclose the substance abuse problem to the provider. And finally, the provider may have contact with parents that indicates that substance abuse is an issue for the family.

Treatment begins with effective case finding. The child health provider may look for any physical signs of stress that might be induced by parental substance abuse, as described above, such as stomach aches, headaches, and fatigue. The provider should also be alert to signs of birth defects or impaired cognitive function that may result from neurological damage from alcohol and/or drug use, and evidence of injury from physical or sexual abuse (Baird, 1992). It is important to remember that while many of the behaviors discussed in this article are commonly exhibited by children of substance abusing families, they are not proof of parental substance abuse. If the provider encounters a child with these symptoms, he or she should simply probe further at this point.

In addition to the physical clues of distress, the provider might also observe a wide range of symptoms of emotional distress, such as excessive guilt and self-blame, fearful and anxious demeanor, low self-esteem, denial of problems, emotional withdrawal and isolation, confusion, lack of trust in adults, ambivalence, shame, and excessive shyness. (Kinney, 1991).

There might also be symptoms suggesting the presence of a psychiatric problem. For example, a child might exhibit a pervasive sad, hopeless mood, suggesting depression (Kinney, 1991). In this case, the risk for suicide should be carefully assessed. Other children might exhibit Attention Deficit Hyperactivity Disorder, whose symptoms include restlessness, inability to concentrate, difficulty sitting still, and learning difficulties, such as an inability to follow directions, failure to finish projects started, distractibility, impulsive behavior, difficulty taking turns, and excessive talking in inappropriate situations. Adolescents may present to the provider with symptoms that suggest an eating disorder, acting out or antisocial behavior, or a preoccupation with gambling. The provider should always look for signs of early and heavy use of alcohol and other drugs. Finally, because adolescent children of substance abusers are more likely to run away to escape the family tensions, the provider should be alert for indicators of this behavior as well.

Some additional clues to look for include:

- unkempt or inappropriate clothing.
- unexplained bruises or burns, or other indications of physical abuse or neglect
- fatigue
- unusual or sophisticated knowledge of drinking or other drug practices
- changes in social or academic behavior, or tardiness, absenteeism, moodiness, or unpredictable or secretive behavior
- discomfort when issues of alcoholism or other drug abuse are brought up. Some children may joke about or ridicule the topic. More typically, children will seem uncharacteristically sad, or ask questions about this issue.

Some child or adolescent health providers may be reluctant to get involved in the process of identifying parental substance abuse because they are not sure how to determine when appropriate alcohol consumption changes into problematic use. One very simple answer is that

problem drinking is present if the child thinks that a parent or other significant person in the family drinks too much, and the drinking in some way interferes with the child's health and well-being. Use of any drugs - legal or illegal - is problematic if the frequency and intent of use is other than that prescribed by a health care provider.

When the health care provider is working with an elementary school student, simple, open-ended questions about parental substance abuse are most effective conversation starters. A provider who suspects a child is from a substance abusing family might say to a young child, "Tell me what things are like at home" or more directly, "Have you ever wished your mom or dad didn't drink or use other drugs so much?" In work with older students, the provider can use a modification of the CAGE test as a screening tool (Baird, 1992, p. 205):

- Have you ever [wished] that your parent [would] **C**ut down on his/her drinking?
- Have you ever felt **A**ngry about your parent's drinking?
- Have you ever felt **G**uilty about your parent's drinking?
- Does anyone in your family have **E**ye-openers (drink first thing in the morning)?

Others have recommended variations on these questions, such as: Have either of your parents ever tried to cut down on their drinking? Have either of your parents become angry or annoyed by criticisms of their drinking? Have either of your parents felt guilty about their drinking or something that happened because of their drinking? Other screening tools include the CAST and the CAST-6.

Providers might also ask if the parent has ever been drunk or high at family gatherings, if the parent has gotten into trouble because of his or her drinking or drug use, whether he or she has ever attended AA or Alanon meetings or been in treatment for drinking or other drug problems, and what concerns the child has about the parent's drinking or drug use. The CAGE questions can also be used in discussions with parents.

It should be explained to the patient that any information about family substance abuse will be kept confidential, according to professional ethics and state policies. However, selective data may need to be shared with other professionals who are responsible for dealing with the substance abuse problems of students and their families. It is important for the provider to obtain the patient's permission to share confidential information with others or to assist the patient to directly share the information on a "need to know" basis. If the provider suspects or knows that a child is being neglected or abused, a report must be filed with the appropriate state authorities. The provider needs to be familiar with the regulations and policies of the local municipality and state.

Sometimes the provider will become aware of family substance abuse problems through interactions with parents. For example, this might include a parent who exhibits behavior, speech, or smell that indicates intoxication during an office visit or when contacted by phone. The provider can attempt to ascertain whether or not there is problem by using the CAGE questions as a screening tool, or by including questions about substance abuse when conducting a family history. If parents indicate there is a family substance abuse problem, the provider can use this as an opportunity to provide some health teaching about responsible decision-making about alcohol and other drugs, the effects of substance abuse on family members, especially children, as well as local community resources for treatment and support of lifestyle changes. However, if the provider suspects substance abuse in the family, the child should always be supported, whether or not the parent admits to the problem or seeks help.

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Children of Alcoholics Foundation Research

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In a 1990 study of 1.6 million subscribers of Independence Blue Cross/Blue Shield, children of parents who had received treatment for alcoholism were compared to other youngsters. The data showed that:

- children of alcoholics' rate for inpatient admissions per thousand subscribers was 24% greater than other children's
- children of alcoholics' average length of hospital stay was 29% greater than other children's
- children of alcoholics' rate of hospital days used per thousand subscribers was 62% greater than for other children
- children of alcoholics' rate of inpatient hospital charges per thousand subscribers was 36% greater than for other children
- the rate of injuries and poisonings among children of alcoholics was more than one and one-half times as high as that of other children
- the substance abuse admission rate per thousand subscribers for children of alcoholics was nearly triple that of other children
- the rate per thousand subscribers of admissions for mental disorders for children of alcoholics was almost double that of other children, as was the rate of admissions for endocrine/nutritional/ metabolic diseases
- children of alcoholic mothers were hospitalized for substance abuse at a rate almost twice that of children with alcoholic fathers
- children of alcoholics' had higher rates of inpatient admissions, average lengths of stay and charges incurred within specific diagnosis categories, most notably in substance abuse and mental disorders.

Other Research

The National Institute on Alcohol Abuse and Alcoholism found that, on the average, alcoholics' families used health care services and incurred costs at a rate of twice that of similar families with no known alcoholic members. Average monthly health care costs over four years ran $210 and $107 per person, respectively, for these two groups. Hospitalization costs accounted for most of this difference: ambulatory care usage was similar for the two groups. This same data showed that families with alcoholic members incurred 70% more health care costs than comparison families even when the expense of alcoholism treatment was eliminated from the calculation of total health care usage (Holder and Blose, 1986).

A Blue Cross study of families whose members entered drug and/or alcohol abuse treatment found that the non-substance abusing family members used hospital services at a rate nearly 50% higher in the five months before the substance abuser entered treatment than in the five months post-treatment (Blue Cross, 1987). This difference in rates was even greater for dependents than for adults.

In a study of alcoholics treated in a fee-for-service clinic, Robert and Brent (1982) found that the alcoholics' family members had significantly higher utilization rates, higher rates of distinct diagnoses, and a disproportionate number of diagnoses of trauma and stress-related diseases than a group of nonalcoholic control families. Members of alcoholic families had an average of 9.7 physician visits per year, compared to 6.5 visits for control family members. The number of distinct diagnoses per year was 6.3 and 4.5, respectively, suggesting that families of alcoholics have more health problems than families of nonalcoholics. In particular, alcoholics' families had significantly higher proportions of diagnoses in six categories: trauma, gastrointestinal, neuroses, other mental and psychological, endocrine/nutrition/metabolic and genitourinary.

Nylander (1960) found an increased risk of psychosomatic disorders among girls raised by their biological alcoholic parents. The children in his study population were almost six times (29%) as likely to show signs of depression and anxiety as controls (5%). Teachers were five times (48%) more likely to assess the alcoholics' children as problem children, especially younger boys, than the control group children (10%). In a study comparing 82 children of alcoholic fathers with children of nonalcoholics attending a pediatric outpatient clinic, teenagers from alcoholic family environments were twice as likely to receive psychiatric treatment for emotional disorders and anxiety-depressive syndromes (Herjanic et al., 1971).

Another psychiatric disorder which has been noted in children of alcoholics and indirectly affects health care utilization is bulimia (Pyle, Mitchell and Eckert, 1981). In studying 34 bulimic women, Pyle, Mitchell and Eckert found that half of the women reported alcoholism in at least one first-degree relative. Bulik (1987) studied patterns of drug and alcohol abuse in 35 bulimic women, 35 healthy control subjects and their first- and second-degree relatives (parents, siblings and grandparents). Alcoholism occurred significantly more frequently in the first- and second-degree relatives of bulimic subjects (both alcoholic bulimics and those who did not exhibit alcohol-related problems) than in those of control subjects.

An association between being a child of an alcoholic and high incidence of asthma has been suggested by Schneiderman (1975).

There are many reports of an increased incidence of child abuse in families of alcoholics. Researchers estimate a range of 12% to 69% of identified child abusers are also alcoholics (Orme and Rimmer, 1981). Famularo et al. (1986) studied 31 families randomly selected from a group of 246 parents referred to a psychiatric clinic. They found that the group of child-abusing parents had a higher incidence of alcoholism (38%) than the control group whose children were inpatients in a general pediatric hospital (8%). One-half (52%) of the child-abusing families had at least one parent with a history of alcoholism compared to the control families, where only one-eighth (13%) were alcoholics. Behling's (1979) report of 51 cases of child abuse found that two-thirds (69%) involved a history of alcoholism or alcohol abuse in at least one parent.

Physical abuse may directly affect children's injury rates (Putnam, Rockett and Stout, 1985; Chafetz, Beane and Hill, 1971; Roberts and Brent, 1982). Putnam, Rockett and Stout (1985) questioned

whether the higher injury rates of children of alcoholic mothers could be due to child abuse or lack of attention and also conjectured that injuries may also be due to risk- or attention-seeking behavior on the part of children neglected by their parents.

However, some authors (Orme and Rimmer, 1981; El-Guebaly and Offord, 1977) have concluded that the methodological problems in child abuse and alcoholism research are so great, and the definitions used for alcoholism and child abuse so varied, that little confidence can be placed in findings of causality between familial alcoholism and child abuse.

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CHILD ABUSE AND NEGLECT

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Although child abuse was identified as a social problem in the last century, it took almost 100 years for violence toward children to be considered a major national problem. In the 1940s, through the use of diagnostic x-ray technology, physicians began to notice patterns of healed fractures in young children that could have resulted only from repeated blows. Although pediatric radiologists were diagnosing child abuse, it was not until C. Henry Kempe and his associates published their classic work, "The Battered Child Syndrome," in the *Journal of the American Medical Association* in 1962 that battering and abuse became a focal point of public attention. As a result, model legislation for child abuse reporting was proposed by four groups: the U.S. Children's Bureau, the Children's Division of the American Humane Association, the American Medical Association, and the Council of State Governments. By the end of that decade, all states had passed laws requiring the reporting of child abuse and neglect and had initiated efforts to treat abused children and their families. In 1974, the U.S. government established the National Center on Child Abuse and Neglect to provide a mechanism for increasing knowledge about the causes of child abuse and neglect and to identify steps toward prevention and treatment.

The causes of child abuse and neglect are complex and varied. Child maltreatment can be inflicted by anyone responsible for caring for children, and it occurs in all types of families and settings. Children of all ages may be physically abused. Although infants and young children are more likely to receive serious or life-threatening injuries, adolescent abuse also occurs and is often unrecognized.

Physicians must always remain alert to the possibility that abuse may be occurring, even when the child says nothing or says that she or he has never been hurt, because children frequently do not complain about the abuse they are receiving. Current research has found that the following child and family characteristics may be risk factors for child abuse and/or neglect.

Child Characteristics:

- the child was born prematurely
- the child has disabilities or abnormalities
- the child exhibits certain behaviors of infancy and childhood, such as persistent crying

Family Characteristics:

- there is other violence in the home (in particular, the father abuses the mother or siblings abuse one another)
- substance abuse, including alcohol abuse, by the parents or caretakers
- the parents or caretakers lack the necessary maturity to care for the child
- parental expectations are inconsistent with the child's developmental abilities
- the caretaker is socially isolated (ie, has no external support systems)
- the family is experiencing high levels of stress from events such as loss of a job, increased financial burdens, serious illness, death in the family, separation or divorce
- adult members of the family have themselves been abused as children, either physically or sexually

These risk factors are not necessary antecedents to abuse, however, and physicians must consider abuse or neglect whenever physical or behavioral signs are suggestive, regardless of the presence or absence of the foregoing risk factors. Otherwise, instances of abuse may not be identified.

In situations where the physician provides care for all members of the family, knowledge of the medical and social histories of the child's parents or caretakers will help ensure that fewer cases of child abuse elude detection. Different forms of abuse can and do coexist in families. Moreover, abusive behavior often occurs in successive generations of families, a phenomenon known as the "cycle of violence."

Although some studies have indicated a correlation between child abuse and factors such as income, race, education and marital status, some of these studies may have been subject to bias since physicians may be more likely to consider child abuse when the family has a lower income or is non-white.

Ethical Considerations

When a physician who has a prior professional relationship with a family suspects that a child is being abused by the parent(s), a conflict will likely arise between the physician's duty to report the abuse and the parents' desire to keep that concern between the physician and family. Physicians resolve this problem by calling parents' attention to the reporting mandate and by being neutral in their attitudes. Nonetheless, many parents may decide to terminate their relationship with the reporting physician. If the physician not only identifies the suspected abuse but also carries out the "definitive" medical assessment for abuse, she/he must be prepared to testify against the parent in an adversarial proceeding, making a continued physician-patient relationship involving the parent or other caretaker extremely difficult.

Most primary care physicians resolve this problem by referring the child for the definitive forensic medical assessment and continuing to offer supportive and medical services to the child and family. If the primary physician is also the most qualified provider of definitive assessments, referral of the family to a new primary physician may be necessary. The problem cannot legally be resolved by failing to report the suspected abuse because this can endanger the child.

Diagnosis of Abuse

Physical abuse is defined as inflicted injury to a child and can range from minor bruises and lacerations to severe neurologic trauma and death. In making the diagnosis, the physician must conduct a thorough health assessment, including a history, physical examination, and developmental assessment, on any child who may be a victim of abuse. Laboratory studies (eg, x-ray, CT scan, bone scan, coagulation studies) are useful in delineating the nature and extent of current trauma, in defining the presence of previous trauma, and in excluding other medical causes.

During the diagnostic process, the physician should:

- assess the child's immediate medical needs
- obtain the past medical and social history of the child and family members
- assess the plausibility of the history being provided in light of any pre-existing medical conditions
- determine the level of risk to the child if she or he returns home

physical abuse

Certain types of injuries are more commonly associated with abuse: the injuries are not explained by the history provided, are often located on multiple body sites and often are in different stages of healing. However, the medical recognition of child abuse may be based on the existence of a single injury.

The following physical findings may be indicative of physical abuse:

- bruises and welts forming regular patterns, often resembling the shape of the article used to inflict the injury (eg, hand, teeth, belt buckle, electrical cord)
- burns
  - cigar or cigarette burns, especially on the soles, palms, back, or buttocks
  - immersion burns (stocking or glove-like without splash burns on extremities, doughnut-shaped on buttocks or genitals)
  - patterned burns resembling an electrical appliance (eg, iron, burner, grill)
- lacerations or abrasions
  - rope burns, particularly on wrist, ankles, neck, torso

  - palate, mouth, gums, lips, eyes, ears
  - external genitalia
- fractures
  - skull, ribs, long bones, metaphyseal
- abdominal injuries
  - bruises of the abdominal wall
  - intramural hematoma of duodenum or proximal jejunum
  - intestinal perforation
  - ruptured liver or spleen
  - ruptured blood vessels
  - kidney or bladder injury
  - pancreatic injury
- Central Nervous System injuries
  - subdural hematoma (often reflective of blunt trauma or violent shaking)
  - retinal hemorrhage
  - subarachnoid hemorrhage (often reflective of shaking)
  - cerebral infarction, secondary to cerebral edema
- other indications
  - Munchausen syndrome by proxy
  - symptoms of suffocation
  - chemical abuse

deprivational syndromes

Deprivation related disorders develop when the basic needs of the child are not being met: adequate nutrition, clothing, shelter, emotional support, love and nurturing, education, safety, and medical and dental care. The reasons for parental failure to meet these needs may be multifactorial and include lack of resources, inadequate access to care, parental substance abuse, parental psychopathology (eg, depression), parental priorities which relegate the needs of the child to a lower rank, or even a history of abuse of the caretaker when she or he was a child. In the latter case, the psychological effects may limit the caretaker's recognition of neglect as maltreatment. The major symptomatology displayed by the deprived child may be global or may reflect an area of isolated deprivation.

Historical findings:

- lack of appropriate well-child care, including immunizations
- lack of appropriate medical care of chronic illness
- absence of necessary health aids, such as eyeglasses or hearing aids
- absence of appropriate dental care

Physical findings:

- undernutrition (on examination or as evidenced by plotting on appropriate growth curves)
- poor hygiene, such as being extremely filthy or having extraordinarily severe diaper rash
- developmental delay
- untreated medical conditions
- rampant dental caries

Behavioral findings:

- depression
- anxiety
- enuresis
- sleep disturbances
- excessive masturbation
- impaired interpersonal relations (eg, lack of cuddliness, gaze avoidance, preference for inanimate objects)
- discipline problems, aggressive behavior
- poor school performance
- role reversal, in which child assumes caretaker role
- excessive household responsibilities, including child care

Like the risk factors for abuse, these findings are not specific to cases of neglect. In cases of neglect, the finding may be related to the omission of basic needs or the failure to protect, while in other cases, there is inflicted emotional abuse, including unreasonable parental demands, constant or persistent harassment, belittling or verbal attacks. Such forms of emotional maltreatment are particularly difficult to document, and consultation with mental health experts may be useful.

sexual abuse

Presenting behavioral symptoms are nonspecific and caution must be exercised not to attribute all such complaints to sexual abuse. The symptoms also may be indicators of nonabuse-related stressors. Reactions to stressors depend on the age and emotional maturity of the child, the nature of the incident, the duration of the stress, the child's history, and the manner in which the child relates to the source of the stress.

The child, depending on age, may:

- display extremes of activity (hyperactivity or withdrawal)
- manifest poor self-esteem
- evidence poor peer relationships
- express general feelings of shame or guilt
- display a distortion of body image (distorted drawings)
- display regressive behavior
- have enuresis and/or encopresis
- appear frightened or phobic, especially of adults
- show pseudomature behavior
- exhibit a deterioration in academic performance
- have an eating disorder
- display sexually provocative behavior
- engage in compulsive masturbation
- sexually abuse a sibling, friend, or younger child
- become sexually promiscuous
- become pregnant
- run away
- attempt suicide

Among the more specific signs and symptoms of sexual abuse are:

- rectal or genital pain
- rectal or genital bleeding
- sexually transmissible diseases in prepubertal children
- sexually precocious behavior, particularly if persistent

Any of the following physical signs may also be present in sexual abuse

- abrasions or bruises of the external genitalia (labia majora, penis or scrotum) and/or inner thighs
- distortion or attenuation (marked reduction in amount) of the hymen
- alterations in anorectal tone (severe anospasm or marked laxity)
- sexually transmissible diseases, particularly in prepubescent children
- pregnancy

It is important to realize that physical findings are frequently not seen in sexually abused children and that the absence of such findings does not preclude the diagnosis of sexual abuse.

Interviewing Process

When abuse is suspected, the physician must gather a detailed medical history from the child, if possible, and the caretakers. This history should follow the format of a thorough pediatric health assessment with special attention to the injuries and to factors that may help in determining continued risk to the child. In abuse cases, the explanation of an injury is frequently implausible or changes over time. The locally designated child protection agency and/or the police must be informed.

If possible, the child should be interviewed separately. The interviewer must be sensitive to the child's possible fears and apprehension when discussing the home situation and should tailor the interview to the child's developmental level. Although repetitive interviews can be problematic, the physicians must gather the basic information necessary to help make decisions that are in the best interest of the child. When talking with younger children, it is best for the interviewer to sit at the child's eye level. Questions beginning with "How come..." are more productive than questions beginning with "Why..."

Local child protection service personnel or teams may be involved in the initial interview if requested. In cases of severe abuse, parents may flee with the child; thus it is advisable to contact the mandated reporting agency prior to

informing the parents of the suspected diagnosis. Above all else, the primary concern is to protect the child.

interviewing the child

When interviewing the child:

- attempt to obtain pertinent information from others prior to the interview, including the specifics of the abuse - the date, exact time, place, sequence of events, people present and time lag before seeking medical attention - and a complete social history, including where the child resides, length of residence, other household members, support systems available to the family, and child care arrangements
- sit near the child, not across a desk or table, and at the child's eye level
- attempt to establish an empathic trusting relationship
- conduct the interview in private and without the caretaker being present
- have the child interviewed by the most experienced professionals available
- find out who else has questioned the child
- explain the purpose of the interview to the child in language appropriate to her/his developmental level
- use the child's own words and terms in discussing the situation whenever feasible
- always ask the child if she/he has any questions and answer them
- carefully explain to the child the reason and nature of her/his removal from the home, if imminent
- ask the child to explain words or terms that are unclear
- acknowledge that the situation must have been a difficult one for the child and emphasize that the child was not at fault.

Do not:

- suggest answers to the child
- press the child for answers that she/he is unwilling to give
- criticize the child's choice of language
- suggest that the child feel blame or guilt for the situation
- leave the child unattended or with unknown persons
- display shock or horror concerning the child or the situation
- offer rewards to the child

talking to parents

Maintaining a professional approach with the family, although not always easy, can facilitate the interviewing process. Explaining the reporting process and what the parents can expect to happen is often helpful. A nonaccusatory statement such as "I am required by law to make a report to the child protective service agency whenever I see a child with an injury (a condition) like this one" should be used.

When interviewing the caretakers:

- reserve judgment until all facts are known
- tell them the reason for the interview
- advise them of the physician's legal obligation to report cases of suspected abuse
- conduct the interview in private, or, when indicated, with appropriate personnel (eg, child protection service personnel)
- attempt to be objective
- reassure the caretakers of the physician's continued availability
- explain further actions that will be required
- answer questions honestly

Do not:

- attempt to prove abuse or neglect
- display anger, horror, or disapproval of the caretakers or situation
- place blame or make judgments
- give feedback on the caretakers' explanation of how the injury occurred since this will permit them to change an implausible explanation based on your feedback.

In cases where the caretaker was abused as a child and has unresolved issues related to her or his own trauma, the physician may encounter some resistance to questions, necessitating a separate evaluation. In addition, resistance may be more likely in those cases where violence is ongoing within the home, particularly where the mother

is being abused: child abuse reportedly occurs in one third to one half of all cases of domestic violence.

It is not unusual for caretakers who were themselves abused as children to relive their victimization experiences during the investigation process. Female caretakers, for example, have been known to regain once-repressed memories of their own abuse after the traumatic discovery that their children have been victimized. It is also possible that a prior unresolved history of abuse may affect the caretaker's ability to recognize injurious behavior as abuse or to detect evidence of abuse, even when it occurs within the caretaker's household. Consequently, physicians must remain sensitive to the needs of all family members.

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reprinted with permission: Shields ME. "Interviewing Victims of Child Abuse - Practical Pediatric Techniques" presentation at annual Fall conference, American Academy of Pediatrics, October 11, 1992, Mary Ellen Shields, M.D.

Why Interview?

Remember, you are a doctor, not an attorney, law enforcement officer, child protective services worker or therapist. You are attempting to make a diagnosis and develop a treatment plan. This needs to be accomplished in a manner consistent with medical standards. A doctor gathers information from all sources available, including the child, and does a physical examination. This process is the old familiar *History and Physical*. Just as we would not evaluate "chest pain" without doing a careful history, so we would not evaluate a child who may have been abused without doing a history. We were instructed in medical school that the history is usually the most important part in reaching a diagnosis; this is true in the diagnosis of child abuse as well.

Establishing Rapport and Observing the Child's Developmental Level

1. Narrow the age gap
   - allow the child power by asking questions which let him or her help you or by giving the child choices. For example: "Hi. You must be Molly. Who are these people with you?" allowing the child to introduce the adults; "Can you help me spell your name?" at the beginning of note-taking; "Where would you like to sit?" "Is it ok to sharpen my pencil?"
   - comfort questions: "Who do you think is older, you or me?" or "Are you married or still single?"
   - sit at eye level with the child; if the child chooses to sit on the floor, you sit on the floor, letting the child choose which cushion he or she wants to use. If sitting in chairs, don't have your desk separate you from the child, sit on the same side of desk or around a little table.
2. Introduce yourself as a "kid person"
   - "My name is Dr. Shields and I talk to lots and lots of kids."
   - "My name is Dr. Shields and I talk to lots of kids who are six, and guess what, I used to be six just like you."
3. Ask the child to tell you if he or she knows why they are here. Clarify any misperceptions. Plant the seed for the purpose of the interview and then back off to establish rapport.
   - previously disclosing child - "Well, I talk to lots of kids about touching trouble. I'm going to talk to you about touching trouble later on, but right now we're going to talk about some other stuff."
   - symptomatic child - "I'm concerned about the problems you've been having (wetting, getting in trouble because of games with other kids, tummy aches, sore bottom, the bruises on your arm, etc.) and I need to ask you some questions so I'll know what to do to help. But right now we're going to talk about other stuff."
   - non-disclosing suspected victim of abuse (physically asymptomatic child who has been questioned by someone before and is not disclosing) - in most cases, it is more appropriate for this

child to be evaluated by a mental health professional first. If you need to see this child (eg, mental health professional is quite certain abuse has occurred due to child's behavior, but child is not disclosing) let the child know what you intend. "I talk to lots of kids who have problems. I'm going to talk to you about anything that might have happened to you that made you feel hurt or uncomfortable. But right now we're going to talk about other stuff."

4. Ask questions which build rapport and offer information
   - "Where do you go to school?" "Do you like school?" "What's your favorite part?" "What grade are you in?" "Who lives with you?" "Do any cats live in your house?"
5. Observe the child's speech and language skills so you can match your language to that of the child.
6. Test the child's skill level as regards counting, locations or positions, telling time and measurement.

Confidentiality

For older children, this can be an issue. Be honest about what you can and cannot do.

Ground rules

Some studies have shown that such instructions facilitate children's performance on free and cued recall of past events.

1. Instruct the child it's ok to answer "I don't know." "There may be questions you don't know the answers to. That's ok. Nobody knows the answers to everything. Just say, 'I don't know.' Don't guess or make things up. It's very important to tell me only what you really remember."
2. Instruct the child that it's ok to decline to answer. "If you don't want to answer a question, just let me know by saying something like, "I don't want to answer that question."
3. Instruct the child that it's ok to ask for clarification of a question. "If you don't understand something I ask you, tell me 'I don't know what you mean.' Tell me to say it a different way."
4. Instruct the child that some questions might be asked more than once. "I might ask you some questions more than one time. Sometimes I forget what I asked and sometimes I want to be sure I got your answer right. You don't need to change your answer, just tell me what you remember."

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