



## HOW TO ASSESS CHILDREN FOR NEGLIGENCE, ABUSE, AND SEXUAL ABUSE

Of all the situations that provoke sadness, fear, or anger in a clinician, none is as intense as an adult's hurting or degrading or molesting a child or leaving the child so unprotected that she becomes prey to someone else doing those things. Neglect, abuse, and sexual abuse can be unbearably painful to think about. However, even as we are wishing, hoping, and praying that such things never happen to another child, the law, and society, and our own consciences demand that we think about them, learn to recognize the *possibility* that they might be occurring and, when we have reason to be concerned, inform others about that concern.

It is especially important to think about and understand the meaning of the word emphasized in the paragraph above: that is, the *possibility* that neglect, abuse, or sexual abuse is taking place. Unless you work in an agency whose mandate is to make a determination about whether such behavior is occurring, your responsibility as a clinician is to raise your concerns with the appropriate person or agency and to provide all relevant documentation—*not to prove* that a child is being neglected, abused, or sexually abused.

Every state has its own law defining abuse and neglect, and every state has a system for reporting them. They also have their own designations of *who is required* to report. These desig-

nations may be based on professional training, licensure, job description, etc. Therefore, your first task is to clarify whether or not you are a *mandated reporter* of suspected child abuse. If you are a mandated reporter, that means there can be legal consequences for you if you *do not* report suspected abuse or neglect.

Whether you are a mandated reporter or not, your agency will undoubtedly have guidelines concerning the need to report suspected abuse and neglect. Your second task is to familiarize yourself with those guidelines and to talk with your supervisor about how they are implemented. Ask to see the forms which must be filled out and find out to what agency in your state such reports are made.

It is especially important in cases of suspected abuse or neglect that you do everything you possibly can to *avoid making a unilateral decision to report*. You should use the support and experience of those around you to guide you and to calm the inevitable anxieties that are raised by having to talk with parents or contact a child welfare agency. The obligation to inform another agency also carries with it a particularly powerful responsibility to be conscientious and deliberate in your information-gathering, since both a child's safety and the well-being of a family may be at risk.

The first purpose of this chapter therefore, is to help you make that conscientious and deliberate assessment so that you have garnered as much data as possible for your consultations with more experienced staff members. The second purpose is to provide both the tools and the confidence so that, should you find yourself in a situation where you believe that a child is at risk and you *truly* have no one else to advise you, you will act without hesitation to protect that child's safety.

The chapter will clarify the concepts of neglect and abuse

**REMEMBER**

- Find out if you are a mandated reporter of child abuse and neglect.

**HOW TO AVOID MAKING A  
UNILATERAL DECISION TO REPORT  
CHILD ABUSE OR NEGLECT**

1. Learn your agency's procedures regarding suspected abuse or neglect.
2. If possible, only schedule first interviews with children when a senior staff member is at your agency.
3. If #2 is not possible, see if a rotation of senior workers on call by telephone might be possible.
4. If #3 is not possible, ask for your supervisor's home telephone number and for clarification of the circumstances under which you should use it.
5. Ask for your agency director's home telephone number and for clarification of the circumstances under which you should use it.
6. When you think a child's safety is at risk, do not let feelings of embarrassment or feelings that you "shouldn't bother her at home" stand in the way of calling a senior staff member, your supervisor, or the director of your agency.

and discuss some of the ways in which they might become evident in a session. You will learn what to ask if such information does arise and how to assess the imminent risk to the child. In addition, this chapter addresses the three critical areas to think about routinely when seeing a child in order to evaluate the risk that this child is being either neglected or physically/sexually abused. These three areas are: *physical symptoms*, *behavioral signs*, and *caretaker characteristics*.

You will find a detailed list of physical symptoms, behavioral signs and caretaker characteristics at the end of the chapter. The reason for this list is not just to provide you with an easy reference but also to remind you that there are many clues to the possibility that a child is being hurt, some of which may not in and of themselves seem related to abuse or neglect. Therefore, it is important to familiarize yourself with the possible combina-

tions of signs, symptoms, and caretaker characteristics which could be indicators as well. The list is also intended to help you avoid jumping to conclusions. Especially when you are feeling anxious, you must resist the tendency to rush rather than soliciting all the information needed to make a conscientious decision.

So, keeping all those aspects in mind, let us first begin with a preliminary demarcation between neglect and abuse, bearing in mind, however, that definitions and language also vary from state to state. What is described here as neglect may be referred to in your laws as maltreatment or abuse; physical abuse may be called excessive corporal punishment. Broadly speaking, however, *neglect* can be defined as the parent or legally designated caretaker *not doing something for the child* that should have been done, whereas *abuse* can be conceptualized as the parent or legally designated caretaker *doing something to the child* that should not have been done.

It is perhaps confusing to note that both of these definitions involve action or inaction only by the parent or legally designated caretaker, since it is certainly true that someone other than a parent or caretaker might hurt a child and that you might become aware of such an incident and correctly assess that you have a responsibility to inform the appropriate agency.

For example, a man might physically or sexually abuse his girlfriend's child. Depending on the laws in your state and the nature of his action against the child, his behavior might be deemed by the courts to be assault, rape, sodomy, or some other charge. On the other hand, the mother who for whatever reason left her child unprotected from harm might be deemed neglectful because, as stated above, neglect implies the *absence* of some action that the parent should have taken, and it invariably arises out of inertia or a lack of something in caring for a child.

This lack manifests itself in five different identifiable forms of neglect, the first and seemingly most apparent of which is *physical neglect*. The operative word here (as it is with all five types of neglect) is *seemingly*, because trying to assess whether or not a situation is potentially neglectful can sometimes bring into play significant cultural and social differences, which can cloud one's judgment in making a sound assessment. For example, if an infant was brought to your office who was dirty, or

dressed in ragged or seasonally inappropriate clothing, or was unwashed, you might be repelled, angry, or convinced she was neglected. However, if the child were 12, her appearance might have a different meaning—just as it might if the family were newly arrived from a very different culture, or homeless, or of a particular religious persuasion, or refugees, or even just returned from a camping trip.

Therefore, in your assessment of any type of prospective neglect, it is important to ask yourself two questions: First, is the condition in which you find the child one which appears to have been going on *over a period of time*? In other words, do you have some information to suggest that this is the typical level of caretaking this child receives? Second, might it be *endangering the health or safety* of the child? If the answer is yes to either question, then you can feel more confident that what you are observing, hearing about, or feeling anxious about requires further evaluation.

Let us now return to the definition of physical neglect, since it involves more than assessing a child's appearance. Broadly speaking, physical neglect not only refers to inappropriate or insufficient clothing but can also be used to describe a situation involving inadequate shelter, sanitation, or food. Given the parameters described above—that is, length of time and risk to the child's health or safety—it should not be terribly difficult to know if the child's well-being is at risk.

If you feel concerned but aren't sure, then ask—not in an accusatory or inquisitorial way but in a way that transmits your concern both for the parent's wish to be a good parent and for the child's well-being. Ask the child or ask the parent, depending on which seems most appropriate and likely to give you the clearest sense of what is happening to the child. Ask when the child last ate, or had a bath, or had clean clothes. Ask where she lives and how many people live with her. Ask if she has a room. If not, ask if she has a bed, and if she does, how many people sleep in it. Ask what she had for breakfast, or who fed her. And, if the answers seem crucial, write them down.

The second kind of neglect about which you must be concerned is often directly related to the first—that is *medical neglect*. The most straightforward example of this would be a child who is not getting enough to eat and is suffering from malnutri-

tion, but there are many other examples as well, for instance: giving a child some dangerously inappropriate medication or remedy for a condition or illness; or not taking her for regular medical follow-up of a potentially serious condition; or any other absence of the provision of medical treatment without which the child might die or lose some essential bodily function.

The third area of concern is *educational neglect*, which means, quite simply, that the child is not going to school or being educated by some acceptable alternative system for reasons having to do with the need or condition of the caretaker, not of the child. For example, an alcoholic or depressed parent may be up all night and sleep during the day, making it impossible for the child to be brought to school on any consistent basis. Or a parent may routinely keep an older child at home as caretaker for a preschooler or an ill sibling.

Fourth is the neglect arising out of *inadequate supervision*. This refers to leaving a child alone or untended at an inappropriate age; exposing a child to dangerous circumstances, such as a surrogate caretaker who is mentally or physically unfit to protect the child; placing a child in situations where she may see or hear or participate in activities that are unsuitable, such as pornography or prostitution or the use of drugs; or simply the abandoning of a child.

Lastly, there is *emotional neglect*, in which a parent scapegoats a child, isolates the child from human contact for long periods of time, or humiliates the child. In addition, a parent might constantly threaten the child with dire consequences, subject her to some other form of mental duress, or just ignore her for long periods of time.

Those are the five ways that neglect can manifest itself and some examples of each. As you have no doubt realized by now, potentially neglectful situations can sometimes be precipitated by events over which the caretaker may have very little control. That reality poses a particularly thorny problem for the clinician.

In fact, homelessness, substance abuse, a death in the family, a job loss, mental illness or retardation, or many other circumstances may explain why a child is not being cared for properly. And all those extenuating circumstances may contribute to feelings of guilt and confusion on your part about whether or

not you have the right to add to this parent's burden by raising issues about a child's well-being. This is one of the reasons why it is especially important for you to share the information you have with your supervisor and the treatment team *as early as possible*, so that you will have their guidance in deciding what you must do to protect the child.

This is, of course, equally true in cases of possible *physical abuse*, which can be defined as an *intentional* rather than accidental causing of injury to a child. These injuries may include bruises, burns or bites, beatings, stabbings, broken limbs, or many other forms of physical injury. The injury itself may be apparent when you see a child, or it may be hidden. It may have been the result of one incident or an ongoing series of assaults. It may have happened yesterday or last month or last year.

You are going to have to tailor your inquiry about possible abuse according to many factors. For example, one child may be of an age where she can easily describe what has happened; another child's experience may emerge only as she plays with dolls or does a drawing. One child may tell you she is "accident prone," while another explains that she always wears long sleeves on Mondays because she stays at her father's house on the weekends.

And every child will have a very different understanding of the implications of what is happening to her. One might readily volunteer information about injuries and why, how, and under what circumstances her parent or parents punish her. Another might tell you what happened but just as quickly explain that it happened because she was bad, or didn't listen, or ate too much popcorn. Others may be suspicious, or guarded, or make up incongruous explanations for marks or bruises that you can see, or deny that they have any marks on their body that can't be seen, or simply become visibly frightened, silent, or tearful.

Just as you must learn to appreciate the myriad ways in which children will inform you that they are being physically abused, so, too, there is a wide range of knowledge and opinion among parents of what constitutes abusive behavior toward a child. These views can vary enormously according to cultural and ethnic values in the community. For example, what may appear to be excessive physical punishment of a child may be seen by the parent, as well as many in the subculture of that

parent, as appropriate discipline, without which the child would become unruly or disrespectful. And that parent may be completely unaware that such discipline might constitute child abuse in the broader culture.

At the other end of that spectrum are parents who are very much aware of what the law considers abusive behavior, or who have warned their child to lie about marks or injuries or suffer further punishment, and who know how and where on a child's body to inflict injury where it is least likely to be observed. In addition, parents may have had previous reports of suspected child abuse made against them; they may even have had this or some other child removed from the family after a previous finding of abuse by an agency designated to protect children.

Given this wide range of understanding on the part of parents of the meaning of their actions and your understanding of your responsibility to protect a child, you must use common sense while you are conducting an interview. Ask yourself how you can best acquire the information you need to be certain the child is safe, while making certain you are not doing anything that might further endanger a child about whom you may already have concerns.

Common sense and tact are equally necessary when assessing a child for possible *sexual abuse*, which, simply defined, refers to any use of a child for a sexual purpose. That purpose can range from fondling to oral, anal, or genital intercourse. It may have occurred once or many times. It can be perpetrated by a man or a woman. It can be perpetrated against a male child or a female child. The child can be 15 days old or 15 months old or 15 years old.

Regardless of the nature of the sexual interaction, the age of the child, the gender of the perpetrator, or the number of times the abuse took place, there are two essential facts about sexual abuse of children to keep in mind: First, sexual abuse of children occurs in every race, ethnic group, and economic class in society. In other words, *anyone* can sexually abuse a child. Second, the perpetrator is most likely to be someone the child knows—either a family member or a friend who is trusted enough to have access to the child.

Depending partly on a child's age and partly on the manner in which the perpetrator has involved the child in the abuse (that

is, threateningly or seductively), the child may reveal the fact that she is being sexually abused in various ways. For example, a young child may say something quite straightforward, like "Uncle Bobby put his pee-pee in me and it hurt," or play with two dolls in an overtly sexualized way and, when asked what the dolls are doing, simply tell you that they are "doing the thing like my babysitter does to me."

However, it is more likely, especially as children who are being sexually abused get older and the implication of what is happening to them become clearer, that they will experience shame and intense fear: fear of humiliation if the abuse is revealed; fear of being injured or killed; fear that they will be accused of betraying a loved one; fear of hurting a parent whom they believe is unaware of the abuse; fear of destroying the family. From the clinician's point of view the sum of all those fears is that in most cases it is extremely painful, even terrifying, for a child to reveal that she is being sexually abused.

All of the reasons to "keep the secret" can powerfully conspire against your asking the child—but you have to learn to ask anyway. If a child seems to know a lot more about sexual matters than makes sense for a child her age, then you need to ask in some simple, straightforward way, in language she can understand, where she learned all about that. If a child tells you that she doesn't like the way her babysitter touches her, then ask her to show you with two dolls how her babysitter touches her, or to point to the places on her body where the babysitter touches her. If an adolescent tells you that her mother's boyfriend is weird or her mother ought to get rid of the creep, you can ask what he says or does that makes her uncomfortable.

There are many ways to ask and, as you can see from the list at the end of the chapter, many indications of when it might be prudent to do so. So the question then becomes: If you ask a child about sexual abuse—or physical abuse—and she indicates that it is occurring, what do you do next?

The answer is that you try, without putting words in the child's mouth, to get some basic data, and you write it down. What is the *name* of the person who touched her or hurt her? Does that person *live* with the child? Is that person *at home* right now? *When* did, or does, the abuse occur? (For example, at night or when mommy is at work.) *Where* did the abuse take

**HOW TO REPORT SUSPECTED ABUSE  
OR NEGLECT**

- 1. Read over your notes from the session and underline or extract the material you need to report,**
- 2. Some states have special telephone numbers to be used by mandated reporters. Make sure you call the right number.**
- 3. Identify yourself by name and, if you are a mandated reporter, say so.**
- 4. Identify your agency by name, address and telephone number.**
- 5. Be prepared to give the following facts, if possible:**
  - (a) the child's name, age and date of birth**
  - (b) the parents' names**
  - (c) the names and ages of other children living in the household**
  - (d) the name of anyone else living in the household**
  - (e) the address and telephone number where the child who is the alleged victim lives**
  - (f) the parents' telephone numbers at work**
  - (g) the name of the alleged perpetrator**
  - (h) the alleged perpetrator's relationship to the child**
  - (i) the time and date when the alleged incident(s) occurred.**
  - (j) the place at which the alleged incident(s) occurred**
  - (k) a description of the alleged incident(s) as the child described them: e.g., the child reported that her father hit her approximately 10 times with an extension cord on the backs of her legs and on her face.**
  - (l) a description of any corroborating information: e.g., the child had seven thin red welts on the back of her knees and two marks on her right cheek.**
  - (m) some description, if the child told you, of what precipitated the incident: e.g., the child got a poor report card.**
- 6. Ask the person who is taking the report for his/her name.**
- 7. Ask for the number which is being assigned to the report.**

place? (For example, in my cousin's bed, or at my big sister's house.) *What* did the person hurt the child with? (For example, his fist, his mouth, an iron, a belt.) *How many times* has the abuse taken place? What was the *most recent occurrence*, including the date and approximate time of day, if the child can tell you? *Where on the child's body* was she hurt or touched? (The child can point to the places on her body and/or show you what she did to protect herself.) Does the child have any *marks or places that hurt right now*? And lastly, *whom* has the child told?

When you have that information, and while the child is still with you, inform your supervisor or some other member of the treatment team, so that the two of you can evaluate the information the child has given you. Based on that information, you and your supervisor together will do an *imminent risk assessment* before making a decision as to what to do next. That assessment will consist of evaluating a number of factors:

1. The recentness and nature of the abuse.
2. The age of the child and, therefore, the degree of dependency on an adult for protection.
3. The ease of access the alleged perpetrator has to the child.
4. The need of the child for immediate medical care or evaluation.
5. The capacity and reliability of the person who is responsible for protecting the child.
6. Any known previous history of abuse or neglect of this or some other child in the family.

Based on your joint evaluation of these factors, a decision will then be made as to how best to proceed in order to protect this child, including making a report to a child protection agency if that is necessary. When that is completed, next make sure you have met whatever obligations your agency has for documenting such an event and fulfill any tasks you are required by law to perform. When you have done all those things, you should feel reassured and satisfied that you have done everything *you* can to ensure that the child is safe.

**PHYSICAL SIGNS OF NEGLECT**

Physical signs of neglect are observable. A child may look:

- Dirty or dressed inappropriately
- Listless or tired
- In need of dental care, glasses, or medical treatment
- As if development, including speech, is delayed

**BEHAVIORAL SYMPTOMS OF NEGLECT**

A child may report that she:

- Is hungry
- Steals food for herself or other children
- Has never been to school or skips school
- Has no one to care for her at home
- Cannot stay awake

**MOST FREQUENT CHARACTERISTICS OF  
NEGLECTFUL CARETAKERS**

- The home is chaotic or disorganized.
- The caretaker is a substance abuser.
- The caretaker is socially isolated and lacks friends or family as sources of support.
- The caretaker demonstrates lack of interest or involvement in the child's hygiene, or safety, or emotional needs.
- The caretaker demonstrates a lack of interest or involvement in the child's medical needs.
- The caretaker exhibits a critical or demeaning attitude toward the child.
- The caretaker has a tendency to frighten or humiliate the child.
- The caretaker has a tendency to isolate the child from social or emotional nurturance.

### SIGNS OF PHYSICAL ABUSE

Signs of physical abuse may not always be observable. They may be on parts of the child's body which are not readily seen. Pay particular attention to injuries that seem incongruent with the description of how the child got them.

- Burns, especially matching burns on both ankles or hands that suggest the child may have been immersed in hot liquid; cigarette burns; burns in the shape of objects, such as steam irons or curling irons.
- Bruises and welts, especially on both sides of the face or body, since accidental injuries rarely leave symmetrical marks; bruises that suggest that a child has been grabbed with two hands; patterned bruises which indicate the shape of an object such as a belt buckle, hairbrush or extension cord.

(Bruises do not always look "black and blue." On darker skin they may look more like blotches, or shiny, or have a purplish cast. Bruises on lighter skin will appear purplish or yellow in successive stages of healing.)

- Bites
- Broken bones
- Injuries to the head or eyes

### BEHAVIORAL SYMPTOMS OF PHYSICAL ABUSE

- The child is socially withdrawn.
- The child has frequent fights with other children.
- The child is unusually passive or compliant.
- The child exhibits concern or anxiety when other children get hurt.
- The child is fearful or guarded when her parents are present.
- The child is fearful or guarded around other adults.
- The child is fearful of going home.
- The child covers injuries with clothing or makeup.
- The child has repeated accidents.
- The child engages in self-mutilating or self-destructive behavior.
- The child runs away.
- The child makes a suicide attempt.
- There are reports from teachers of frequent crying or of learning difficulties in which an identifiable learning problem has been ruled out.

### MOST FREQUENT CHARACTERISTICS OF ABUSIVE CARETAKERS

- The caretaker perceives the child as being responsible for the caretaker's well-being.
- The caretaker has unreasonable expectations of the child's capacities.
- The caretaker uses forms of discipline which do not match the child's age or the child's behavior.
- The child is described consistently as "bad," "irresponsible," or "different" from other children.
- The caretaker is a substance abuser.
- The caretaker was abused as a child.
- The caretaker is socially isolated from friends, family, and community resources.

*(continued)*

- The caretaker sees him/herself as unable to "keep control."
- The caretaker is in crisis due to the loss of a loved one, possible incarceration, job loss, etc.
- The caretaker is mentally ill.

### PHYSICAL SIGNS OF SEXUAL ABUSE

- Bed-wetting
- Indications or reports of pain, bruises, bleeding, or recurrent infections in the genitals or rectum, or recurrent urinary infections
- Indications or reports of pain, bruises, bleeding, or recurrent infections in the mouth
- Venereal disease in mouth, genitals, or rectum
- Sexually transmitted diseases in children who would not be expected to be sexually active
- Pre-teen or early teen pregnancy
- Recurrent vomiting or stomachaches

### BEHAVIORAL SYMPTOMS OF SEXUAL ABUSE

- The child is hypervigilant.
- The child has sleep disturbances.
- The child reports fear of a particular person or place.
- The child is preoccupied with her own or other children's genitals.
- The child attempts sexual interactions with other children.
- The child is unusually mature, knowledgeable or seductive sexually.
- The child exhibits sudden social withdrawal.
- The child is fearful or unwilling to expose her body in normal situations (e.g., changing into a bathing-suit or during a routine medical examination).
- The child exhibits infantile behavior or excessive withdrawal into fantasy.
- The child reports having no friends.
- The child exhibits oversexualized or seductive behavior with a caretaker.
- The child becomes involved in antisocial behavior, e.g., truancy, delinquency, running away, substance abuse, prostitution, or other sexual promiscuity.
- The child engages in self-mutilating behavior or suicide attempts.

### MOST FREQUENT CHARACTERISTICS OF SEXUALLY ABUSIVE CARETAKERS

All characteristics described as common in a family where physical abuse or neglect occurs would also apply in a family where a child is being sexually abused. In addition, the following characteristics are common.

- One caretaker who is passive and dependent, and one who is authoritarian
- A caretaker who is overly protective of a child
- A caretaker who is jealous of the child making an attachment to another person
- A caretaker who seems inappropriately seductive or who touches the child in what seem to be inappropriate ways
- One or both caretakers have experienced a history of physical or sexual abuse
- Marital or sexual conflict between caretakers
- Encouragement by a caretaker of the child's observing or participating in sexual acts with others, or in pornography or prostitution
- A caretaker who is physically or mentally ill