Selected Multicultural Guidelines

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Fear of caretaker or home environment

A child afraid of returning home or afraid of parental notification may be less concerned about possible retaliation from the parent and more worried about shaming the parent. Many ethnic groups have a historic distrust of outside authority figures that may be apparent in a child interviewed in a school environment. Fear of a caretaker may be a sign of physical or psychological abuse; children who are sexually abused, however, often feel a kind of closeness or bond with the abusing caretaker, and thus will not show fear.

Many ethnic groups have a historic distrust of outside authority figures that may be apparent in a child interviewed in a school environment.

A child normally considered at risk in dominant culture families with the mother's boyfriend present may not be at risk in certain Native American groups. In such groups, children may be readily accepted by the mother's boyfriend or nonbiological father—many Native American men do not deny paternity (Horejsi, 1987).

Conclusion

This is a brief example of how multicultural factors can be taken into account when assessing particular risk factors. While the complexity of these influences and the difficulty of establishing their existence on a reliable, measurable basis are daunting, the historic and current effects of institutional racism and the dynamics introduced by differing levels of acculturation and assimilation make it imperative for CPS professionals to consider multicultural issues when assessing the risk of child maltreatment in families.

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ASSESSING RISK FACTORS FOR CHILD ABUSE: GUIDANCE FOR MEDICAL AND NURSING PROFESSIONALS

—by Peter Stringham and Paula McNabb-Ippolitto

As mandated reporters of child abuse and neglect, physicians, nurses, and other health care providers are key in identifying and assessing the risk of maltreatment. They might see a child before, during, and after child protective services (CPS) involvement, thus providing a vital link in efforts to protect children.

Like most medical practitioners, we don't make use of formal risk assessment instruments (RAIs) in our practice. Still, faced with the need to determine whether children are at risk in a clinical context, we have become aware of many of the risk factors associated with child abuse, including, among others, whether a child is disabled, blind, chronically sick, or hyperactive; whether the family has experienced financial stress, alcoholism within the immediate family, divorce, or social isolation; and whether the parent is a teenager, is mentally ill, has had previous children removed from home by state agencies, or has a personal history of violent behavior (Vandeven & Newberger, 1994; Cicchetti & Carlson, 1989; English & Pecora, 1994; Newberger, 1990).

Yet child abuse practitioners agree that the vast majority of parents with some or even many of these risk factors do not abuse their children. One intensive study showed that the predictive accuracy of risk factors for child abuse was only 30% to 48% (Strauss, Gelles, & Steinmetz, 1980); thus, most checklist diagnoses would mislabel 52% to 70% of certain families as "at risk for child abuse."

We have worked in the pediatric department of a busy inner-city neighborhood health center for over 20 years as a doctor-nurse practitioner team delivering pediatric care to a working-class and lower-class neighborhood. About one-third of the families in the practice live below the poverty level, and many have experienced several or many of the previously identified risk factors. A very small proportion abuse their children.

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We realize that even as extremely experienced clinicians, we cannot identify which parents will end up abusing their children physically or emotionally merely by knowing their risk factors. We use three tools to help clarify who may be at risk: As part of every routine visit we 1) observe the parent-child interaction; 2) ask standardized, age-appropriate questions in a direct, supportive way, trying to form a therapeutic alliance; and 3) observe whether the clinician-parent alliance created in this manner remains intact. If the parents repeatedly demonstrate that they are frustrated by their child's behavior; if they answer questions in worrying ways; and if, despite our best efforts, the attempt to establish a connection between the parent(s) and clinician is going poorly, we consider the child to be at risk and think about an outside intervention. Obviously, this decision is not based on rigorous scientific evidence; rather, it is based on experience and observation of families' behaviors and responses in a clinical setting.

Table 1: BEHAVIOR CATEGORIES

Great Worry	Some Worry	No Worry
Poor eye contact with infant at each visit	Poor eye contact some visits	Good eye contact
Rough handling of infant	Careless handling of infant	Caring handling of infant
Child's clothes inappropriate for weather and very poor hygiene	Some inappropriate dress for weather and some poor hygiene	Appropriate clothes to weather; fair to adequate hygiene
Screaming and swearing at child in office	Some yelling at child office	Warm limit setting by parents
Primary caretaker obviously "high" and impaired in office	Alcohol or drug behavior in one parent	No current drug or alcohol behavior
Hitting child viciously in office	Slapping child in office	Warm limit setting by parents
Unexplained injuries	Many accidental injuries	Few injuries
Evidence of sexual abuse		No evidence of molesting
Very abnormal child behavior, including sexual behavior	Unexplained child depression or acting out behavior	Fairly normal range of child behavior disorders
Child takes all behavior cues from parent or seems fearfully obedient	Child is extremely obedient	Normal amount of obedience without fearfulness
Parent acting "crazy" with hostility toward child	Parent acting "crazy" with warmth toward child	Parents have mentally healthy attitude toward child

Direct observations

One observation may not mean anything. A sleep-deprived mother may seem poorly attached to her child on one visit and very warm when she has had more sleep. Many behaviors need to be taken into account. The way we categorize certain behaviors is shown in Table 1.

Routine questions for each age for all families

We ask all questions in a warm, direct, and supportive manner to ensure that a therapeutic connection is established and maintained. We ask these additional questions of all families at comprehensive health visits, not just to assess for abuse but to determine the issues with which the family wants help.

Some questions we ask the parent(s) of newborn babies are (see Table 2):

- Who lives at home? Who is around to help you with the child? How will they help?
- (As part of family history) Has anyone in the family had trouble with alcohol or other drugs?
- (When father is not present) How do you and the baby's father get along? Everyone argues sometimes. How often would you have a yelling or screaming fight? How about a pushing or shoving fight (if any)? Tell me about the last one. Tell me about the worst one. Ever injured? Ever beat up? Ever threatened with a weapon? Are you afraid now? Do you know what to do if you feel afraid?
- What do you do that you really enjoy? How do you relax?
- Is there a gun in the house? (If yes) What is it for? Is it loaded? Locked up?
- (An open-ended question to test for parental expectations) What kind of personality do you think this child has?

Table 2: BEHAVIOR CATEGORIES: PARENT(S) OF NEWBORNS

Great Worry	Some Worry	No Worry
No social supports for mother	Few social supports for mother	Good social supports for mother
Admits to severe trouble in recent past but strongly denies current parental abuse of alcohol or other drugs and states that no program is needed to help them with this problem	Past history of parental alcohol and other drug abuse but parents involved with self-help program	No parental alcohol or other drug abuse
Abuse of mother by baby's father or her current boyfriend	No abuse or coercion of mother, but much conflict in parents' relationship	No coercion and good relationship between parents
Parents cannot identify anything that they enjoy or that helps them relax	Parents have few or inaccessible ways to enjoy themselves or relax	Parents have many accessible ways to enjoy themselves and relax
Loaded unlocked gun in home. Not able to see that child might be at risk		No gun in home, or locked unloaded gun in home
Very negative description of new infant's personality	Vague response to question of child's personality	Warm, positive description of infant's personality

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Routine questions for parent(s) of infants ten months through three years old (see Table 3):

These questions have been designed to be appropriate to this age group and so differ slightly from the questions directed to parents of newborns:

- How do the people in the house get along? How do they treat each other?
- Are there any major family stresses?
- How often are you getting out and enjoying yourself? What are you doing?
- How do you correct this child when she bites or hits? (choose an age-appropriate transgression)
- How do other people who discipline this child correct him?
- What helps this child calm down if she is upset?
- What kind of television does your child like?
- If you had to describe her personality to a relative who did not know him how would you describe him?

Routine questions for an older child and his or her parents

Questions move from the parent toward the child as the age increases. Here are some questions that we ask the parent(s) of older children (see Table 4):

- How is everyone in the household getting along? (Assess for coercion if necessary, with child out of the room.) Any major stress? (Follow up on previously identified problems.)
- What do you do as a parent to enjoy yourself? When are you the most happy?
- How does this child play with other children? Any fights with them? Does he have close friends? How does this child get out of a fight if another child wants to fight with him? What have you told him about fighting?
- Any gun in the house? (As before but the child spends time home alone.)
- How do you correct this child when he makes a mistake? How do you discipline him?

Some questions we ask the child directly are (see Table 5):

- How is school going? (If there are school problems find the cause.)
- Tell me about your best friends.
- What do you really enjoy doing? What about you are you the most proud of?
- What makes you a good brother or sister?
- What do you like to watch on television?
- How do you get out of a fight?
- Has anyone ever touched your body in a way you didn't like? (This is an assessment for sexual abuse.)

Table 3: BEHAVIOR CATEGORIES: PARENT(S) OF INFANTS

Great Worry	Some Worry	No Worry
People in house treat each other aggressively	Some meanness of people in house toward mother	People in house treat each other well
Major family stresses that overwhelm parents	Some stresses	No major stresses other than the stresses of child rearing
Primary caretaker does not get out and feels trapped—not able to relax	Primary caretaker does not get out enough	Primary caretaker gets out enough and is able to relax
Very harsh discipline advocated and frequently but inconsistently enforced	Harsh discipline but consistently dealt out, or warm but inconsistent discipline	Warm consistent discipline—talking to child, using time out
Other caretakers use harsh inconsistent discipline	Other caretakers use inconsistent discipline	Other caretakers use warm consistent discipline and follow the same rules as the parents
Parents can find no strategy to calm down upset child	Parents find strategy that sometimes can work	Parents find several ways to help child calm himself down when upset
Exposure to 'slasher' movies and very violent television	Large amount of exposure to violent television	Large or small exposure to mainstream television
Negative description of child's personality	Neutral or mildly negative description of child's personality	Positive description of child's personality

Table 4: BEHAVIOR CATEGORIES: PARENT(S) OF OLDER CHILDREN

Great Worry	Some Worry	No Worry
Parental coercion, abuse or major family stress	Moderate parental feeling of being overwhelmed	Normal feelings of being overwhelmed
No methods for parent to relax and feel enjoyment other than thrill seeking or substance abuse	Some ability to relax	Parent able to relax and enjoy self sometimes
Few friends—violent fights with friends—parents encourage this behavior	Some friends—some fights or parents encourage fighting	Friends—few fights—parents don't encourage fights
Parents cannot see danger of keeping loaded gun around child when the child seems very angry, impulsive, or depressed	Very active impulsive child, depressed child, or angry child in home with loaded gun "put up high," or unloaded gun and bullets stored unlocked close together	No gun in house or locked, unloaded guns in house
Harsh discipline that lacks all warmth delivered in an inconsistent manner	Compassionate but very inconsistent discipline, or harsh discipline dealt out frequently with many rules	Warm consistent discipline

Parent-clinician interaction

All of us have seen families with many of the problems noted in the "great worry" category, but if the parents

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themselves are worried about the problems and are willing to work on them for the betterment of their children, we are much less concerned that their children will be abused. Greater worry about future child abuse may be warranted when parents in trouble refuse to participate in plans to relieve family difficulties. If neither a helping professional nor a helping community member can make an alliance or connection with a troubled family, the parents may be making their own family decisions in isolation—and could end up abusing their children in their frustration (see Table 6).

Table 5: BEHAVIOR CATEGORIES: OLDER CHILDREN

Great Worry	Some Worry	No Worry
Teachers worried about poor attendance, acting out behavior, and school failure	Single problem of poor attendance, acting out, or school failure	Usual school problems
Antisocial group of friends or no friends	Consistently reports only acquaintances	Friends
Child identifies nothing that he enjoys—or identifies sadistic activities or thrill-seeking activities—identifies few things of which he can be proud	Child identifies only thrill-seeking activities--identifies a variety of activities that cause enjoyment and pride	
Not able to see self as a giving sibling		Able to identify good qualities as a sibling
Child enjoys horror movies—watches a lot of "action" television	Child watches a lot of violent television	Moderate exposure to media violence
Child seems shocked that anyone would think of not fighting to solve a conflict	Child only knows violent strategies for getting out of fights	Child can talk to and calm down someone who wants to fight
Child states he was sexually touched	Child seems embarrassed and will not say if he was touched in any way	Calmly denies ever being touched in any way or complains of minor hits by friends

We strongly advocate that pediatric practitioners attempt to form therapeutic alliances by emotionally connecting with the families under their care. The parents have a level of expertise and direct knowledge of their children and circumstances; the professionals have theoretical and practical knowledge about things that can help families raise children well. Parents and pediatric caregivers should be able to establish a therapeutic alliance despite any kind of family trouble. If one caregiver cannot make the connection, another can try.

If we are unable to make a connection, and the parents refuse to work with anyone to improve obvious problems, then we worry about abuse and neglect.

An assumption of the presence or absence of child abuse in a family based only on a list of risk factors is likely to be erroneous. We advocate a series of rapport-building interviews at all routine medical visits. When we note worrying behaviors and worrying responses to our questions, and are unable to form a connection with parents, we consider a child to be vulnerable to child abuse and start an intervention. We discuss the family's needs and our concerns with a multidisciplinary team; together we determine how to evaluate and treat a troubled family through social casework, therapy, health services, family referral to CPS interventions, substitute care, battered women's services, and referral to state agencies (Newberger, 1982).

The way we evaluate the risk of child abuse in particular families under our care is not supported by scientific data; most pediatric practitioners' child abuse risk assessment methods are not. Through our years of confronting these issues on a daily basis, however, trial and error have led us to the method illustrated here for assessing the risk of child abuse and neglect in families. The use of these interviewing techniques to

Table 6: BEHAVIOR CATEGORIES: PARENT-CLINICIAN INTERACTION

Great Worry	Some Worry	No Worry
Frequent missed appointments despite convenient time and parent reminder	Some missed appointments despite convenient time and reminder to patient	Few missed appointments
Frequent changes of medical caregivers	Seeking medical care distant from neighborhood that physician knows	Consistent caregivers in neighborhood
Parents have reason for rejecting all plans designed to help family and can think of no alternative solutions themselves	Parent rejects some plans without a good reason	Parents able to adapt plan for their particular needs
Facile agreement with every suggestion, but lack of follow-through	Some poor follow-through for major medical or emotional problems in family	Fairly good follow-through on major medical and emotional problems in family
Refusal to allow any professional into the home	Refusal to allow some reasonable professionals into the home	No refusal of professionals or reasonable refusal of professionals who don't make a connection with parents
Inability of all staff to feel a connection to the parent	Inability of most staff to feel a connection to the parent	Ability of most staff to feel a connection with the parent
Feeling by concerned staff that parent is almost always lying to them	Feeling that sometimes parent is lying to them	No feeling that parents are lying
Parents frequently attack and bully medical staff—particularly nonprofessional office staff	Some inappropriate outbursts toward medical staff	No outbursts; justifiable arguments with medical staff

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establish an alliance with parents has proven effective in our practice.

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Introduction

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development of vocabulary and typologies by those who study and write in the field can make a major contribution.

The articles in this volume summarize the current status of implementation nationally and address many of the questions that arise in agency policy and practice.

Louis Cicchinelli reviews the hopes for risk assessment, current applications of risk assessment methodologies, and implementation of risk assessment tools nationwide. He describes their use in case prioritization, guidelines for investigation, and family assessment, noting the difference between empirically based (actuarial) models and models based on consensus. Cicchinelli notes that one of the most promising benefits for future practice is the development of a longitudinal database with respect to initial recorded risk elements and outcomes for the child.

Jill Korbin, Claudia Coulton, and Jennifer Furin suggest that neighborhood factors create a milieu that may impede or enhance a family's abilities to parent in a nonabusive, nonneglectful fashion. The authors define the concept of neighborhood and describe neighborhood risk factors that are consistently associated with maltreatment rates, such as impoverishment, child care burden, proximity to other high-poverty areas, and population instability. Multiple methods of risk assessment and a focus on outcome and context are recommended.

Deborah Daro raises the issue of how to ensure that prevention services reach those most in need of assistance, and notes that as resources become more limited, policy makers as well as the general public are looking for aggregate measures to indicate that early intervention can have a positive impact on costly social problems. Daro points out that the absence of RAIs with perfect predictive capabilities is a major reason for advocating the expansion of universal primary prevention, but suggests that other problems inherent in the universal care strategy can make it problematic. She presents Hawaii's Healthy Start program as a model for ensuring that care and support reach those most in need.

Thomas Curran reviews the legal issues in the use of risk assessment instruments. He cites the bases for actions against child welfare agencies and workers and illustrates how the limitations of risk assessment instruments in their current state of development and use make workers and agencies vulnerable to suit. Agencies have a responsibility to select instruments according to the latest scientific information in the field and to train workers thoroughly in their use and in the knowledge base that supports their application.

Wayne Holder and Therese Roe Lund describe how workers can use risk assessment information in outcome-oriented case management. The authors suggest that risk factors that are malleable can be used to identify successful outcomes. They introduce the process whereby risk can be translated to outcome and discuss outcome measurement. Using this foundation they walk through a case study to illustrate the application of case management to targeting and achieving desired outcomes.

Peter Pecora, Diana English, and Vanessa Hodges offer selected multicultural guidelines for risk assessment. They summarize some of the multicultural issues that must be considered when assessing the risk of child maltreatment. These guidelines are organized by child characteristics, severity of child abuse or neglect, caretaker characteristics, parent/child relationship, and social economic factors. Specific examples are given and implications for worker practice are addressed.

Peter Stringham and Paula McNabb-Ippolitto review their use of direct observation in the medical setting as well as their use of structured and semi-structured interviewing techniques. They stress the importance of establishing a relationship between clinician and parent to help determine the parents' ability and willingness to protect the child. The authors provide an outline of questions that should be asked and indicators of problems in parental response to medical intervention. This operationalization of risk assessment for medical professionals based on the available literature is a good illustration of how the risk assessment knowledge base can be used to structure inquiries in cases that prompt a medical professional's concern.

Together, these articles offer fresh perspectives on the questions that trouble us in the field, illustrate concrete methods of implementation, and point the way to new directions in risk assessment.

TELL US WHAT YOU THINK

Members' ideas and comments are always welcome at the national office. Please call anytime and tell us what you're thinking, at 312-554-0166.