

Position Statement on Child Abuse and Neglect by Adults

This statement was proposed by the Committee on Family Violence and Sexual Abuse¹ of the Council on Children, Adolescents, and Their Families. It was approved by the Assembly of District Branches in May 1991 and by the Board of Trustees in June 1991.

Child abuse and neglect is a major public health problem. Although research, cultural, and forensic considerations have resulted in different definitions, the American Psychiatric Association (APA) maintains that child abuse and neglect exists whenever physical pain and injury, sexual exploitation, or psychological harm has been inflicted on a child by any adult; the problem is only magnified when that adult is responsible for the child's protection and nurturance.

The spectrum of abusive and neglectful experiences includes inadequate food, clothing, or shelter; deprivation of adequate emotional attention and support; inadequacy of protective supervision; infliction of physically painful and damaging injuries under the guise of punishment or discipline; denial of adequate education or health care; exposure to sexual overstimulation or exploitation or other sexually abusive experiences; infliction of personally denigrating and humiliating experiences; and isolation from contact or communication with others, especially those who are emotionally important. No child is invulnerable; every child is affected by such experiences.

Extensive clinical experience has demonstrated the destructive effects on both child victims and child witnesses of abuse and neglect. Child maltreatment contributes to the development of lifelong anxieties, disturbance of behavior, depression, suicidal behavior, substance abuse, and severe disturbances in personality formation. These disturbances may include social isolation, withdrawal, and alienation; antisocial, hostile, and destructive character disorders; disruption of the ability to form or to sustain loving, caring relationships with others; development of paraphilias, including child-abusive aberrations; and inability to adequately parent the next generation of children. Sexual abuse is also a risk factor for HIV infection.

APA therefore states the following:

1. The goals of psychiatric intervention must be, first, the protection of children and other family members from maltreatment and, second, the provision of relevant treatments for children and their families with the aim of reversing the psychological and physical sequelae of the maltreatment, improving the quality of parenting, and preserving the family unit whenever possible.

2. Psychiatrists need to be informed of the mandatory reporting requirements of all applicable laws. The reporting of maltreatment to the appropriate agency is the responsibility of any psychiatrist, treating either or both children and adults. Psychiatrists should have access to legal consultation, to APA, and to their district branches when they have questions about reporting responsibilities and procedures.

3. The needs of children for adequate protection from abuse and neglect and for adequate treatment or care in order to recover from the psychic trauma of victimization must supersede the support for the integrity, reintegration, or reunification of children's families.

4. Parental religious convictions should not stand in the way of providing children and adolescents with essential life-saving medical care, including such psychiatric care. Medical child neglect must be considered present if such care for children is refused by the parents.

5. Whenever alleged abuse or neglect of a child is of such magnitude as to warrant legal action, whether in a civil or a criminal court, it should be the obligation of that court to provide both independent advocacy for the child and psychiatric evaluations of the child and the child's primary caretaker(s) in order to guide the court regarding the protection of the child. These psychiatric evaluations should include recommendations to the court regarding the child's participation in legal proceedings; any need for psychiatric treatment for the child, for the perpetrator (parents or parent substitutes) of the child's alleged maltreatment, and for other family members; placement needs of the child; and/or the termination of parental rights.

6. While judicial action is frequently used to protect the victim and other children and to re-empower the traumatized victim, judicial action in all cases should not further abuse and victimize the child.

7. While policies and procedures of courts and child protective agencies provide useful guidelines, the uniqueness of each child and family must be respected. Individualized assessment of each child's needs and individualized prescriptions for treatment and for delivery of supportive and therapeutic services must be designed and implemented to meet the particular needs of each child and each child's family. Treating psychiatrists and agencies receiving reports of child maltreatment must closely coordinate their work. This close coordination, with the permission of families in treatment, should include feedback to the treating psychiatrist regarding investigations, as well as the ongoing collaboration between psychiatrists and child protective service and law enforcement agencies. This collaboration will assure the safety of children and minimize family disruption and the disruption of treatment for victims and their families.

Furthermore, APA recommends the following:

Reporting laws and protective services. APA supports the efforts of public policy makers to protect children through the enactment of child abuse reporting laws and the development of civil child protective services and specialized child abuse and vice units in the criminal justice system. (Such legislation must include provisions for funding adequate individualized and comprehensive psychiatric assessment and treatment for the victimized child and for the child's family, including foster care when needed.)

Training. At a minimum, the curriculum for training regarding child abuse and neglect would facilitate greater awareness of all forms of domestic violence and their frequent coexistence within the same family; delineate the physician's role and responsibility in prevention, detection, reporting, treatment, and consultation to and collaboration with social service, judicial, and police agencies; and stress the individual and family dynamics of domestic violence in the teaching of diagnostic and intervention techniques for child victims, abusive and neglectful adults, and other members of these families.

Research. Research is vital for interrupting the intergenerational cycle of abuse. Such research necessarily includes biogenetic, neurophysiological, cognitive, and emotional sequelae of all aspects of child maltreatment and the effectiveness of intervention programs. (Such research must involve psychiatrists and must be supported by private and public agencies.)

The uniqueness of each child and family must be respected in designing programs for their protection and treatment. Policies and procedures of courts and child protective agencies should include mechanisms for individualized assessment of each child and each family, and supportive and therapeutic services must be tailored to the particular needs defined during these assessments.

¹ The members of the Committee on Family Violence and Sexual Abuse are Sandra Janet Kaplan, M.D. (chairperson), Marion Zucker Goldstein, M.D., Arthur H. Green, M.D., Elaine Carmen, M.D., Herschel D. Rosenzweig, M.D., Matilda Rice, M.D. (Assembly liaison), Mary Lystad, Ph.D., Howard Davidson (consultant), Christine B.L. Adams, M.D., Karen Taylor-Crawford (corresponding member), David Chadwick, M.D. (corresponding member), and Kathryn Jo Kotrla, M.D. (APA/Burroughs Wellcome Fellow).