MEDICINE

SOME THOUGHTS ON CHILD NEGLECT

—by Howard Dubowitz

Editor's Comments

—by Martin Finkel

In an effort to prevent the neglect of neglect, Howard Dubowitz, MD, Assistant Professor in the Department of Pediatrics at the University of Maryland School of Medicine, raises provocative and insightful questions about this widespread phenomenon. He challenges practitioners to ascertain whether or not neglect has occurred or potentially could have occurred in any given set of circumstances. Dr Dubowitz illustrates that validating this complex form of maltreatment requires considerable skill.

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A majority of reports of child maltreatment and about half of the fatalities due to child maltreatment involve child neglect (1,2). Despite its apparent importance, neglect has been largely ignored in favor of abuse, and its definition and assessment remain matters of considerable confusion. The neglect of neglect is not altogether surprising, given that neglect is inherently quite abstract and little research has addressed the issue (3). Although a coherent definition of neglect would certainly aid our efforts to protect children, many complex factors impede efforts to formulate such a definition.

In any society, the definition of child neglect rests upon agreed-upon values concerning adequate, not optimal, care. Parents who do not provide at least a minimum threshold of care are deemed neglectful.

However, in the pluralistic United States, many views regarding the appropriate care of a child coexist. For example, some families would not consider leaving their four-year-old in the care of a ten-year-old for a few hours in the afternoon, whereas their neighbors do it routinely. Some parents might religiously follow the American Academy of Pediatrics's guidelines for periodic check-ups while the people down the block don't even know they exist.

In addition to myriad individual differences, some differences in viewpoint are systematic, based on cultural or religious practices. In a recent case in Boston, for example, a child died needlessly because his parents, who were Christian Scientists, allowed only prayer-based treatment for a bowel obstruction. To call such action child neglect is to impose the will of the majority on the minority. Should we do that?

Questions about what constitutes neglect are complicated by the fact that child neglect is such a heterogeneous phenomenon. A number of typologies of neglect include categories pertaining to physical and mental health, child supervision and custody, hygiene, nutrition, housing hazards and sanitation, and education (6).

Definition is further complicated because much neglect does not inhere in specific behaviors. Whether a behavior is neglectful or not depends in part on the child's age and developmental level: newborns and adolescents have very different minimal needs. Too, different professionals and agencies use differing definitions of child neglect to serve specific purposes (2,6). Such differing perspectives and agendas make establishing standards of adequate care difficult.

Nevertheless, Polansky found that considerable agreement on child neglect does exist among subjects representing rural and urban living and a range of socioeconomic status (4,5). For example, most people agreed that leaving an infant alone in a bathtub is negligent. Consensus also seems to be that neglect occurs when important needs of the child are not met due to acts of omission by the caretaker which result in actual or potential harm to the child. Those areas in which a substantial consensus exists among both lay people and professionals provide a useful foundation on which to build a working definition, a definition flexible enough to allow for varied approaches, yet clear enough to provide a useful conceptual scheme for guiding assessments and research, and shaping interventions and public policy.

One question on which consensus seems to be growing is whether harm to the child is a necessary criterion of neglect. Most state laws recognize either actual harm (e.g., failure to thrive) or potential harm (e.g., the probable sequelae of not attending school). To restrict neglect to instances where actual harm has occurred would exclude many neglectful situations in which harm is not obvious but might be apparent in the long-term. In addition, the criterion of potential harm (endangerment) allows for preventive intervention.

Other important points in most definitions of neglect are the frequency and duration of a neglectful behavior. A child who is occasionally filthy is in a very different situation from a child who is continually filthy. Sometimes, a single lapse in supervision places the child at risk for significant harm, or causes actual harm. Leaving an infant alone in a bathtub is a good example. Even if a terrible outcome ensues, this would probably be seen as tragic—an occasional lapse being only human—and not neglectful. Generally, neglect would be inferred if a pattern of behavior is established that is inappropriate for given circumstances. For a child struggling to breathe, a few hours' delay in seeking health care might be considered neglectful; for a school-aged truant, days or weeks of failing to ensure that the child goes to school might be needed to qualify as neglect.

Substantial agreement exists as well on the question of whether parents are responsible when they have delegated their child's care to another person who is then neglectful or abusive. In most working definitions, parental responsibility hinges on what efforts have reasonably been made to ensure the adequate care of the child. If reasonable measures have been taken, the parent can't fairly be considered neglectful. In addition, although the parents have primary responsibility for the child's care, the caretaker who accepts temporary responsibility for a child also has an obligation, sometimes legal, to provide adequate care.

The issue of reasonable efforts raises questions about the parents' ability to protect their children. The role of poverty in child maltreatment has been controversial (7). Although poverty *per se* is not the cause of maltreatment, a strong association exists between poverty and neglect. Within a sample of impoverished families, neglect was associated with the most desperate poverty (8). Most poor families do not neglect their children; nevertheless, the burdens and stresses of poverty can compromise the nurturant abilities of parents.

One type of neglect that differentially affects impoverished families concerns safety hazards in the home. Parents who are grateful to have an apartment might not be able to fix, or get fixed, the peeling lead paint or rickety bannister. Are they neglectful? Should homeless parents be found neglectful for failing to provide adequate shelter for their children? What if a mother with post-partum depression inadequately responds to her infant's hunger cues, or a first-time mother incorrectly mixes her infant's formula?

From the child's viewpoint, crucial needs are not being met. But the question is, who is neglectful? Sometimes it's not meaningfully the parents' responsibility, but that of landlords, governments, and the society at large. If a city lacks decent low-income housing or pre-partum and post-partum care and education for impoverished mothers, labelling the consequences parental neglect seems unfair if not cruel. Our awareness of underlying causes should shape intelligently helpful and not punitive responses.

The heterogeneity of neglect requires various approaches and interventions that take into account both important needs of children and reasonable expectations of parents. Research is needed to refine our understanding of what factors contribute to child neglect, what child outcomes are associated with certain parental behaviors,

Continued on next page

MEDICINE

MEDICAL SIGNS WHICH MAY MIMIC SEXUAL ABUSE

—by Jan Bays

Editor's Comments

—by Martin Finkel

Dr. Bays and her colleague, Dr. Jenny, in this article bring to light the spectrum of anogenital complaints which to the untrained eye might be misconstrued as due to sexual abuse. In light of the seriousness of the allegation of possible sexual abuse, it is appropriate for all disciplines to be aware of those medical problems that raise false suspicion of sexual abuse.

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Between ten and twenty-five percent of children are sexually abused. Not surprisingly, physicians are increasingly asked to examine children for physical signs of possible sexual abuse. A diagnosis of sexual abuse has serious consequences for the child, family, and suspected offender. Physicians should be familiar with conditions causing physical signs in the genital and anal areas which might be confused with the physical findings due to child sexual abuse. *The Color Atlas of Child Sexual Abuse* (see references) is a helpful resource, presenting color picture of normal anatomical findings, findings due to abuse, and findings that commonly result from nonsexual or indeterminate etiology. In an article to be published in *American Journal of Diseases of Children* (v.144, 1990), Carol Jenny and I review the existing literature on such conditions and present representative cases from our clinical practice at sexual assault centers in the Pacific Northwest. Six general categories of conditions are discussed in the article: dermatologic, traumatic, congenital, anal, urethral, and infectious. This newsletter article is a condensation of the journal article.

Dermatologic. Dermatologic conditions range from the common, such as genital redness due to bubble bath or yeast diaper rash, to the uncommon, such as a disease called *lichen sclerosis*, which can cause bleeding in the genital area from such mild trauma as wiping with toilet paper.

Traumatic. Marks which mimic bruises can be caused by the juice from plants like limes, figs or celery contacting the skin prior to sun exposure. One child was reported for possible abuse when an adult who had been squeezing limes at a tequila party grabbed the child's arm, leaving a hand print in lime juice, which developed into a dark "bruise" after sun exposure.

Labial fusion is a common finding in nonabused girls who are still in diapers, but may indicate abuse if seen in an older girl.

Straddle injuries are usually easy to diagnose as they involve a dramatic and acute history, and involve injuries which are usually unilateral, anterior, and external.

Masturbation is not reported to cause genital injuries except in children who self-mutilate, are severely developmentally delayed, or have been abused.

Congenital. Congenital conditions include red birthmarks on the genitalia and a variety of midline structures such as tags, pits, epispadius and failure of midline fusion.

Anal. A number of anal conditions may raise concerns about possible abuse. Anal changes mimicking abuse can be caused by Crohn's disease, hemolytic uremic syndrome, *lichen sclerosis*, and neurogenic *patulous anus*. Perianal streptococcal cellulitis is an infection which can cause a painful perianal rash and bleeding.

Urethral. Bleeding and pain with urination can be caused by urethral prolapse, polyps, hemangiomas, and carbuncles.

Infectious. Sexually transmitted infections like genital warts and Chlamydia in children out of infancy should raise concerns about abuse. An infant, however, may be infected at birth but not show symptoms for several months.

Conclusion

A physician who discovers a condition which may be due to sexual abuse should take a complete medical history to rule out other diagnoses. The child may be interviewed alone to ask about touching in her "private parts." Different examination positions and manipulative techniques should be used to determine that the exam is truly abnormal (Bays, J., et al., 1990). Referral for a second exam and an in-depth interview by trained experts may be appropriate.

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DUBOWITZ *(Continued from page 4)*

and what interventions are effective for different types of neglectful situations. To address adequately the complex and widespread problem of child neglect, professionals, communities, and governments must share responsibility with parents.

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HART *(Continued from page 3)*

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