THE ABUSED CHILD PRIMER

A brief guide for early identification, reporting procedures, and routes of rehabilitation.

Prepared by:

DONALD C. PHILLIPS, M.D., F.A.A.P.
Chairman, Subcommittee on the Abused Child,
Maternal and Child Health Committee,
Washington State Medical Association

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"We are just as responsible for the evil we allow as for the evil we commit."

-Elton Trueblood-

FOREWORD

Every time you care for, or have knowledge of, an injured or "neglected" child, consider it may be "nonaccidental" and he was possibly ABUSED. Keep in mind three thoughts:

1. Unless you find him, his abuse will be recurrent and he may be permanently disabled--or die!

2. Unless you report him, you may be sued for malpractice under the "Negligence Per Se" statutes. (In the fall of 1972, an out-of-court settlement of approximately $600,000 was made by several California Pediatricians who were sued for "failure to report" an abused child who subsequently became a ward of the state.)

3. The law provides immunity if you do report.

The material in this booklet is a distillation of experiences and discussions with colleagues individually and in the setting of workshops and conferences on the subject and represents current thinking on the abused child.

Its intended brevity (for easy reference) precludes giving individual source credits, but I am deeply indebted to and grateful for the many who have devoted so much effort and whose knowledge and research comprise the background that allows this to be produced. In this light, your criticisms, additions, and suggestions will be most welcome in the interest of improving what is presented here.

In its present form, this information should not be considered as an answer to the problem, but rather a beginning, presenting simple outlines of recognition, reporting, Rx., and rehabilitation. It is doubtful if abuse will ever be eliminated from society.

Finally - remember: Yours is only the responsibility to be concerned and knowledgeable - to include in the differential diagnosis: "SUSPECTED CHILD ABUSE OR NEGLECT"--to report the same - to establish: "Is this particular child in need

of help or protection?" Do NOT judge, accuse, or antagonize! Keep your cool!! Overall major responsibility is mandated to Protective Services.

Donald C. Phillips, M.D., F.A.A.P.

TYPES OF NEGLECT AND ABUSE

I. PHYSICAL NEGLECT
Nonaccidental omission of basic food, shelter, clothing, and/or essential protection producing failure to thrive.

II. MEDICAL NEGLECT
Right of care and/or life vs. freedom of religion or parental rights.

III. EDUCATIONAL NEGLECT
Intrinsic (system) and/or extrinsic (family) variable deficiencies. Some parents/children do have options.

IV. MORAL NEGLECT
Intangible sexual and/or criminal influences which, if uncorrected, either may corrupt, are in danger of corrupting, or have already corrupted the child.

V. EMOTIONAL NEGLECT
Failure to Thrive - Lack of nurturing elements necessary to support and engender total growth--the child withdraws, sometimes totally lacking response (whispering a cry for help).
Environment: Sterile - Rejective - Negative
(Less than 12%: Psychotic.)

VI. PHYSICAL ABUSE*
Nonaccidental - Serious - Usually repetitive - Often fatal.
(High percentage of sequellae: Physical and/or emotional.)

VII. SEXUAL ABUSE**

Both moral and physical insults generally involving older (usually female) children.

In a recent study:

75% of offenders known to child and/or her/his family.

27% were members of the child's household.

11% were related but not living in the household.

25% were strangers or alleged strangers.

VIII. EMOTIONAL ABUSE

Continued inappropriate debasement of a child's feelings - rarely recognized prior to crisis state, then manifest by externalizing--hyperactive, often antisocial acting out (shouting a cry for help).

Environment: Punitive, hostile, verbal abusive, critical, devisive of loyalty with constant fear, fact, or threat of losing one (or both) parents.

IX. DRUG ABUSE

Drugging (or even poisoning) either administered directly to quiet, or indirectly (via placental transfer) to the unborn.

*See pages 8-10.
**See pages 14-16.

DEFINITIONS

I. PHYSICAL ABUSE:

"The perpetration of nonaccidental acts causing visible or invisible injury of variable extent to the child entrusted for care."

II. NEGLECT:

"The nonaccidental omission of basic necessities causing physical and/or emotional harm of variable extent to the child entrusted for care."

* * * * * * * * * * *

There is no single, nor simple, solution to this problem - present since recorded time. Hence, we must (for the safety of children) develop a philosophy:

"EVER CONCERNED - - ALWAYS SUSPICIOUS"

Tragically, a fair percentage of child abuse is not recognized in time to refer and rehabilitate the whole family as a unit, and protect the abused from further abuse.

Isolation and frustration are an integral part of the dynamics of abuse and a crisis (or an accumulation of small crises) usually precipitate the actual incident of abuse.

The majority of abusers initially appear not too dissimilar to others and can come from all races, creeds, and walks of life. Most of the abused children seem not much different than the "norm."

However, when evaluated in depth, most abusers and abused have have certain similar characteristics that are identifiable and are listed on pages 4 and 5.

COMMON DENOMINATORS

I. ABUSER: (Often abused as a child)
In questioning a suspected abuser, sympathetically ask: "Did you have a happy childhood?" and later follow with: "Were you ever mistreated?" (If positively clued, utilize these "key" questions: "How were you and your spouse disciplined?"; "Do you and your spouse get along?"; "When you are desperate for help, to whom do you turn?" and "When should babies be toilet trained?") Listen, do not judge, then discreetly seek out whether he/she meets most of the following criterion:

A. Isolated

B. Alienated

C. Unrealistic (Ambivalent image of:)
1. Impressions of "Mothering" - (Parents)
2. Expressions of punishment - (Discipline)
3. Evaluations of own worth - (Self)
4. Expectations of trust - (Others)
5. Interpretations of marriage - (Spouse)
6. Conceptions of childhood - (Children)

and inquire whether the child was unwanted, or the "wrong sex."

II. ABUSED: (Odds good will become abuser, or worse, if survives)
When examining an injured or scrawny infant or child, ask yourself subconsciously: "Is he/she

A. "Different"
1. Congenitally deformed
2. A "F.L.K." (funny looking kid)
3. A "look-alike reminder": (someone disliked)
   a. Ask quietly: "Who does he/she remind you of?"

B. "Difficult"
1. Premature
2. Colicky
3. Retarded

C. "Deviant"
1. Too fearful or too friendly
2. Overly apathetic or submissive
   a. Doesn't cry or resist appropriately

III. CRISIS: (Catalyst present in majority of physical abuse)
Gently seek out the crisis or crises (examples: alcoholic, financial, family discord, or as simple as "wet pants" or "spilled milk"). Do NOT mistake for the cause! (Suggested approach: "It has been a helluva day for me, have you had problems, too?")

THE ABUSED CHILD IN THE EMERGENCY ROOM SETTING

Statistics indicate 12-25% of children under seven years who appear injured in the "E.R." are NONACCIDENTAL! (Of these 70% are under age three - 32% less than six months of age.) The following "Index" should be posted in each emergency room:

INDEX OF SUSPICION

1. Characteristic age - usually under three

2. Has injuries not mentioned in (or not compatible with) the history

3. General health - indicative of neglect

4. History of previous similar episodes
   a. Frequent change of doctors

5. Prolonged interval between trauma and presentation

6. Brought in by other than parent

7. Allegedly "self-inflicted injuries" in an infant

8. Unexpected location and amount of soft tissue injury

9. Characteristic distribution and type of bone trauma
   Single fracture in baby or spiral in young child -
   Multiple bone trauma near joints -
   Epiphyseal displacement, metaphyseal fragmentation, Cortical thickening, or avulsion of parts of the provisional zone of calcification.

10. Unusual location or type of burns

11. Evidence that trauma occurred at different times - are in different stages of resolution

12. Inappropriate behavior of parent and/or child

13. Suspicious status and story:
    a. New patient - new in area - history of frequent moves
    b. Cause of recent trauma in question

14. No new lesions during child's hospitalization
    a. Often parents show inappropriate concern and/or anger, or do not visit child at all

SIGNS OF ABUSE AND NEGLECT

I. BATTERED CHILDREN*

A. Soft tissue
- Abrasions
- Contusions
- Ecchymosis
- Tenderness
- Scars

} all often in different stages of resolution

B. Bone Trauma
- Peri-epiphyseal
  - (usually under age of three)
- Fractures
  - Long bones; skull; ribs; spine

C. Internal Injuries
- Subdurals common (shaking alone can produce)
  - full anterior fontanelle and/or seizures
- (?retinal hemorrhages)
- Thorax
- Abdomen
- (ruptured viscus, torn mesentery, bowel obstruction from hematoma)

D. Lacerations

E. Punctures

F. Burns (does the distribution fit the story?)
- (Cigarette?)

G. Poisoning (?Drugging)

H. Drowning

I. Suffocating

II. NEGLECTED CHILDREN

A. Malnutrition
- Failure to thrive (2-5% of battered)

B. Skin changes
- Severe diaper rashes
- Frostbite or chilblain
- Sunburn
- Infestations
- Infections

III. SEXUALLY MOLESTED**

A. Usually girl - generally older
- Secretions, contusions, tears, etc. - see pages 14-16.
- (OB-Gyn consultation advisable)

B. Venereal disease in pre-pubertal child

IV. EMOTIONALLY ABUSED***

A. Failure to thrive

B. Withdrawal

C. Overfearful

NOTE: With unexplained death in an infant less than eight months of age, ALWAYS consider first SUDDEN INFANT DEATH SYNDROME and act accordingly.

Estimated incidence in the U.S.: *50,000-75,000/year (30-40% serious), **100,000-120,000/year, ***200,000-250,000/year.

If any doubt exists, seek knowledgeable consultation rather than return the child to further abuse and possible permanent disability--or DEATH! (Estimated 7-10%)

Should you have REASONABLE CAUSE TO BELIEVE you have a case of "nonaccidental" injury or neglect, follow this suggested

IDEAL ROUTE

I. Always admit to hospital - regardless of degree of injury

II. Report to*

A. Your local Child Welfare Agency.
(ask for "Protective Services")
1. (If you know a felony has been committed, you are also obligated to report known facts to the local prosecuting attorney.)

B. Involve "SCAN" Committee** early while abuser is still concerned about child's condition.

III. Document:

A. Photographs (colored best).

B. Accurate measurements:
1. Use infant grid if "failure to thrive."
2. Serial measurements of head if ? subdurals.

C. Blood survey; include C.B.C., P.T.T., clot retraction, platelet count, prothrombin time, Tourniquet test, and ivy bleeding time.

D. Radiologic survey*** (most helpful under age three) (?repeat in three weeks if clinically suspicious)

E. Pertinent nurse's notes (behavior and visiting).

F. Consultations: May need to refer the whole case.****

IV. Provide necessary care:

A. Pediatric.

B. Surgical, neurosurgical, orthopedic, etc.

C. Seek Psychiatric and Social Service for both abused and abuser whenever indicated.

V. Utilize multidisciplined community resources for both as indicated.

A. Always include Protective Services

VI. Rehabilitate and reunite whenever possible.

A. In some cases, Protective Services may utilize the Juvenile Court for temporary wardship (and a very few may require termination of parental rights). Your cooperation in helping an expert witness then is necessary. Do so for the ultimate protection of the child.

VII. Follow up until assured the child's welfare is no longer at risk.

*Know the current reporting laws in your state.
**See page 17.
***See 9 on page 6.
****The path of "going it alone" without reporting or consultation is fraught with legal pitfalls, heartbreaks, and self-guilt. Even with the best consultants, the ultimate realization that there is no "pat" solution is often grimly evident.

By being constantly aware of a potential abuser's Common Denominators, it is often possible to uncover one prior to abuse. If you can recognize the potential, you may be able to prevent abuse by providing realistic information regarding child development, disrupting isolation, and by maintaining lifelines with gentle, understanding supervision by those knowledgeable in the dynamics of child abuse.

CLUES TO THE POTENTIAL ABUSER

I. PRENATAL*:

A. The extremely young.

B. The "illegitimate" that is being kept.

C. The unsuccessful attempted abortion.

D. Unrealistic views of motherhood.
   1. Expecting the baby to solve parents' problems

E. Overconcern regarding:
   1. Baby's sex and/or appearance being "just right"
   2. Spoiling and ability to control "bad behavior" in baby

II. IMMEDIATE POST-PARTUM*:

A. Lack of finger, facial, or eye contact between mother and baby when first presented.

B. Verbal expressions of pity or dissatisfaction.

C. Apparent distaste or profound rejection.

D. Failure to name the baby.

E. Baby reminds mother of disliked person.

F. Post-partum depression ("The third day blues").

G. Prematurity--especially in unwed mother (early separation).

III. STAGE OF INFANCY:

A. Apathy during history and especially during examination.

B. Use of negative terms: "slow" - "mean" - "bad" - "spoiled" - "miserable" - pitiful" - etc.

C. Description alien to physical findings:
   1. Either better or worse
   2. Unexpected change in grid patterns

D. Intuitive feeling that all is not well between parent and child.

*Introduce visiting PUBLIC HEALTH NURSE services for follow-up care while mother is still in hospital. (Whenever Social Services are involved, include Protective Services.)

PROCEDURE OUTLINE FOR SUSPECTED SEXUAL ASSAULT

Unfortunately, the sexually abused continues to suffer secondary emotional trauma that may supersede the initial tragic experience. Extreme care in the handling is indicated--each case on its own merit--but always with gentleness and kindness, keeping the child's own interest uppermost in mind.

The following "MINIMAL CONSIDERATIONS" are outlined:

I. Carefully documented history including time, place, and circumstances of the alleged assault (obtain from adult and child separately).

II. Observation and description of general appearance, clothing, and emotional state of the child and her/his parents.

   A. Save all clothing removed.*

III. Thorough examination with special attention to external genitalia, vagina, and anal region for signs of trauma and for secretions.

   A. Describe all marks of violence using drawings and measurements.

   B. If not bleeding, speculum exam not necessarily required.

IV. Obtain the following diagnostic tests: (may use sterile swabs without speculum). Medico-legally, all tests must be delivered personally to the pathologist, and all containers and slides dated and initialed preferably with a glass marker.

   A. Smears from endocervical region for
      1. Gram stain, Thayer-Martin, and blood agar cultures for gonococcus.
      2. Wet smears (may use saline lavage aspirate) and gram stain for Spermatozoa.
         a. Only valid within 24 hours of alleged attack.

   B. Samples of suspicious secretions (or saline lavage aspirate) for quantitative acid phosphatase testing.
      *1. "Squares" of suspicious clothing stains should be soaked in normal saline and tested for acid phosphatase and for blood groups substances (?assailant's).

   C. Urinalysis for pregnancy test in menarchial.

   D. Two cc. of blood for VDRL - must repeat in 6-8 weeks.

V. Report to appropriate authority as mandated.

   A. Place in protective environment if necessary. (A must if incest suspected.)

   B. Involve "SCAN" Committee** immediately.

VI. Treat all injuries as found.

   A. Calm and reassure patient - prescribe tranquilizers if needed.

   B. Rx. appropriately for V.D. as indicated (risk: 3-4%).

   C. If menarchial, start drug management to prevent possible pregnancy (risk: less than 1% - use hormone withdrawal Rx.)

** See page 17.

VII. Utilize Social Service, Psychiatric, and/or Physician follow-up with gentle consideration for the child's total welfare.

VIII. May need crisis intervention for hysterical parents, over-zealous police, and/or over-reactive physicians.

Current concepts being applied in recognition, prevention, and rehabilitation should be directed at the abuser as well as the abused. I suggest the term: "K.P. PROGRAMS" ("K" for kids; "P" for parents) be utilized to best describe that the aims and directions intended should reach both.

"K.P. PROGRAMS"

1. SCAN (Suspected Child Abuse and Neglect) Committees: Hospital-based consulting teams composed of a knowledgeable pediatrician, Protective Services worker, and a coordinator with other disciplines available for consultation as indicated. An important must for every community and/or hospital.

2. Hot Line: 24-hour crisis phone providing "Friend" for help and referral.

3. Parent Aides: Lay workers as noncritical friend and "lifeline."

4. Visiting P.H. Nurse Services: Emphasis on prevention and rehabilitation.

5. Crisis Nurseries & Day Care Centers: Children can be left during periods of stress.

6. Special Co-Op Nursery Schools: Structured nonpressured learning experience for mother and child.

7. "Parents Anonymous" or "Mothers Anonymous": Similar to A.A. but regarding abuse understanding and intervention.

8. Foster Grandparents: To cuddle hospitalized kids, especially the neglected and abused.

9. Homemaker Services: Friendly help to relieve stress, and teach home and child care.

10. Selected Foster Homes: Stable, warm, consistent, and loving substitute family care when needed.

11. Community Mental Health: Facilities available for diagnosis and treatment.

(Above programs suggested by the National Training Center for Prevention & Treatment of Child Abuse & Neglect in Denver.)

An interdisciplinary approach with open communication and cooperation among ALL of each community's assets is mandatory. I propose that each of us (individually and collectively) become knowledgeable and involved in Child Abuse (or utilize available consultants when in doubt.)

SUGGESTED READING:

"The Battered Child," Drs. Henry Kempe & Ray Helfer: University of Chicago Press, 1968. Second edition - April 1974.

"Helping the Battered Child and His Family," Drs. Kempe & Helfer: Lippincott, 1972.

"Somewhere a Child is Crying," Dr. V. J. Fontana: MacMillian Co., New York, 1973

or write for numerous excellent pamphlets on abuse (particularly sexual), legislation, and protective services from the

Children's Division; The American Humane Association
P. O. Box 1266; Denver, Colorado 80201

Finally--as an aid in remembering and understanding the dynamics of abuse, the following "RECIPE" may be of help:

If considered, all of the underlined ingredients will be present in Child Abuse.

RECIPE FOR CHILD ABUSE

INGREDIENTS:

Take one ADULT - (Capable of abusing)
Add one CHILD - (Capable of being abused)
Slowly stir in repeated dollops of FRUSTRATION,
place in ISOLATION of considerable degree until volatile-
at last minute,
Add one CRISIS - (May use several, if small)

PRODUCES:

IMMEDIATE CHILD ABUSE OF VARIABLE TYPE AND INTENSITY DEPENDING UPON VOLATILITY OF INGREDIENTS.

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Note: Future changes in the law may affect portions of this booklet which was prepared in July, 1974.

END